STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0174 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Provide access to a telephone for resident to use in private.** Based on observation and interview, the facility failed to provide a place for 74 residents to make calls without being overheard. The phone that was set up for residents to use was located in a common area of the 200 hall near the nurses station. This phone had a cord and was attached to the wall jack. This failure could affect 74 residents quality of life by preventing them from having privacy when making phone calls to individuals and entities within and external to the facility. The findings were: In a confidential interview on 03/29/17 at 3:30 p.m., six Confidential Interviewees (CIs) said the telephone that was made available for residents to use was in a common area on the 200 hall across from the nurses station. The CIs said there was no privacy in making phone calls from the resident's phone because it was not a cordless phone and they could not take it to a place that would be more private. Observation of the resident's phone on 03/30/17 at 8:45 a.m. revealed it was located in the common area of the 200 hall and was attached to the wall jack with a cord. Five residents were sitting around the telephone in the common area. In an interview on 03/30/17 at 3:55 p.m., when asked where the telephone for the residents to use was located, Licensed Vocational Nurse (LVN) A and Nurse Practice Educator (NPE) B said the residents telephone was on the 200 hall in the common area across from the nurses station. Surveyor asked if residents on the 300 hall had access to a residents phone and LVN A and NPE B answered the 300 hall residents used the phone located in the 200 hall common area. The facility's Centers for Medicare and Medicaid Services Form 672 dated 03/28/17 documented a facility census of 74 residents.
F 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that three Residents, (R #1, R#4 and R#14), of 26 Residents reviewed for abuse and neglect, was free from neglect, in that: -The facility staff did not follow R #4's Physician order [REDACTED]. R#4's oxygen concentrator setting was observed at 2 and 2.5 LPM on three occasions on [DATE]-[DATE], and during transfer to the shower room when R #4 was provided with no oxygen. The facility did not ensure that R #14 wore her oxygen during ambulation, she became short of breath and she fell , fracturing her right hip and hitting her head. The facility did not follow R #14's Physician order [REDACTED]. R #14 expired on [DATE], in the facility. The facility did not ensure R #4's most current oxygen therapy order of continuous Oxygen at 3 liters per nasal cannula was accurate on her Treatment Administartion Record and the oxygen therapy was consistently monitored. The facility did not ensure the oxygen tubings were changed weekly, as per the facility's policy and oxygen concentrator filters remained clean for R #4, R #17, and R #19. The above failures resulted in an Immediate Jeopardy (IJ) situation on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a potential for more than actual harm with a scope identified as pattern. The facility was continuing to monitor to ensure continued implementation of their plan of removal. This failure could place 22 residents who required oxygen therapy at risk for shortness of breath and respiratory distress. -R #1's Stage 2 coccyx pressure ulcer discovered on [DATE], acquired in the facility, steadily worsened to an unstageable pressure ulcer by [DATE]. The facility did not provide R #1 with pressure relief (offloading) off her buttocks at least every two hours on two separate days. The facility did not ensure R #1 wore her Prevelon Boots (pressure relieving devices for the feet) as ordered. R #1 developed three separate Deep Tissue Injuries (DTI) on her left heel that the facility was not aware of, until the surveyor's injury. The facility's Assistant Director of Nurses (ADON) inaccurately identified R #1's DTI's as calluses and incorrectly measured each wound. The above failures resulted in an Immediate Jeopardy (IJ) situation on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at actual harm with a scope identified as pattern. The facility was continuing to monitor to ensure continued implementation of their plan of removal. These failures could affect four residents with pressure ulcers and 53 residents receiving preventative skin care and place them at risk for developing new pressure ulcers or a decline in existing pressure ulcers. The findings included: R #4: R #4's Face Sheet dated [DATE] documented a [AGE] year-old female admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. R #4's [DATE] Treatment Administration Record (TAR) documented O2 (Oxygen) via NC (nasal cannula) @ (at) 2LPM as needed for SOB. Start date: [DATE]. R #4's physician's orders [REDACTED].@ 3 LPM via NC continuously. R #4's Care Plan dated [DATE] documented (R #4) exhibits a risk for complications of infection related to increased risk of reoccurence of aspiration pneumonia .Approaches: .O2 as ordered. R #4's Significant Change MDS dated [DATE] documented R #4: -Rarely made self understood and rarely understood others. -Had short and long-term memory problems and had severely impaired cognitive skills for daily decision making. -Had an active [DIAGNOSES REDACTED]. -Received oxygen therapy while not a resident and while a resident at the facility. Observation of R #4 on [DATE] at 8:50 a.m. revealed R #4 was sleeping and was receiving O2 @ 2 LPM via NC. Observation of R #4 on [DATE] at 10:51 a.m. revealed R #4 was receiving O2 @ 2.5 LPM per NC. At 10:54 a.m., Licensed Vocational Nurse (LVN) I and Certified Nurse Aides H and J assisted to transfer R #4 from the bed to the Geriatric chair. During this time, CNA H removed R #4's nasal cannula, leaving R #4 without any oxygen administration. Both CNAs escorted R #4 to the shower room, without any oxygen therapy. At 11:33 a.m., R #4 was escorted back to her bedroom in the Geriatric

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) chair and transferred to bed with the assistance of LVN I and CNAs H and J. Once R #4 was in bed, LVN I replaced R #4's nasal cannula in R #4's nares at 11:45 a.m The oxygen concentrator was set at 2.5 LPM. -R #4 was not provided with oxygen therapy from 10:51 a.m.- 11:45 a.m. Observation of R #4 on [DATE] at 11:30 a.m. revealed R #4 was lying in bed receiving O2 @ 2.5 LMP via NC. LVN K entered the room and said R #4 had continuous O2 @ 3LPM ordered when asked how much oxygen R #4 should be receiving. Upon the surveyor's request, LVN K inspected R #4's oxygen concentrator and stated It is set at 2.5 liters, it should be at 3 liters. LVN K adjusted R #4's oxygen concentrator to 3 LPM and then checked R #4's oxygen saturation which was 92%. LVN K stated LVN I was currently R #4's nurse. Interview with LVN I on [DATE] at 11:35 a.m. revealed she stated R #4 was ordered to receive continuous O2 @3LPM via NC. LVN I was informed of R #4 only receiving O2 @ 2.5 LPM on [DATE] and [DATE]. At this time LVN K approached LVN I and the surveyor that R #4's concentrator was set at 2.5 LPM but was adjusted to 3LPM. LVN I verified she had not verified that R #4's oxygen concentrator was set at 3 liters. LVN I explained R #4 used to receive O2 at 2.5 LPM but her order was recently changed to 3 LPM. LVN I reviewed R #4's Treatment Administration Record and said It still say's 2 liters as needed, that's not right. After LVN I reviewed R #4's physician's orders [REDACTED]. The new order was not transcribed to the record, I will do it immediately. LVN I was informed of the surveyor's observation of R #4 not receiving any oxygen on [DATE] while being prepared and escorted to the shower room; LVN I verified she witnessed R #4 without any oxygen in the shower room then said R #4 should have had the oxygen since her order was to receive oxygen continuously. LVN I stated R #4 should have been provided with a portable oxygen tank. LVN I said she took responsibility for not ensuring R #4 had oxygen on and then said each nurse caring for R #4 was responsible to ensure R #4 received continuous oxygen. LVN I stated the procedure was that any nurse that received a new order, transcribed that order to the Medication Administration Record. LVN I said each nurse caring for R #4 should have referred to the Treatment Administration Record to document the prescribed treatment administered but that was not done. R #14: Review of the Admission Record (closed record) dated [DATE] revealed R#14 was initially admitted on [DATE] and readmitted on [DATE]. R#14's [DIAGNOSES REDACTED]. R#14 was [AGE] years old. R #14 expired on [DATE], in the facility. Review of R#14's Quarterly Minimum Data Set ((MDS) dated [DATE] revealed she was clearly able to understand others and had good ability to express her ideas and wants. R#14 had no cognitive deficits and scored 15 out of 15 points on the Brief Interview for Mental Status (BIMS). R#14 had no mood or behavior problems. R#14 was able to walk independently using a walker in her room or corridor with supervision, could dress herself, toilet herself, but required physical help in part of the bathing activity with the help of one person. R#14 was not steady in her balance during transitions and walking but was able to stabilize herself without staff assistance. R#14 was continent of bowel and bladder. R#14 had frequent pain and was on scheduled pain medication. R#14 had shortness of breath or trouble breathing with exertion, when sitting at rest and when lying flat. R#14 received oxygen therapy. Review of R#14's Care Plan included the following: R#14 requires assistance/is dependent for ADL (Activities of Daily Living) care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: SOB (shortness of breath) with exertion secondary to [MEDICAL CONDITION]. Interventions included R#14 was independent with bed mobility and with transfers. There were no other interventions listed. Initiated [DATE] and revised [DATE]. R#14 is at nutritional risk and may gain or lose weight due to fluid retention as evidenced by [MEDICAL CONDITION] to lower extremities. Interventions included evaluating for proper consistency of diet, honoring food preferences within meal plan, weighing weekly and alerting dietitian and physician to any significant loss or gain, monitoring for changes in nutritional status, and monitoring intake at all meals. Initiated [DATE]. No interventions were noted regarding elevating BLE when [MEDICAL CONDITION] was present. R#14 has [MEDICAL CONDITION]. Interventions included administering oxygen as ordered/indicated, evaluating breath sounds and respiratory function for rate, rhythm, depth, rhonchi, wheezes q (every) shift and with a change of condition, notify physician of changes from baseline; observe patient at rest and exertion, notify physician of increased weakness and fatigue, and observe for worsening SOB, notify physician if unrelieved or new SOB at rest. Initiated [DATE] with no updates. Review of R#14's Order Summary Report printed on [DATE] for the date range [DATE] to [DATE] revealed the following physician orders [REDACTED]. [DATE]: [MEDICATION NAME] 2 puffs inhale two times a day related to [MEDICAL CONDITION] [DATE]: Oxygen at 2L(liters)/min (minute) via nasal cannula continuously, every shift related to [MEDICAL CONDITION] [DATE]: [MEDICATION NAME] ER Extended Release 30 mg two times daily for pain [DATE]: Duo Neb .5 mg (milligram)/3 mg one vial with Nebulizer every six hours as needed [DATE]: [MEDICATION NAME] Liquid 100 mg/5ML Give 10 ml by mouth every 6 hours as needed for cough [DATE]: Check O2 (oxygen) daily and prn (as needed) every day shift for dyspnea. [DATE]: [MEDICATION NAME] Solution XXX,[DATE].5 (3) mg/3ML (milliliters) 1 vial inhale orally every 6 hours related to [MEDICAL CONDITION] [DATE]: Daliresp Tablet 500 mcg (micrograms) Give 1 tablet by mouth one time a day related to [MEDICAL CONDITION] [DATE]: [MEDICATION NAME] Tablet 20 mg once daily for [MEDICAL CONDITION] Review of Interdisciplinary Team Notes dated [DATE] revealed After speaking with nurse verified that resident is on continuous O2 at 2 L/M per NC (two liters of oxygen per nasal canula). Review of R#14's Treatment Administration Record (TAR) for February, 2017 revealed the following oxygen levels when they were checked during the day shift 8:00 a.m. to 4:00 p.m.: [DATE]: 93 [DATE]: 95 [DATE]: 95 [DATE]: 93 [DATE]: 93 [DATE]: 96 [DATE]: 94 Review of Progress Notes from R#14's facility record revealed the following: [DATE]: R#14 was found on floor in front of her recliner. Cause of fall was slippery socks. Socks changed out. [DATE]: R#14 with increased occurrence of shortness of breath/cough. Administered nebulizer treatment with little results observed. Oxygen inspected and working properly. Oxygen sats = 84% and toes cyanotic. Oxygen increased to 3.5L via nasal canula. Oxygen sats were 90% after oxygen adjustment. [DATE]: R#14 slipped while ambulating to the restroom in her room. No injury sustained. Root cause was R#14 was wearing inappropriate footwear. [DATE]: Family member of R#14 expressed concern that R#14 had swelling in bilateral extremities (BLE). Nurse noted 2+ [MEDICAL CONDITION]. Nurse notified physician and physician gave no new orders but will see R#14 on [DATE]. [DATE]: physician progress notes [REDACTED]. Referral to Pulmonologist was pending since [DATE]. Cancel that referral and refer R#14 to a different physician. BLE Venous Doppler (blood flow test) ordered, as well as chest xray, an echocardiogram, and labs. For [MEDICAL CONDITION], change [MEDICATION NAME] 60 mg QD (daily) to [MEDICATION NAME] 60 mg BID (twice daily) and monitor fluid status. Review of Telephone Physician order [REDACTED]. Review of chest xray report dated [DATE] revealed R#14 had mild [MEDICAL CONDITIONS]. Review of Progress Notes from R#14's facility record revealed the following: [DATE]: Results from Ultrasound and Venous Doppler were negative at this time. [DATE] 02:25: R#14 resting quietly in bed with head of bed raised for comfort. Oxygen via nasal canula in place at this time. 3+ [MEDICAL CONDITION] to BLE noted. No cough observed or reported. Seems to tolerate increased [MEDICATION NAME] well. Denies pain. [DATE] 15:09: Nurse Practitioner (NP) Progress Note. NP seeing R#14 due to episode of [MEDICAL CONDITION] with sats dropping to 85%. Staff report she was walking to the bathroom without her oxygen and became very short of breath. ,[DATE]+ [MEDICAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) CONDITION] to BLE. Chest xray showed mild [MEDICAL CONDITION]. [MEDICATION NAME] increased to 80 mg BID X 3days, then resume 60 mg BID. Prognosis: Guarded, worse today. Today with episode of [MEDICAL CONDITION]. [DATE]: Facility staff meeting, reviewed R#14's condition. Nursing, Social Services, Dietary Manager, ADON, and Administrator present. R#14 has gained 11 pounds in 30 days. R#14 has 2+ [MEDICAL CONDITION] to BLE, is sedentary and compliant with elevating her lower extremities. Started on weekly weights X 4 weeks to monitor fluid balance. [DATE] 10:37: Referral to Pulmonologist. Expected to be one to two weeks before appointment can be made but it would be made as soon as possible. [DATE] 12:25: physician progress notes [REDACTED]. Yesterday with episode of [MEDICAL CONDITION]. Follow up in a few days around ,[DATE]. [DATE] 12:16: R#14 had an unplanned transfer. [DATE] 17:55: Change in Condition. Per CNA F, R#14 was standing awaiting shower and fell against door, hitting head, arm and hip on floor upon landing. R#14 oxygen saturation 82 on room air at time of incident and 95% on 31 NC (nasal canula) upon return to room. Observations included labored breathing, shallow breathing crackles/rales present, right upper, right lower, left upper, left lower pitting right LE [MEDICAL CONDITION], pitting left LE [MEDICAL CONDITION], lower body right side weakness. Review of hospital History and Physical revealed R#14 was admitted to the hospital on [DATE] at 18:21. Review of R#14's present illness revealed she had [MEDICAL CONDITION] from diastolic dysfunction [MEDICAL CONDITION], hypertensive [MEDICAL CONDITION], type 2 diabetes, chronic [MEDICAL CONDITION] pacemaker defibrillator, dementia, history of [MEDICAL CONDITION] (rapid heart rate), [MEDICAL CONDITION], left carotid endarterectomy (surgery on neck artery), depression, history of back surgery, hysterectomy, and rotator cuff injury. Review of hospital Assessment and Plan dated [DATE] revealed R#14 had Pneumonia, right femoral neck fracture, [MEDICAL CONDITIONS] with exacerbation, and Chronic [MEDICAL CONDITION]. In an interview on [DATE] at 11:45 a.m., CNA E said on [DATE] she assisted R#14 out of her room to go to the shower room. CNA E said R#14 complained of being a little dizzy when she opened the shower room door and R#14 fell to the side. CNA E said R#14 fell right inside the shower room by the door. CNA E said R#14 said she was dizzy and could not breathe. CNA E said R#14 used her regular walker with a portable oxygen tank on it but she was not using oxygen when she was walking. CNA E said she had showered R#14 before and R#14 usually only needed help with washing her back and drying off. CNA E said R#14 usually had her portable oxygen on the other side of the wall from the shower and she wore the nasal canula in the shower. CNA E said R#14 told her she did not need her oxygen and sometimes did not wear her oxygen. CNA E said she was not given instructions about whether R#14 needed to wear her oxygen all of the time but she knew R#14 could not be left alone. CNA E said they just walked two doors down from R#14's room to the shower room when R#14 fell . In an interview at 11:55 a.m. on [DATE], Family Member (FM) BB, who also resided in the facility, said he was receiving therapy when R#14 fell on [DATE]. FM BB went to check on R#14 and found her sitting in a chair in bad pain. FM BB said R#14 told him she got out of her wheelchair and walked into the bathroom and fell . R#14 had a big knot on the right side of her head and broke the knob off of her hip. FM BB said R#14 returned to the facility after her hip was repaired, and passed away as he was talking to her on [DATE]. In an interview on [DATE] at 1:00 p.m., FM CC, a family member of R#14, said R#14 always had her oxygen on when he visited her, and when R#14 left the facility, she was always using her portable oxygen In an interview at 10:10 a.m. on [DATE] with CNA E, when asked if she had asked R#14 to put her oxygen on before they walked down the hall toward the shower room on [DATE], CNA E said she did not ask R#14 to put on her oxygen because she did not want to pressure her to wear her oxygen. CNA E said sometimes R#14 wore her oxygen and sometimes she did not wear it. In an interview at 10:20 a.m. on [DATE], the Assistant Director of Nurses (ADON), when asked how often R#14 wore her oxygen, said R#14 went without her oxygen sometimes and probably wore her oxygen about 50% of the time. The ADON said R#14 would go around the building without it sometimes. Surveyor asked the ADON if there was any change in R#14's breathing and need for oxygen the week before she fell , and the ADON replied that she did not know of any change. In an interview with the Administrator on [DATE] at 10:10 a.m., the Administrator said she did not report the incident with R#14's fall on [DATE] because it was a witnessed fall. The Administrator said they talked with staff and determined it was not a reportable incident. Review of Event Summary Report of incident with R#14 dated [DATE] at 11:30 a.m. revealed R#14 sustained an abrasion, bruise, fracture and skin tear. Emergency Medical was called and R#14 was transferred to the hospital at 12:15 p.m. Circumstances of the event and immediate actions taken: Resident (R#14) amb (ambulated) 30 ft (feet) to shower room. became dizzy and fell . CNA reported immediately to LVN who assessed. O2 Sat at 85%. Resident c/o (complained of) pain to head and right arm, skin tear noted. Neuro check complete and WNL (within normal limits). Full ROM (range of motion) to all extremities. Resident assisted back to room and requests to sit in recliner. O2 applied, SAT return to 95% (in less than) 1 min. (minute). Skin Tear cleansed and covered. The fall was related to ambulation status, resident was weak and stated she felt dizzy once arriving to shower area. R#14 had a change of condition in the last seven days with 3+ [MEDICAL CONDITION] to bilateral feet, with [MEDICATION NAME] increased to 80 mg. Current medication that may be causative to the fall included antihypertensives, diuretics, and narcotics. R#14 was administered [MEDICATION NAME] ER Tablet Extended Release 30 mg within eight hours prior to the fall. Review of Event Summary Report of incident with R#14 dated [DATE] revealed root cause to be Resident oxygen saturation decreased and caused resident become dizzy. O2 at 2L ordered continuous, but resident refuses to wear O2 while in bathroom in room and while showering. CNA was unable to effectively catch resident in time to prevent fall. Corrective actions included further education on use of oxygen continuous, standby assistance and s/s (signs/symptoms) of possible complications related to oxygen dependent residents. Resident needs to use her portable oxygen during bathing process to prevent desaturation. Resident c/o pain to right hip over one hour after being in chair and was sent out to hospital with a right [MEDICAL CONDITION]. Review of Witness Statements dated [DATE], attached to the facility Risk Management System report, revealed the following: I, (CNA E) did observe on [DATE] at 10:20 a.m. I went to (R#14's) room and told her it's her shower day. Let's go get your shower. She said okay. I have my clothes and stuff together lets go. I was walking her to the shower room. We opened the door. Right when she was entering the bathroom, (R#14) stood very still then she lost balance and fell over on the floor. I tried to catch her but she fell too quickly. She ended up falling on her shoulder and hit her head. I, (CNA G), did observe on (blank) at (blank). Have witnessed (R#14) to refuse to use her oxygen to the restroom or the shower room. On occasion. I, (CNA H), did observe on (blank) at (blank). In the past I have known (R#14) not to wear her o2 to bathroom or shower room. The facility's Oxygen: Transport of Patient on Continuous Oxygen Policy dated [DATE] documented The center will provide full (oxygen level at time of departure), portable oxygen equipment (concentrator, compressed oxygen, liquid portable oxygen) for patients requiring continuous oxygen .Portable oxygen will be set up by a licensed nurse, respiratory therapist, or rehabilitation therapist as appropriate. The duration begins . or allows for travel time to the destination where capability to continue to deliver oxygen exists. The facility's Oxygen Concentrator Procedure dated [DATE] documented 1. Verify order .11. Set liter flow per order. 12. Attach prescribed oxygen delivery device and apply oxygen delivery to the resident . Review of the Facility Abuse Prohibition Policy, revised [DATE], revealed the following: POLICY (Facility) will prohibit abuse, neglect, misappropriation of resident property, and exploitation for all residents. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. The Center will implement an abuse prohibition program through the following: -Screening of potential hires; -Training of employees (both new employees and ongoing training for all employees); -Prevention of occurrences; -Identification of possible incidents or allegations which need investigation; -Investigation of incidents and allegations; -Protection of patients during investigations; and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 3) -Reporting of incidents, investigations, and Center response to the results of their investigations. Federal Definitions: Neglect is defined as the failure of the Center, its employees, or service providers to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. State Definitions: Neglect is defined as the failure to provide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness. PURPOSE To ensure that Center staff are doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown source, exploitation, and misappropriation of property for all patients. PROCESS 1. The Center Executive Director (CED), or designee, is responsible for operationalizing policies and procedures that prohibit abuse, neglect, involuntary seclusion, injuries of unknown source, exploitation, and misappropriation of property. 4. Actions to prevent abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, will include: 4.3. Identifying, correcting, and intervening in situations in which abuse, neglect, and/or misappropriation of patient property is more likely to occur. 5. Staff will identify events--such as suspicious bruising of patients, occurrences, patterns, and trends that may constitute abuse--and determine the direction of the investigation. This also includes patient-to-patient abuse. 5.1 Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately. 5.1.1 The notified supervisor will report the suspected abuse immediately (not to exceed 24 hours) to the CED or designee and other officials in accordance with state law. 5.1.1.1 If the patient/resident sustains serious bodily injury, report no later than two (2) hours after forming the suspicion. Refer to Reporting Suspected Crimes Under the Elder Justice Act (EJA) policy. 6. Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of property, the CED or designee will perform the following: 6.1 Enter allegation into the Risk Management System (RMS). 6.2 Immediately, not to exceed 24 hours, notify the Texas Department of Aging and Disability Services either: 6.2.1 Online at report incident online, or 6.2.2 By phone at [PHONE NUMBER], regardless of the day or time; select option 5 from the main menu 6.7 Initiate an investigation within 24 hours of an allegation of abuse that focuses on: 6.7.1 whether abuse or neglect occurred and to what extent; 6.7.2 clinical examination for signs of injuries, if indicated; 6.7.3 causative factors; and 6.7.4 Interventions to prevent further injury. 7.3 The CED or designee will report findings of all completed investigations within five (5) working days utilizing: 7.3.1 DADS Form 3613-A, Provider Investigation Report 7.3.2 Submit the investigation as follows: 7.3.2.2.1 Texas Department of Aging and Disability Services Consumer Rights and Services-Complaint Intake Unit R #17: R #17's [DATE] physician's orders [REDACTED].Oxygen at 3 LPNC continuously- start date: [DATE]. R #17's [DATE] TAR indicated the order for oxygen at 3 LPNC but did not indicate when her oxygen tubing should have been changed. Observation of R #17 on [DATE] at 9:48 a.m. revealed she received oxygen at 3 liters per nasal cannula. R #17's oxygen tubing was dated [DATE]. On [DATE] at 9:50 a.m., the Administrator was informed an IJ situation was identified due to the above failures. Observation of R #16 on [DATE] at 9:51 a.m. revealed she received oxygen at 3 liters per nasal cannula. R #16's oxygen concentrator filter had white dust covering the filter. R #16's oxygen tubing was dated [DATE]. R #19: R #19's Face Sheet dated [DATE] documented a [AGE] year-old female asmitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. R #19's admission orders [REDACTED]. Observation of R #19 on [DATE] at 9:54 a.m. revealed she received oxygen at 3 liters per nasal cannula. R #19's oxygen tubing was not dated. Interview with LVN U on [DATE] at 10:14 a.m. revealed she did not know how many liters of oxygen R #19 should be receiving. LVN U reviews R #19's [DATE] Medication Administration Record [REDACTED]. I have to check her orders. LVN U consulted with LVN K then LVN K reviewed R #19's physician's orders [REDACTED]. On [DATE] at 11:08 a.m., LVN K informed the surveyor that she received orders for R #19 and provided a copy of the orders. R #19's physician's orders [REDACTED].@ 2LPNC PRN (as needed) for saturation level less than 90% for [DIAGNOSES REDACTED].#19's oxygen should have retrieved anorder from her physician for the oxygen. R #18: R #18's [DATE] physician's orders [REDACTED]. Review of R #18's [DATE] TAR indicated her oxygen concentrator filter was only cleaned on [DATE]. The TAR contained a signature on [DATE], indicating that the oxygen tubing was changed on that day. -However, observation on [DATE] revealed R #18's tubing was dated [DATE]. Observation of R #18 on [DATE] at 9:57 a.m. revealed she received oxygen at 4 liters per nasal cannula. R #18's oxygen concentrator filter was covered with white dust. R #18's oxygen tubing was dated [DATE]. Interview with LVN U on [DATE] at 10:09 a.m. revealed she stated she had recently started working in the facility approximately one week ago. LVN U said oxygen tubing should be changed weekly but did not know what the facility's policy and procedure was or who was responsible for cleaning them. LVN U stated she did not know anything about the maintenance of the filters. Interview with LVN I on [DATE] at 10:12 a.m. revealed she stated oxygen tubing should be changed and dated weekly, at the same time the concentrator filters were cleaned. LVN I said this was scheduled on Sundays and the night shift was responsible for ensuring it was done. LVN I said each resident's Treatment Administration Record should have address the cleaning of filters and changing of oxygen tubing. On [DATE] at 5:59 p.m., the facility was notified of the acceptance of the final Plan of Removal (POR). The final Plan of Removal documented: This Plan of Removal is in response to the alleged identification of Immediate Jeopardy communicated by the survey team on [DATE] during a return visit prompted by the annual survey with exit date of [DATE] at (the facility). The alleged Immediate Jeopardy findings were identified in the following areas: -Quality of Care -Neglect The facility respectfully submits this Plan of Removal (POR) pursuant to Federal and State regulatory requirements. Submission of this Letter of Credible Allegation does not constitute an admission or agreement of the facts alleged or the conclusions set forth in the verbal and written notice of Immediate Jeopardy and/or any subsequent Statement of Deficiencies. Corrective Action and Identification: Review of orders identified 22 of 72, residents as having orders for Oxygen. This facility has put in place immediate corrective action as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 4) 1. On [DATE], nursing administration provided education on abuse and neglect to staff members. On [DATE], nursing administration reeducated staff members on abuse and neglect. 2. On [DATE] residents on oxygen therapy assessed and compliance with orders verified by nursing administration. 3. On [DATE], a complete audit of residents using oxygen was conducted by nursing administration and care plans were reviewed and revised accordingly. 4. On [DATE], nursing administration provided education to nursing staff regarding use of oxygen and maintenance of filter and tubing. 5. On [DATE], the MAR indicated [REDACTED]. MAR indicated [REDACTED]
F 0225 **Level of harm** - Immediate jeopardy **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 interview and record review, the facility failed to report to the State Survey Agency an incident of neglect of one Resident,(R#14), of 15 Residents reviewed for abuse and neglect. The facility did not report an incident in which R#14 walked to the shower without wearing her oxygen, which was ordered by the physician to be worn continuously, became short of breath and fell , fracturing her right hip and hitting her head. This failure to provide specialty care services for R#14 resulted in an Immediate Jeopardy (IJ) situation on 04/13/17 at 9:50 a.m. While the IJ was removed on 04/14/17 at 2:54 p.m., the facility remained out of compliance at a potential for more than actual harm with a scope identified as pattern. The facility was continuing to monitor to ensure continued implementation of their plan of removal. The failure to thoroughly investigate and report the incident in which R#14 fell and fractured her hip while not receiving oxygen could place 22 residents who required oxygen therapy at risk for neglect. The findings were: Review of the Admission Record dated 02/22/17 revealed R#14 was initially admitted on [DATE] and readmitted on [DATE]. R#14's [DIAGNOSES REDACTED]. R#14 was [AGE] years old. Review of R#14's Quarterly Minimum Data Set ((MDS) dated [DATE] revealed she was clearly able to understand others and had good ability to express her ideas and wants. R#14 had no cognitive deficits and scored 15 out of 15 points on the Brief Interview for Mental Status (BIMS). R#14 had no mood or behavior problems. R#14 was able to walk independently using a walker in her room or corridor with supervision, could dress herself, toilet herself, but required physical help in part of the bathing activity with the help of one person. R#14 was not steady in her balance during transitions and walking but was able to stabilize herself without staff assistance. R#14 was continent of bowel and bladder. R#14 had frequent pain and was on scheduled pain medication. R#14 had shortness of breath or trouble breathing with exertion, when sitting at rest and when lying flat. R#14 received oxygen therapy. Review of R#14's Care Plan included the following: R#14 requires assistance/is dependent for ADL (Activities of Daily Living) care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: SOB (shortness of breath) with exertion secondary to [MEDICAL CONDITION]. Interventions included R#14 was independent with bed mobility and with transfers. There were no other interventions listed. Initiated 11/06/16 and revised 01/24/17. R#14 is at nutritional risk and may gain or lose weight due to fluid retention as evidenced by [MEDICAL CONDITION] to lower extremities. Interventions included evaluating for proper consistency of diet, honoring food preferences within meal plan, weighing weekly and alerting dietition and physician to any significant loss or gain, monitoring for changes in nutritional status, and monitoring intake at all meals. Initiated 02/07/17. No interventions were noted regarding elevating BLE when [MEDICAL CONDITION] was present. R#14 has [MEDICAL CONDITION]. Interventions included administering oxygen as ordered/indicated, evaluating breath sounds and respiratory function for rate, rhythm, depth, rhonchi, wheezes q (every) shift and with a change of condition, notify physician of changes from baseline; observe patient at rest and exertion, notify physician of increased weakness and fatigue, and observe for worsening SOB, notify physician if unrelieved or new SOB at rest. Initiated 11/03/16 with no updates. Review of R#14's Order Summary Report printed on 03/30/17 for the date range 01/01/16 to 02/28/17 revealed the following physician orders [REDACTED]. 10/28/16: [MEDICATION NAME] 2 puffs inhale two times a day related to [MEDICAL CONDITION] 10/31/16: Oxygen at 2L(liters)/min (minute) via nasal cannula continuously, every shift related to [MEDICAL CONDITION] 11/22/16: [MEDICATION NAME] ER Extended Release 30 mg two times daily for pain 11/28/16: Duo Neb .5 mg (milligram)/3 mg one vial with Nebulizer every six hours as needed 11/28/16: [MEDICATION NAME] Liquid 100 mg/5ML Give 10 ml by mouth every 6 hours as needed for cough 12/23/16: Check O2 (oxygen) daily and prn (as needed) every day shift for dyspnea. 12/26/16: [MEDICATION NAME] Solution .5-2.5 (3) mg/3ML (milliliters) 1 vial inhale orally every 6 hours related to [MEDICAL CONDITION] 12/27/16: [MEDICATION NAME] Tablet 20 mg once daily for [MEDICAL CONDITION] 12/27/16: Daliresp Tablet 500 mcg (micrograms) Give 1 tablet by mouth one time a day related to [MEDICAL CONDITION] Review of Interdisciplinary Team Notes dated 11/10/16 revealed After speaking with nurse verified that resident is on continuous O2 at 2 L/M per NC (two liters of oxygen per nasal canula). Review of R#14's Treatment Administration Record (TAR) for February, 2017 revealed the following oxygen levels when they were checked during the day shift 8:00 a.m. to 4:00 p.m.: 02/01/17: 93 02/02/17: 95 02/03/17: 95 02/04/17: 93 02/05/17: 93 02/06/17: 96 02/07/17: 94 Review of R#14's TAR for February, 2017 revealed nebulizer treatments were administered at noon only on 02/01/17, 02/06/17 and 02/08/17. Review of Progress Notes from R#14's facility record revealed the following: 01/14/17: R#14 was found on floor in front of her recliner. Cause of fall was slippery socks. Socks changed out. 01/19/17: R#14 with increased occurrence of shortness of breath/cough. Administered nebulizer treatment with little results observed. Oxygen inspected and working properly. Oxygen sats = 84% and toes cyanotic. Oxygen increased to 3.5L via nasal canula. Oxygen sats were 90% after oxygen adjustment. 01/27/17: R#14 slipped while ambulating to the restroom in her room. No injury sustained. Root cause was R#14 was wearing inappropriate footwear. 02/02/17: Family member of R#14 expressed concern that R#14 had swelling in bilateral extremeties (BLE). Nurse noted 2+ [MEDICAL CONDITION]. Nurse notified physician and physician gave no new orders but will see R#14 on 02/03/17. 02/03/17: physician progress notes [REDACTED]. Referral to Pulmonologist was pending since 12/27/16. Cancel that referral and refer R#14 to a different physician. BLE Venous Doppler (blood flow test) ordered, as well as chest xray, an echocardiogram, and labs. For [MEDICAL CONDITION], change [MEDICATION NAME] 60 mg QD (daily) to [MEDICATION NAME] 60 mg BID (twice daily) and monitor fluid status. Review of Telephone Physician order [REDACTED]. Review of chest xray report dated 02/03/17 revealed R#14 had mild [MEDICAL CONDITIONS] Review of Progress Notes from R#14's facility record revealed the following: 02/04/17: Results from Ultrasound and Venous Doppler were negative at this time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	**04/18/2017**

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 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) 02/06/17 02:25: R#14 resting quietly in bed with head of bed raised for comfort. Oxygen via nasal canula in place at this time. 3+ [MEDICAL CONDITION] to BLE noted. No cough observed or reported. Seems to tolerate increased [MEDICATION NAME] well. Denies pain. 02/06/17 15:09: Nurse Practitioner (NP) Progress Note. NP seeing R#14 due to episode of [MEDICAL CONDITION] with sats dropping to 85%. Staff report she was walking to the bathroom without her oxygen and became very short of breath. 2-3+ [MEDICAL CONDITION] to BLE. Chest xray showed mild [MEDICAL CONDITION]. [MEDICATION NAME] increased to 80 mg BID X 3days, then resume 60 mg BID. Prognosis: Guarded, worse today. Today with episode of [MEDICAL CONDITION]. 02/07/17: Facility staff meeting, reviewed R#14's condition. Nursing, Social Services, Dietary Manager, ADON, and Administrator present. R#14 has gained 11 pounds in 30 days. R#14 has 2+ [MEDICAL CONDITION] to BLE, is sedentary and compliant with elevating her lower extremities. Started on weekly weights X 4 weeks to monitor fluid balance. 02/07/17 10:37: Referral to pulmonologist. Expected to be one to two weeks before appointment can be made but it would be made as soon as possible. 02/07/17 12:25: physician progress notes [REDACTED]. Yesterday with episode of [MEDICAL CONDITION]. Follow up in a few days around 2/9. 02/08/17 12:16: R#14 had an unplanned transfer. 02/08/17 17:55: Change in Condition. Per CNA F, R#14 was standing awaiting shower and fell against door, hitting head, arm and hip on floor upon landing. R#14 oxygen saturation 82 on room air at time of incident and 95% on 31 NC (nasal canula) upon return to room. Observations included labored breathing, shallow breathing crackles/rales present, right upper, right lower, left upper, left lower pitting right LE [MEDICAL CONDITION], pitting left LE [MEDICAL CONDITION], lower body right side weakness. Review of hospital History and Physical revealed R#14 was admitted to the hospital on [DATE] at 18:21. Review of R#14's present illness revealed she had [MEDICAL CONDITION] from diastolic dysfunction [MEDICAL CONDITION], hypertensive [MEDICAL CONDITION], type 2 diabetes, chronic [MEDICAL CONDITION] pacemaker defibrillator, dementia, history of [MEDICAL CONDITION] (rapid heart rate), [MEDICAL CONDITION], left carotid endarterectomy (surgery on neck artery), depression, history of back surgery, hysterectomy, and rotator cuff injury. Review of hospital Assessment and Plan dated 02/08/17 revealed R#14 had Pneumonia, right femoral neck fracture, [MEDICAL CONDITIONS] with exacerbation, and Chronic [MEDICAL CONDITION]. In an interview on 03/30/17 at 11:45 a.m., CNA E said on 02/08/17 she assisted R#14 out of her room to go to the shower room. CNA E said R#14 complained of being a little dizzy when she opened the shower room door and R#14 fell to the side. CNA E said R#14 fell right inside the shower room by the door. CNA E said R#14 said she was dizzy and could not breathe. CNA E said R#14 used her regular walker with a portable oxygen tank on it but she was not using oxygen when she was walking. CNA E said she had showered R#14 before and R#14 usually only needed help with washing her back and drying off. CNA E said R#14 usually had her portable oxygen on the other side of the wall from the shower and she wore the nasal canula in the shower. CNA E said R#14 told her she did not need her oxygen and sometimes did not wear her oxygen. CNA E said she was not given instructions about whether R#14 needed to wear her oxygen all of the time but she knew R#14 could not be left alone. CNA E said they just walked two doors down from R#14's room to the shower room when R#14 fell . Review of ADL Report of ADLs provided by CNAs revealed no documentation of the bathing task in the month of January, 2017. In February, 2017, R#14 was showered on 02/03/17 and 02/06/17 and required extensive assistance with the help of one person. The Walk in Corridor task in February, 2017 was not applicable or resident refused for almost all entries, which were made three times daily, for 02/02/17 through 02/08/17. In an interview at 11:55 a.m. on 03/30/17, Family Member (FM) BB, who also resided in the facility, said he was receiving therapy when R#14 fell on [DATE]. FM BB went to check on R#14 and found her sitting in a chair in bad pain. FM BB said R#14 told him she got out of her wheelchair and walked into the bathroom and fell . R#14 had a big knot on the right side of her head and broke the knob off of her hip. FM BB said R#14 always wore her oxygen and only took it off once in a while if she was eating ice cream. FM BB said R#14 returned to the facility after her hip was repaired, and passed away as he was talking to her on 02/17/17. In an interview on 04/14/17 at 1:00 p.m., FM CC, a family member of R#14, said R#14 always had her oxygen on when he visited her, and when R#14 left the facility, she was always using her portable oxygen. In an interview at 10:10 a.m. on 03/31/17, when asked if she had asked R#14 to put her oxygen on before they walked down the hall toward the shower room on 02/08/17, CNA E said she did not ask R#14 to put on her oxygen because she did not want to pressure her to wear her oxygen. CNA E said sometimes R#14 wore her oxygen and sometimes she did not wear it. In an interview at 10:20 a.m. on 03/31/17, the Assistant Director of Nurses (ADON), when asked how often R#14 wore her oxygen, said R#14 went without her oxygen sometimes and probably wore her oxygen about 50% of the time. The ADON said R#14 would go around the building without it sometimes. Surveyor asked the ADON if there was any change in R#14's breathing and need for oxygen the week before she fell , and the ADON replied that she did not know of any change. In an interview with the Administrator on 03/31/17 at 10:10 a.m., the Administrator said she did not report the incident with R#14's fall on 02/08/17 because it was a witnessed fall. The Administrator said they talked with staff and determined it was not a reportable incident. Review of Event Summary Report of incident with R#14 dated 02/08/17 at 11:30 a.m. revealed R#14 sustained an abrasion, bruise, fracture and skin tear. Emergency Medical was called and R#14 was transferred to the hospital at 12:15 p.m. Circumstances of the event and immediate actions taken: Resident (R#14) amb (ambulated) 30 ft (feet) to shower room. became dizzy and fell . CNA reported immediately to LVN who assessed. O2 Sat at 85%. Resident c/o (complained of) pain to head and right arm, skin tear noted. Neuro check complete and WNL (within normal limits). Full ROM (range of motion) to all extremities. Resident assisted back to room and requests to sit in recliner. O2 applied, SAT return to 95% (in less than) 1 min. (minute). Skin Tear cleansed and covered. The fall was related to ambulation status, resident was weak and stated she felt dizzy once arriving to shower area. R#14 had a change of condition in the last seven days with 3+ [MEDICAL CONDITION] to bilateral feet, with [MEDICATION NAME] increased to 80 mg. Current medication that may be causative to the fall included antihypertensives, diuretics, and narcotics. R#14 was administered [MEDICATION NAME] ER Tablet Extended Release 30 mg within eight hours prior to the fall. Review of Event Summary Report of incident with R#14 dated 02/08/17 revealed root cause to be Resident oxygen saturation decreased and caused resident become dizzy. O2 at 2L ordered continuous, but resident refuses to wear O2 while in bathroom in room and while showering. CNA was unable to effectively catch resident in time to prevent fall. Corrective actions included further education on use of oxygen continuous, standby assistance and s/s (signs/symptoms) of possible complications related to oxygen dependent residents. Resident needs to use her portable oxygen during bathing process to prevent desaturation. Resident c/o pain to right hip over one hour after being in chair and was sent out to hospital with a right [MEDICAL CONDITION]. Review of Witness Statements dated 02/10/17, attached to the facility Risk Management System report, revealed the following: I, (CNA E) did observe on 02/08/17 at 10:20 a.m. I went to (R#14's) room and told her it's her shower day. Let's go get your shower. She said okay. I have my clothes and stuff together lets go. I was walking her to the shower room. We opened the door. Right when she was entering the bathroom, (R#14) stood very still then she lost balance and fell over on the floor. I tried to catch her but she fell too quickly. She ended up falling on her shoulder and hit her head. I, (CNA G), did observe on (blank) at (blank). Have witnessed (R#14) to refuse to use her oxygen to the restroom or the shower room. On occasion. I, (CNA H), did observe on (blank) at (blank). In the past I have known (R#14) not to wear her o2 to bathroom or shower room. The facility's Oxygen: Transport of Patient on Continuous Oxygen Policy dated 01/02/14 documented The center will provide full (oxygen level at time of departure), portable oxygen equipment (concentrator, compressed oxygen, liquid portable oxygen) for patients requiring continuous oxygen .Portable oxygen will be set up by a licensed nurse, respiratory therapist, or rehabilitation therapist as appropriate. The duration begins . or allows for travel time to the destination where capability to continue to deliver oxygen exists. The facility's Oxygen Concentrator Procedure dated 12/08/14 documented 1. Verify order .11. Set liter flow per order. 12. Attach prescribed oxygen delivery device and apply oxygen delivery to the resident . On 04/13/17 at 9:50 a.m., the Administrator was informed an IJ situation was identified due to the above failures. On 04/13/17 at 5:59 p.m., the facility was notified of the acceptance of the Plan of Removal (POR). The Plan of Removal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	**04/18/2017**

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 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) documented: This Plan of Removal is in response to the alleged identification of Immediate Jeopardy communicated by the survey team on April 13, 2017 during a return visit prompted by the annual survey with exit date of March 31, 2017 at Oak Crest Nursing Center in Rockport, Texas. The alleged Immediate Jeopardy findings were identified in the following areas: Quality of Care Neglect The facility respectfully submits this Plan of Removal (POR) pursuant to Federal and State regulatory requirements. Submission of this Letter of Credible Allegation does not constitute an admission or agreement of the facts alleged or the conclusions set forth in the verbal and written notice of Immediate Jeopardy and/or any subsequent Statement of Deficiencies. Corrective Action and Identification: Review of orders identified 22 of 72, residents as having orders for Oxygen. This facility has put in place immediate corrective action as evidenced by: 1. On March 30, 2017, nursing administration provided education on abuse and neglect to staff members. On April 13, 2017, nursing administration reeducated staff members on abuse and neglect. 2. On April 13, 2017 residents on oxygen therapy assessed and compliance with orders verified by nursing administration. 3. On March 30, 2017, a complete audit of residents using oxygen was conducted by nursing administration and care plans were reviewed and revised accordingly. 4. On April 13, 2017, nursing administration provided education to nursing staff regarding use of oxygen and maintenance of filter and tubing. 5. On April 13, 2017, the MAR indicated [REDACTED]. MAR indicated [REDACTED]. 6. On March 31, 2017 Kardexes were updated to reflect those residents receiving oxygen with the verbiage 'respiratory therapy'. A Kardex is a tool that is used by the CNAs and nursing to communicate what type of care the resident needs from the CNA perspective. The Kardex is located in the CNA electronic tablet that is used to document resident care and provides information regarding resident care and needs specific to the CNA level. It is the equivalent of a care plan. Examples of items on a Kardex are mobility, transfer, eating and oxygen status. 7. On April 13, 2017, Kardexes were updated to reflect those residents that are on oxygen with the verbiage 'Continuous Oxygen therapy' or 'PRN oxygen therapy'. 8. On April 13, 2017, nursing staff educated regarding the MAR updates that reflect the tubing and filter changing and the oxygen tubing/filter maintenance process. The tubing will be changed on Sunday by the charge nurse on the 10-6 shift. Charge nurse to remove and replace old tubing and date new tubing. Remove old filter and replace with new filter. Humidification bottles are to be removed and replaced as needed. Humidification bottles will be dated each time they are replaced. 9. CNAs on April 13, 2017 received education provided regarding the updated Kardex that reflects the verbiage, 'Continuous Oxygen therapy' or 'PRN oxygen therapy'. 10. CNAs on April 13, 2017 received education to alert charge nurses or nurse managers on all resident oxygen use refusals and changes of condition for appropriate intervention and documentation. Example: If the resident refuses oxygen the CNA will alert the charge nurse so that the charge nurse can come assess and speak to the resident to explain the importance of using the oxygen as ordered and check the residents oxygen saturation levels, level of consciousness, nail beds and fingers for cyanosis and encourage the resident to comply with the oxygen as ordered. The nurse will be sure to document the resident's status and concerns and communicate this to nurse management, the attending MD and family if needed. Charge nurse and CNA will ensure that resident is safe from falls or other injury related to refusal of oxygen. Changes of condition related to respiratory distress such as shortness of breath, dusky nail beds, increase in confusion, drowsiness CNA to alert charge nurse, charge nurse to perform respiratory assessment of resident including but not limited to oxygen saturation levels, vital signs, lung sounds and intervene and notify as appropriate, and document findings and outcomes. 11. Care Plans were reviewed and revised to ensure they reflect the current oxygen therapy orders. Care plans will be updated April 13, 2017. 12. Nursing staff to receive the above education before returning to the floor. The Administrator and other consultants re-assessed residents who were identified by the facility as having a need for oxygen thereapy Through this process, on 04/13/17, the facility provided an updated list of those residents on oxygen therapy. Four residents were identified as having physician orders [REDACTED]. The surveyors confirmed through observation, interview and record review that the facility re-assessed all the residents in the facility, including those receiving oxygen therapy. The residents receiving oxygen therapy were found to be receiving oxygen per physician's orders [REDACTED]. On 04/14/17 at 2:54 p.m., the Administrator and the Regional Vice President were informed the IJ was removed. However, the facility remained out of compliance at a severity of the potential for more than actual harm with a scope identified as pattern. The facility was continuing to monitor to ensure assessments and interventions for oxygen therapy were accurate for all residents. Review of the Facility Abuse Prohibition Policy, revised 11/28/16, revealed the following: POLICY (Facility) will prohibit abuse, neglect, misappropriation of resident property, and exploitation for all residents. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. The Center will implement an abuse prohibition program through the following: -Screening of potential hires; -Training of employees (both new employees and ongoing training for all employees); -Prevention of occurrences; -Identification of possible incidents or allegations which need investigation; -Investigation of incidents and allegations; -Protection of patients during investigations; and -Reporting of incidents, investigations, and Center response to the results of their investigations. Federal Definitions: Neglect is defined as the failure of the Center, its employees, or service providers to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. State Definitions: Neglect is defined as the failure to provide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness. PURPOSE To ensure that Center staff are doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown source, exploitation, and misappropriation of property for all patients. PROCESS 1. The Center Executive Director (CED), or designee, is responsible for operationalizing policies and procedures that prohibit abuse, neglect, involuntary seclusion, injuries of unknown source, exploitation, and misappropriation of property. 4. Actions to prevent abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, will include: 4.3. Identifying, correcting, and intervening in situations in which abuse, neglect, and/or misappropriation of patient property is more likely to occur. 5. Staff will identify events--such as suspicious bruising of patients, occurrences, patterns, and trends that may constitute abuse--and determine the direction of the investigation. This also includes patient-to-patient abuse. 5.1 Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) 5.1.1 The notified supervisor will report the suspected abuse immediately (not to exceed 24 hours) to the CED or designee and other officials in accordance with state law. 5.1.1.1 If the patient/resident sustains serious bodily injury, report no later than two (2) hours after forming the suspicion. Refer to Reporting Suspected Crimes Under the Elder Justice Act (EJA) policy. 6. Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of property, the CED or designee will perform the following: 6.1 Enter allegation into the Risk Management System (RMS). 6.2 Immediately, not to exceed 24 hours, notify the Texas Department of Aging and Disability Services either: 6.2.1 Online at report incident online, or 6.2.2 By phone at [PHONE NUMBER], regardless of the day or time; select option 5 from the main menu 6.7 Initiate an investigation within 24 hours of an allegation of abuse that focuses on: 6.7.1 whether abuse or neglect occurred and to what extent; 6.7.2 clinical examination for signs of injuries, if indicated; 6.7.3 causative factors; and 6.7.4 Interventions to prevent further injury. 7.3 The CED or designee will report findings of all completed investigations within five (5) working days utilizing: 7.3.1 DADS Form 3613-A, Provider Investigation Report 7.3.2 Submit the investigation as follows: 7.3.2.2.1 Texas Department of Aging and Disability Services Consumer Rights and Services-Complaint Intake Unit Review of List of Patients on Oxygen dated 04/12/17 and received on 04/13/17 identified four residents as requiring continuous oxygen; one resident as requiring continuous oxygen at night, and 17 residents requiring oxygen as needed, for a total of 22 residents requiring oxygen therapy.
F 0272 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Conduct initial and periodic assessments of each resident's functional capacity.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure comprehensive assessments of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS that included an accurate determination of pressure ulcer risk for one Resident (R #3) of 13 residents reviewed for Minimum Data Set (MDS) assessments. The facility did not accurately complete the determination of pressure ulcer risk assessment portion of the MDS assessments for R #3. The failure placed all 74 residents at risk for not having their skin care needs identified and met. The findings included: R #3's Face Sheet dated 03/21/17 documented R #3 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. R #3's Admission MDS, section M0210-Unhealed Pressure Ulcers dated 03/16/17 documented R #3 had zero unhealed pressure ulcers at Stage 1 or higher. The following section entitled Current Number of Unhealed Pressure Ulcers at Each Stage was not completed. R #3's Admission assessment dated [DATE] documented R #3 had a Stage 2 pressure ulcer to her coccyx that measured length-4.5 X width-4.3 centimeters. Interview with Regional MDS Coordinator (RMDSC) on 03/29/17 at 11:03 a.m. revealed the facility did not have an MDS Coordinator therefore, she was assisting with completing the MDS's. The RMDSC was presented R #3's MDS dated [DATE]; the RMDSC reviewed R #3's Admission assessment dated [DATE] and stated she could not answer or explain why the pressure ulcer section of the assessment was not accurately completed. The RMDSC verified the assessment was incorrect and should have included R #3's pressure ulcer stage and measurement. The RMDSC said this error could reflect R #3's care for his pressure ulcer and then said she would immediately update R #3's MDS. The facility's Centers for Medicare and Medicaid Services Form 672 dated 03/28/17 documented a facility census of 74 residents.
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop a comprehensive person-centered care plan for two Residents, (R#5 and R#10), of 15 residents reviewed for comprehensive care plans. The facility did not have a plan of care in place for R#5's refusal of bathing and grooming. The facility did not have a plan of care in place for R#10's behaviors related to hiding and storing away food and personal items. This failure could affect 21 residents with behavioral healthcare needs. The findings were: R#5 Review of R#5's Admission Record dated 03/29/17 revealed he was admitted to the facility on [DATE]. R#5's [DIAGNOSES REDACTED]. R#5 was [AGE] years old. Review of R#5's Annual Minimum Data Set ((MDS) dated [DATE] revealed he had moderate difficulty hearing others but could usually understand others and could usually make himself understood. R#5 had severe cognitive impairment but had no behavior concerns. R#5 needed supervision with the help of one person to transfer from bed to chair but did not walk. R#5 used a wheelchair to move around the facility. R#5 required limited assistance with dressing, supervision with toileting, and extensive assistance with personal hygiene. R#5 required physical help with one person's assistance with bathing and was unsteady in his balance but could stabilize without staff assistance. R#5 had occasional urinary incontinence but had no bowel incontinence. Review of R#5's Physician order [REDACTED]. Review of R#5's Care Plan dated 02/02/17 revealed R#5 was at risk for alterations in comfort related to chronic pain, with interventions including evaluation of pain characteristics: quality, severity, location, precipitating/relieving factors. Review of R#5's Care Plan dated 10/13/16 revealed he required assistance at times for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, toileting related to Dx (diagnosis) of Dementia. Interventions included providing R#5 with extensive assistance of one for bathing and with set-up, limited assist of one for personal hygiene. There was no care plan related to R#5 resisting or refusing ADL care. R#5 was occasionally incontinent of bowel according to the care plan but there was no mention of urinary incontinence. Review of R#5's Care Plan dated 01/06/15 revealed he had difficulty recalling recent events. Interventions included asking R#5 about preferences throughout the day and to validate his thoughts/feelings when confused or anxious. There was no care plan intervention related to R#5's refusal of ADL care due to his dementia or pain. On initial tour on 03/28/17 at 9:20 a.m., when asked how he was doing, R#5 said I haven't had a bath in days. When asked if he could remember when he last had a bath, R#5 did not reply. R#5 was lying in bed with his covers up to his chin. R#5 had some facial hair stubble on his chin and jaw area. In an interview on 03/28/17 at 12:20, Family Member (FM) AA said there was a shortage of staff at the facility especially on the evening and night shift. FM AA said she visited R#5 in the evening and sometimes noticed R#5 needed a shower and shave, but when she asked a CNA to bathe R#5, they would sometimes reply, No showers tonight. We're short handed. FM AA said R#5 did not like to shower and got confused about time and needed to be approached at different times to get him to shower. FM AA said sometimes R#5's hair smelled dirty. Review of the 300 Hall Shower Schedule (undated) revealed R#5 was scheduled for a bath on Tuesdays, Thursdays and Saturdays during the 6:00 a.m. to 2:00 p.m. shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) Review of the POC (Plan of Care) Legend Report dated 03/29/17 revealed the following codes for the ADL Activity Log: Code 99: Resident not available. Code 98: Resident refused. Code 97: Not applicable. Review of the ADL Activity Log for February, 2017 and March, 2017, revealed the following schedule of bathing for R#5: February, 2017: 02/02/17 (Thursday) : Shower at 1058 02/04/17 (Saturday): Blank 02/07/17 (Tuesday): Shower at 1435 02/09/17 (Thursday): Shower at 1142 02/11/17 (Saturday): Code 97 (not applicable) 02/12/17 (Sunday): Code 97 (not applicable) 02/14/17 (Tuesday): Code 99 (not available) 02/16/17 (Thursday): Code 97 (not applicable) 02/18/17 (Saturday): Shower at 1359 02/20/17 (Monday): Shower at 2150 02/21/17 (Tuesday): Shower at 1311 02/23/17 (Thursday): Shower at 1249 02/25/17 (Saturday): Code 98 (refused) 02/26/17 (Sunday): Code 97 (not applicable) 02/28/17 (Tuesday): Shower at 1359 March 2017 03/02/17 (Thursday): Code 98 (refused) 03/04/17 (Saturday): Shower at 1300 03/07/17 (Tuesday): Shower at 1359 03/09/17 (Thursday): Shower at 1141 03/11/17 (Saturday): Shower at 1306 03/14/17 (Tuesday): Shower at 1127 03/16/17 (Thursday): Code 98 (refused) 03/18/17 (Saturday): Code 98 (refused) 03/21/17 (Tuesday): Code 98 (refused) 03/23/17 (Thursday): Code 97 (not applicable) 03/25/17 (Saturday): Shower at 1311 03/28/17 (Tuesday): Code 98 (refused) In an interview at 1:50 p.m. on 03/29/17, Nurse Practice Educator (NPE) B said she did not know why Certified Nursing Aids (CNAs) would mark not applicable in the computer system on some of the days that R#5 was scheduled for a bath. NPE B said CNAs should tell the charge nurse if R#5 refused showers and the charge nurse should enter a nurses note into the Progress Notes regarding R#5's refusal of a bath. Review of Progress Notes for February, 2017 and March, 2017 revealed only one note related to R#5 refusing showers: 02/26/17: (R#5) refused shower on 02/25/17. Was asked again this shift and again refused. Multiple attempts made with no success. In an interview on 03/29/17 at 2:00 p.m., CNA F said she offered R#5 a shower around 8 a.m. on 03/28/17, and again at 9 a.m. on 03/281/7. CNA F said R#5 said, No, I think I'll stay right here. In an interview on 03/29/17 at 2:30 p.m., CNA C, who worked the 8 a.m. to 2 p.m. shift, said she talked to R#5 on 03/28/17 about taking a bath, and he agreed. CNA C said she got supplies together for bathing R#5 and when she went to get him for his shower, he refused to shower. CNA C said CNA D also tried to get R#5 to bathe on 03/28/17 after CNA C tried, but R#5 refused a shower. In an interview on 03/29/17 at 2:40 p.m., FM AA said no one called her to tell her R#5 was refusing showers. FM AA said she had difficulty showering R#5 when he lived with her because he would say he did not sweat so did not need a shower. FM AA said R#5 did not keep track of time and needed frequent prompting that it was time for a shower. In an interview on 03/29/17 at 3:20 p.m., NPE B provided the following policy dated 03/22/17 regarding residents who refused care: Reporting changes in Condition/Refusal of Care Anytime a resident refuses any portion of their care the charge nurse must be informed. This includes, but is not limited to bathing, turning & repositioning, incontinent care, toileting, dressing, meals, fluids, transfers. For refusal of care only document refusal. Do not use the Not Applicable button. If the resident was not available for your shift document it as such. There are several ways to do this: A verbal report to the nurse; STOP WATCH paper form or on the Ipad through POC (Plan of Care); Give the nurse a note. R#10 Review of R#10's Admission Records dated 03/30/17 revealed she was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. R#10 was [AGE] years old. Review of R#10's MDS dated [DATE] revealed fully able to understand others and could make herself understood. She scored 13 points on the Brief Interview for Mental Status (BIMS), indicating she was cognitively intact. R#10 had some symptoms of feeling down, depressed or hopeless 2-6 days per two week period, and frequently had trouble concentrating on things. No concerns regarding behaviors were noted. R#10 was ambulatory, could transfer, dress, eat, use the toilet, and bathe with only minimal supervision or set up assistance. R#10's balance was not steady but she was able to stabilize without staff assistance. Review of Social Services Assessment (SSA) dated 07/19/16 revealed there were no behavior monitoring interventions and R#10 tending to exhibit hoarding behaviors. The SSA said that R#10 was visited by an LPC (Licensed Professional Counselor) as needed. In an interview on 03/29/17 at 5:05 p.m., R#10 said she liked her room but needed more room for her things. R#10 said she did not remember much about coming to the facility except that a nurse came into her room and took her things away and left her with very little clothing and few belongings. R#10 said she had been afraid to speak with anyone at the facility regarding her missing things because she was afraid of retaliation. R#10 said she could not give much detail on what was taken but she knew it was clothing. R#10 said she had to go to buy more clothing because her missing items were not replaced. Observation of R#10's room during the interview on 03/29/17 at 5:05 p.m. revealed two large bags full of items on the floor against her small chest of drawers; a tall stack of items including books and other personal items; a large tub next to her bed, and a small path available from the bed to the walkway outside the room. When asked what was in the bags of items R#10 answered that they were things that she bought at the store since coming to the facility. R#10 said her family members did not live in the area and she had no one to help her buy things, so she purchased items that she needed, such as snacks, when the facility took residents to the store. In an interview on 03/30/17 at 2:50 p.m., the Assistant Director of Nurses (ADON) said R#10 was a hoarder and she gathered silverware, food, books and other things in her room. The ADON said on shower days, the CNAs tried to go in and check through her belongings to clean out food that was saved, including spoiled food from her tray that she put in a covered plastic tub or under her bed. The ADON said R#10 had never brought up a concern related to missing belongings, but everything that R#10 brought from home was in very poor condition. The ADON said R#10 was living alone at home and was found on the floor of her home. She was taken to the hospital and had a Urinary Tract Infection. The condition of R#10's home was unlivable and she could not return there. Review of R#10's Care plan revealed R#10 had impaired/decline in cognitive function or impaired thought process related to her [DIAGNOSES REDACTED].#10 using external cues, and to approach R#10 in a calm, unhurried manner. The Care Plan also included a risk for falls due to cognitive loss and lack of safety awareness. Approaches included monitoring her vital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) signs, providing medication evaluation as needed, rehabilitation therapies, providing verbal cues to safety, and placing her call light within reach. Review of R#10's Care Plan revealed no plan to address R#10's hoarding behavior. Review of Facility Policy entitled Person-Centered Care Plan effective 11/28/16 revealed the following: POLICY: The Center must develop and implement a baseline person-centered care plan within 48 hours for each patient that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care. Person-Centered care means to focus on the patient as the locus of control and support the patient in making his/her own choices and having control over his/her daily life. A comprehensive, individualized care plan will be developed within 7 days after completion of the comprehensive assessment for each patient that includes measureable objectives and timetables to meet a patient's medical, nursing, nutrition, and mental and psychosocial needs that are identified in the comprehensive assessments. The interdisciplinary team, in conjunction with the patient and/or resident representative, as appropriate, will establish the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. Documentation will show evidence of: -Patient's goals and preferences; -Patient's status in triggered Care Area Assessments (CAAs); -Development of care planning interventions for all CAAs triggered by the MDS; and -Rationale for not care planning for a specific triggered CAA. A comprehensive person-centered care plan must be developed for each patient and must describe the following: 2.1 Services that are to be furnished. 2.4 In consultation with the patient and the resident representative(s): 2.4.2 Preference and potential for future discharge. 2.4.2.1 Document whether the patient's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities. 4. The PointClickCare (PCC) care plan library is used to develop the patient's care plan. 4.1 The care plan must be customized to each individual patient's preferences and needs. 4.2 If there is not a care plan available to meet a patient's needs, staff may develop one using the custom care plan in PCC. 7. The Center has the responsibility to assist patients to participate by: 7.4 Incorporating the patient's personal and cultural preferences in developing goals of care. Review of CMS Form 672 dated 03/28/17 revealed 21 residents with behavioral healthcare needs.
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one Resident, (R#5), of 15 Residents reviewed for Activities of Daily Living (ADL) care, received the necessary services to maintain good grooming and personal hygiene. The facility did not assist R#5 with bathing and grooming according to his regular schedule, and did not offer bathing and grooming at other times when R#5 refused bathing and grooming at his regularly scheduled times. This failure could affect 48 residents who needed the assistance of one or two staff with bathing. The findings were: Review of R#5's Admission Record dated 03/29/17 revealed he was admitted to the facility on [DATE]. R#5's [DIAGNOSES REDACTED]. R#5 was [AGE] years old. Review of R#5's Annual Minimum Data Set ((MDS) dated [DATE] revealed he had moderate difficulty hearing others but could usually understand others and could usually make himself understood. R#5 had severe cognitive impairment but had no behavior concerns. R#5 needed supervision with the help of one person to transfer from bed to chair but did not walk. R#5 used a wheelchair to move around the facility. R#5 required limited assistance with dressing, supervision with toileting, and extensive assistance with personal hygiene. R#5 required physical help with one person's assistance with bathing and was unsteady in his balance but could stabilize without staff assistance. R#5 had occasional urinary incontinence but had no bowel incontinence. Review of R#5's Physician order [REDACTED]. Review of R#5's Care Plan dated 02/02/17 revealed R#5 was at risk for alterations in comfort related to chronic pain, with interventions including Evaluation of pain characteristics: quality, severity, location, precipitating/relieving factors. Review of R#5's Care Plan dated 10/13/16 revealed he required assistance at times for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, toileting related to Dx (diagnosis) of Dementia. Interventions included providing R#5 with extensive assistance of one for bathing and with set-up, limited assist of one for personal hygiene. There was no care plan related to R#5 resisting or refusing ADL care. R#5 was occasionally incontinent of bowel. Review of R#5's Care Plan dated 01/06/15 revealed he had difficulty recalling recent events. Interventions included asking R#5 about preferences throughout the day and to validate his thoughts/feelings when confused or anxious. There was no care plan intervention related to R#5's refusal of ADL care due to his dementia or pain. On initial tour on 03/28/17 at 9:20 a.m., when asked how he was doing, R#5 said I haven't had a bath in days. When asked if he could remember when he last had a bath, R#5 did not replly. R#5 was lying in bed with his covers up to his chin. R#5 had some facial hair stubble on his chin and jaw area. In an interview on 03/28/17 at 12:20, Family Member (FM) AA said there was a shortage of staff at the facility especially on the evening and night shift. FM AA said she visited R#5 in the evening and sometimes noticed R#5 needed a shower and shave, but when she asked a CNA to bathe R#5, they would sometimes reply, No showers tonight. We're short handed. FM AA said R#5 did not like to shower and got confused about time and needed to be approached at different times to get him to shower. FM AA said sometimes R#5's hair smelled dirty. Review of the 300 Hall Shower Schedule (undated) revealed R#5 was scheduled for a bath on Tuesdays, Thursdays and Saturdays during the 6:00 a.m. to 2:00 p.m. shift. Review of the POC (Plan of Care) Legend Report dated 03/29/17 revealed the following codes for the ADL Activity Log: Code 99: Resident not available. Code 98: Resident refused. Code 97: Not applicable. Review of the ADL Activity Log for February, 2017 and March, 2017, revealed the following schedule of bathing for R#5: February, 2017: 02/02/17 (Thursday) : Shower at 1058 02/04/17 (Saturday): Blank 02/07/17 (Tuesday): Shower at 1435 02/09/17 (Thursday): Shower at 1142 02/11/17 (Saturday): Code 97 (not applicable) 02/12/17 (Sunday): Code 97 (not applicable) 02/14/17 (Tuesday): Code 99 (not available) 02/16/17 (Thursday): Code 97 (not applicable) 02/18/17 (Saturday): Shower at 1359 02/20/17 (Monday): Shower at 2150 02/21/17 (Tuesday): Shower at 1311 02/23/17 (Thursday): Shower at 1249 02/25/17 (Saturday): Code 98 (refused)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) 02/26/17 (Sunday): Code 97 (not applicable) 02/28/17 (Tuesday): Shower at 1359 March 2017 03/02/17 (Thursday): Code 98 (refused) 03/04/17 (Saturday): Shower at 1300 03/07/17 (Tuesday): Shower at 1359 03/09/17 (Thursday): Shower at 1141 03/11/17 (Saturday): Shower at 1306 03/14/17 (Tuesday): Shower at 1127 03/16/17 (Thursday): Code 98 (refused) 03/18/17 (Saturday): Code 98 (refused) 03/21/17 (Tuesday): Code 98 (refused) 03/23/17 (Thursday): Code 97 (not applicable) 03/25/17 (Saturday): Shower at 1311 03/28/17 (Tuesday): Code 98 (refused) In an interview at 1:50 p.m. on 03/29/17, Nurse Practice Educator (NPE) B said she did not know why Certified Nursing Assistants (CNAs) would mark not applicable in the computer system on some of the days that R#5 was scheduled for a bath. NPE B said CNAs should tell the charge nurse if R#5 refused showers and the charge nurse should enter a nurses note into the Progress Notes regarding R#5's refusal of a bath. Review of Progress Notes for February, 2017 and March, 2017 revealed only one note related to R#5 refusing showers: 02/26/17: (R#5) refused shower on 02/25/17. Was asked again this shift and again refused. Multiple attempts made with no success. In an interview on 03/29/17 at 2:00 p.m., CNA F said her offered R#5 a shower around 8 a.m. on 03/28/17, and again at 9 a.m. on 03/281/7. CNA F said R#5 said, No, I think I'll stay right here. In an interview on 03/29/17 at 2:30 p.m., CNA C, who worked the 8 a.m. to 2 p.m. shift, said she talked to R#5 on 03/28/17 about taking a bath, and he agreed. CNA C said she got supplies together for bathing R#5 and when she went to get him for his shower, he refused to shower. CNA C said CNA D also tried to get R#5 to bathe on 03/28/17 after CNA C tried, but R#5 refused a shower. In an interview on 03/29/17 at 2:40 p.m., FM AA said no one called her to tell her R#5 was refusing showers. FM AA said she had difficulty showering R#5 when he lived with her because he would say he did not sweat so did not need a shower. FM AA said R#5 did not keep track of time and needed frequent prompting that it was time for a shower. In an interview on 03/29/17 at 3:20 p.m., NPE B provided the following policy regarding residents who refused care: 03/22/17: Reporting changes in Condition/Refusal of Care Anytime a resident refuses any portion of their care the charge nurse must be informed. This includes, but is not limited to bathing, turning & repositioning, incontinent care, toileting, dressing, meals, fluids, transfers. For refusal of care only document refusal. Do not use the Not Applicable button. If the resident was not available for your shift document it as such. There are several ways to do this: A verbal report to the nurse; STOP WATCH paper form or on the Ipad through POC (Plan of Care); Give the nurse a note. Review of CMS Form 672 dated 03/28/17 revealed 48 residents in the facility needed the assistance of one or two staff with bathing.
F 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who entered the facility without pressure ulcers did not develop pressure ulcers and a resident having pressure ulcers received care and treatment consistent with professional standards of practice to promote healing and prevent further development of skin breakdown or pressure ulcers for one resident (R #1) of four residents reviewed for pressure ulcers. R #1's Stage 2 coccyx pressure ulcer discovered on 03/27/17, acquired in the facility, steadily worsened to an unstageable pressure ulcer by 03/28/17. The facility did not provide R #1 with pressure relief (offloading) off her buttocks at least every two hours on two separate days. The facility did not ensure R #1 wore her Prevelon Boots (pressure relieving devices for the feet) as ordered. R #1 developed three separate Deep Tissue Injuries (DTI) on her left heel that the facility was not aware of, until the surveyor's injury. The facility's Assistant Director of Nurses (ADON) inaccurately identified R #1's DTI's as calluses and incorrectly measured each wound. The abovce failures resulted in an Immediate Jeopardy (IJ) situation on 04/14/17. While the IJ was removed on 04/18/17, the facility remained out of compliance at actual harm with a scope identified as pattern. The facility was continuing to monitor to ensure continued implementation of their plan of removal. These failures could affect four residents with pressure ulcers and 53 residents receiving preventative skin care and place them at risk for developing new pressure ulcers or a decline in existing pressure ulcers. The findings included: R #1's Face Sheet dated 03/30/17 documented a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with the [DIAGNOSES REDACTED].(presence of right artificial hip joint) on 03/09/17, and Anxiety Disorder. R #1's Quarterly Minimum (MDS) data set [DATE] documented R #1: -Sometimes made self understood and sometimes understood others. -Had a Brief Interview of Mental Status score of 0 (severely impaired). -Required extensive assistance with one person physical assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. -Was frequently incontinent of urine and always incontinent of bowel. -Was 62 inches tall and weighed 95 pounds. -Was at risk for pressure ulcer development but did not have any unhealed pressure ulcers. -Skin and Ulcer Treatments: Pressure reducing device for bed. R #1's Braden Scale for Predicting Pressure Ulcer Risk dated 01/18/17 revealed a score of 14. The assessments score guide documented MODERATE RISK: Total Score 13-14. R #1's Care Plan revised 02/09/17 documented Resident is at risk for skin breakdown as evidenced by incontinence of bowel and bladder . The care plan did not include a turning schedule specific for R #1. R #1's most current Care Plan was dated 10/20/16, revised 02/09/17 and documented: -(R #1) is at risk for decreased ability to perform ADL (activities of daily living) in bathing, grooming, personal hygiene, dressing, bed mobility, transfer, locomotion, and toileting related to Dementia. Requires extensive assist of two . -(R #1) has impaired/decline in cognitive function/impairment thought processes related to a condition other than [MEDICAL CONDITION]: Dementia . R #1's Admission assessment dated [DATE] revealed R #1 did not have any pressure ulcers. R #1's Skin assessment dated [DATE] revealed no evidence of R #1 having any pressure injury/ulcer to her coccyx/buttocks. R #1's Five Day Assessment Minimum (MDS) data set [DATE] documented R #1: -Sometimes made self understood and sometimes understood others. -Had a Brief Interview of Mental Status score of 1 (severely impaired). -Required extensive assistance with one person physical assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 11) -Was frequently incontinent of urine and always incontinent of bowel. -Was 62 inches tall and weighed 101 pounds. -Was at risk for pressure ulcer development but did not have any unhealed pressure ulcers. -Skin and Ulcer Treatments: Pressure reducing device for bed and wheelchair. R #1's Care Plan revised 03/27/17 documented (R #1) has actual alteration in skin integrity as evidenced by Stage 2 Pressure Ulcer (Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister) to coccyx. Goal: Wound will remain free from signs and symptoms of infection X 90 days. Interventions: Apply skin barrier cream, Pressure redistribution surfaces to chair as per protocol, Weekly wound assessment to include measurement and description of wound . The care plan did not include a turning schedule specific for R #1. R #1's physician's orders [REDACTED]. Softens and loosens necrotic tissue while maintaining a moist wound healing environment) every shift. R #1's Skin-Pressure Ulcer Report dated 03/27/17 at 12:30 p.m. documented: Initial Stage: Stage 2 Date first observed: 03/27/17, acquired in-house Body Location: Coccyx, light drainage amount- serous Wound appearance: Intact/pink: No; Intact/Deep purple: No; Granulation (red): 0%; Eschar (grey/black/brown) (eschar: a slough or piece of dead tissue that is cast off from the surface of the skin): 0% Slough (moist yellow/grey) (slough-yellow [MEDICATION NAME] tissue associated with bacterial activity): 0%; [MEDICATION NAME] (Stage 2): 100%; Surrounding tissue: mascerated (softening and breaking down of skin resulting from prolonged exposure to moisture), purple/maroon; Wound edges: distinct, even with base; Measurement: 3.3 X 3.5 X 0.1 centimeters Interventions: turning program and chair cushion. R #1's Braden Scale for Predicting Pressure Ulcer Risk dated 03/28/17 at 6:21 p.m. revealed a score of 13. The assessments score guide documented MODERATE RISK: Total Score 13-14. Observation of R #1 on 03/28/17 at 8:52 a.m. revealed she sat in her wheelchair (on pressure relieving cushion) in front of the television of the common area of the 300 Hall. Observation of R #1 on 03/28/17 at 9:35 a.m. revealed R #1 sat in her wheelchair in the therapy room engaged in therapy with the speech therapist. Observation of R #1 on 03/28/17 at 10:38 a.m. revealed R #1 she sat in her wheelchair in front of the television of the common area of the 300 Hall. Observation of R #1 on 03/28/17 at 11:05 a.m. revealed R #1 sat in her wheelchair and was being escorted to the dining room. Observation of R #1 on 03/28/17 at 1:20 p.m. revealed R #1 sat in her wheelchair in front of the television of the common area of the 300 Hall. Interview with Licensed Vocational Nurse (LVN) L on 03/28/17 at 2:38 p.m. revealed LVN L stated she was the facility's Treatment Nurse. LVN L explained the facility had a turning program that included repositioning of a any resident needing assistance to turn every two hours. As LVN L was gathering equipment from her Treatment Cart for R #1, LVN L explained R #1 had a Stage 2 pressure ulcer that was acquired in the facility on 03/27/17. LVN L described R #1's wound as An open area, a broken blister to her coccyx with the peri-wound red and it measured 3.3 X 3.5 X 0.1. The surveyor accompanied LVN L into R #1's room. R #1's coccyx/sacrum wound presented as a wound to the coccyx/sacrum extending to both upper buttocks. the wound bed was covered with yellow and black tissue and the peri-wound was red, blanchable at 12 o'clock - 3 o'clock, non-blanchable on the rest of the surrounding area. LVN L said, The wound has significantly deteriorated. I see slough and eschar with some granulation around the wound. The peri-wound is slightly blanchable on top area. There is approximately 75% eschar and slough and there is an [MEDICATION NAME] island. The wound measures 9.5 X 8.5 X 0.4 centimeters. The wound is now Unstageable. I am going to call the doctor before I do the treatment for [REDACTED]. Interview with CNA M on 03/28/17 at 3:33 p.m. revealed she stated all residents who needed assistance in turning or changing were to be repositioned and/or changed at least every two hours. CNA M said that included R #1 until LVN L told her to reposition R #1 every hour due to her wound worsening. CNA M stated she did not ususally reposition R #1 while she was in her wheelchair. CNA M said she did not know if she needed to reposition her while in the wheelchair because That isn't included in her Kardex. It just says to reposition every two hours when in bed. The Kardex is the CNA Care Plan/instructions we follow to care for the residents. Each resident has their own Kardex. CNA M said she assisted R #1 out of bed at approximately 7:30 a.m. CNA M said R #1 was out of bed from approximately 7:30 a.m. to 2:15 p.m. CNA M said R #1 had been busy with therapy all morning and then she went to the dining room for lunch therefore, she could not change or get her out of the wheelchair. CNA M confirmed she provided R #1 with incontinent care twice her shift at 7:15 a.m. and at 2:15 p.m. R #1's Skin-Pressure Ulcer Report dated 03/28/17 at 5:06 p.m. documented: Initial Stage: Stage 2 Date first observed: 03/27/17, acquired in-house Body Location: Coccyx, moderate drainage amount- serous. Deepest Stage: Unstageable (slough and/or eschar prevents evaluation) (unstageable pressure ulcer: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) Wound appearance: Intact/pink: No; Intact/Deep purple: No; Granulation (red): 0%; Eschar (grey/black/brown): 75-99%; Slough (moist yellow/grey): 25-49%; [MEDICATION NAME] (Stage 2): 1-24%; Surrounding tissue: purple/maroon; Wound edges: distinct, diffuse, not clearly visible; Measurement: 8.5 X 9.5 X 0.4 centimeters Interventions: mattress- low air loss, turning program, and chair cushion. R #1's Physician order [REDACTED]. treatment for [REDACTED]. Low Air Loss Mattress and Prevalon Boots when in bed. R #1's Care Plan updated 03/28/17 documented 03/28/17: Stage 2 wound area has deteriorated to an unstageable wound with 75% eschar, 25% slough, and [MEDICATION NAME] islands present. Interventions: 03/28/17: Provide wound treatment as tolerated, Prevelon Boots when in bed, Pressure redistribution surfaces to bed, Pressure redistribution surfaces to chair as per protocol, Weekly wound assessment to include measurement and description of wound. Observation of R #1 on 03/29/17 at 8:50 a.m. revealed she sat in her wheelchair (on wheelchair cushion) in front of the television of the common area of the 300 Hall until 10:10 a.m. At 10:10 a.m. R #1 was escorted to the therapy room and was engaged in therapy still sitting in her wheelchair until 10:33 a.m. At 10:33 a.m., R #1 was assisted to bed on a low air loss mattress. Blue Prevalon boots were applied to R #1's feet. Observation of R #1 on 03/29/17 at 10:45 a.m. revealed R #1 sat in her wheelchair in front of the television of the common area of the 300 Hall. Observation of R #1 on 03/29/17 at 11:15 a.m. revealed R #1 sat in her wheelchair in the dining room. Observation of R #1 on 03/29/17 at 1:50 a.m. revealed R #1 sat in her wheelchair in front of the television of the common area of the 300 Hall. Further interview with CNA M on 03/29/17 at 4:52 p.m. revealed she was caring for R #1. CNA M said R #1 was repositioned every hour when in bed. CNA M said she did not reposition R #1 when R #1 sat in her wheelchair. CNA M stated she had not been instructed to reposition/offload R #1 when sat sat up in the wheelchair or couch. CNA M said she changed R #1's brief at approximately 9:00 a.m. and again at approximately 2:00 p.m., when she put R #1 in bed. CNA M said she was fixing to go back to check if R #1 needed changing. R #1's Skin-Pressure Ulcer Report dated 03/29/17 at 5:01 p.m. documented: Initial Stage: Stage 2 Date first observed: 03/27/17, acquired in-house Body Location: Coccyx, moderate drainage amount- serous. Deepest Stage: Unstageable (slough and/or eschar prevents evaluation) Wound appearance: Intact/pink: No; Intact/Deep purple: No; Granulation (red): 0%; Eschar (grey/black/brown): 75-99%; Slough (moist yellow/grey): 25-49%; [MEDICATION NAME] (Stage 2): 25-49%; Surrounding tissue: mascerated, purple/maroon; Wound edges: distinct, diffuse, not clearly visible; Measurement: 8.5 X 9.5 X 0.4 centimeters

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 12) Interventions: mattress- low air loss, turning program, and chair cushion. Observation of R #1 on 03/30/17 at 8:48 a.m. revealed R #1 sat in her wheelchair in the therapy room with the male therapist assisting her with exercises. Observation of R #1 on 03/30/17 at 10:08 a.m. revealed R #1 sat in her wheelchair in front of the television of the common area of the 300 Hall. Observation of R #1 on 03/30/17 at 10:28 a.m. revealed R #1 was taken to therapy while still seated in her wheelchair. R #1 was escorted back to the 300 Hall common area at 10:51 a.m. and remained seated in her wheelchair in front of the television. At 11:00 a.m., R #1 was assisted with transfer from her wheelchair to the couch in the same area in front of the television. R #1 was relieved from pressure of her buttocks for 10 seconds before she was again seated on the couch. At 11:03 a.m. R #1 was transferred from the couch to her wheelchair and was escorted to the therapy room. Again, pressure was relieved from her buttocks for approximately 10 seconds. At 12:00 p.m. R #1 was observed to be sitting in her wheelchair in the dining room. Interview with CNA's E and O on 03/30/17 at 12:14 p.m. revealed they both assisted R #1 out of bed at approximately 7:15 a.m. on 03/30/17. Observation of R #1 on 03/30/17 at 1:45 p.m. revealed R #1 was transferred from her wheelchair to her bed. LVNs A and L were redirecting R #1 to stay in bed since R #1 was attempting to get out of bed. LVN A said We layed her down but she does't want to stay in bed. Observation of R #1 on 03/30/17 at 1:50 p.m. revealed LVN L was preparing to provide R #1 treatment to her pressure ulcer. LVN L removed R #1's dressing dated 03/29/17; R #1's coccyx/sacrum presented with her per-wound extending further out compared to 03/29/17. The peri-wound also had dark maroon/purple discoloration. Some of the black tissue was seen to attach to the dressing. Approximately 85% of the wound bed contained yellow and black tissue. LVN L said, There is a difference from yesterday to today, a slight improvement is that the Santyl is working to remove the slough and some [MEDICATION NAME] and granulation tissue is evident in a small part of the wound. The peri-wound is deteriorating, the redness extending outward. There is now Deep Tissue Injury (Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or [MEDICATION NAME] separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss) noticeable in the per-wound that was not there yesterday. Just the wound bed measures 9.0 X 7.0 centimeters, now measuring all the peri-wound included is 15 X 8.9 X 0.4 centimeters. LVN L said R #1 should be repositioned every two hours but had instructed staff to reposition her every hour yesterday. LVN L said she did not physically follow-up to ensure R #1 was frequently repositioned. LVN L said she knew the staff left R #1 sitting up at times because she frequently attempted to get out of bed and since she was a high fall risk, staff were trying to prevent her from falling. The surveyor informed LVN L of R #1's observations sitting up in her wheelchair and the couch. LVN L said It sounds like she is up too long without relieving pressure. We have to coordinate with therapy and other staff to come up with a better plan so we can offload her bottom. LVN L confirmed 10 seconds of offloading during a transfer was not enough time to relieve pressure to her buttocks. LVN L said prolonged pressure on the wound could contribute to her pressure ulcer deteriorating. R #1's Skin-Pressure Ulcer Report dated 03/30/17 at 2:42 p.m. documented: Initial Stage: Stage 2 Date first observed: 03/27/17, acquired in-house Body Location: Coccyx, moderate drainage amount- serous. Deepest Stage: Unstageable (slough and/or eschar prevents evaluation) Wound appearance: Intact/pink: No; Intact/Deep purple: No; Granulation (red): 0%; Eschar (grey/black/brown): 75-99%; Slough (moist yellow/grey): 25-49%; [MEDICATION NAME] (Stage 2): 25-49%; Surrounding tissue: mascerated, purple/maroon; Wound edges: distinct, diffuse, not clearly visible; Measurement: 8.5 X 9.5 X 0.4 centimeters Interventions: mattress- low air loss, turning program, and chair cushion. physician progress notes [REDACTED]. The wound is reported to have been 3 X 3 centimeters stage 2 on 03/28/17. It has progressed rapidly since then. Presently she is on an air mattress. Exam reveals a 9.5 X 8.5 centimeter butterfly shaped wound to sacrum. Wound is mostly slough with some eschar, and is thus unstageable. She is receiving Santyl on the slough and covered with a foam dressing Based on my exam noted above and her overall clinical picture, there is a Kennedy ulcer (Kennedy terminal ulcers are irregularly shaped and often resemble a pear, butterfly or horseshoe. They usually start as a blister or an abrasion, but quickly get deeper and turn different colors. It can start as reddish color, then turn yellow or black. Kennedy ulcers also tend to start out larger than a regular bedsore, occurs when someone is nearing the end of life), and she has a poor prognosis. Continue with the Santyl, offloading pressure, and optimize nutrition. Monitor this closely. *Record review of all of R #1's Progress Notes and physician's orders [REDACTED].#1 being in the dying process. The only [DIAGNOSES REDACTED]. There were no orders or referrals for hospice services. R #1 was ordered to receive skilled therapy services from Speech therapy, Occupational Therapy, and Physical Therapy on 03/20/17. Interview with the Assistant Director of Nurses (ADON) on 03/31/17 at 9:31 a.m. revealed she was aware of R #1's deteriorating pressure ulcer. The ADON stated the facility procedure was for every resident to be checked, changed, and repositioned, if needed, at least every two hours. The ADON said each resident had their own care plan and Kardex for individualized care. The ADON said if there was a change in condition of a resident or a change in intervention, then the care plan would be reviewed and revised if needed. The ADON said if the resident was up in the wheelchair a long period of time and could not independently reposition, then the care plan would specify repositioning while in the wheelchair. The ADON said she did not see an intervention in R #1's care plan to be repositioned while she sat in her wheelchair. The ADON stated R #1 received therapy services daily and would probably get up from her wheelchair during that time. The ADON said she would follow-up with R #1's care plan and review the interventions. Further interview with LVN L on 03/31/17 at 10:00 a.m. revealed she and the surveyor reviewed R #1's Skin-Pressure Ulcer report dated 03/30/17. The surveyor informed LVN L of the discrepancy of measurements from R #1's Skin-Pressure Ulcer Report compared to the measurements she called out to the surveyor during the treatment on 03/30/17. LVN L said Oh, these measurements were from 03/29/17, I'm sorry, I messed up, yours are correct, I will have to do an addendum. LVN L asked if the surveyor could provide her with the measurements she called out during the observation of R #1's treatment on 03/30/17. LVN L stated she used the National Pressure Ulcer Advisory Panel recommendations as a reference. LVN L said the facility procedure for identification and treatment of [REDACTED]. LVN L said every resident received a complete skin check on admission and then weekly. LVN L said if the resident had a wound, that wound was assessed and staged by her. LVN L said if a pressure ulcer was present, the resident's care plan was updated and the physician would be kept informed. LVN L explained that the turning program meant that a resident was to be turned every two hours. LVN L said R #1 was not diagnosed to be in the dying process, that she knew of. Interview with LVN A on 03/31/17 at 10:34 a.m. revealed she frequently cared for R #1 and was currently R #1's nurse. LVN A said R #1 was not in the stages of the dying process. LVN A reviewed R #1's clinical record and said R #1 was not on hospice and there was no documentation to suggest R #1 was in the dying process. Interview with Physician T on 03/31/17 at 10:37 a.m. revealed he confirmed he assessed R #1 on 03/30/17. Physician T said he diagnosed R #1 with a Kennedy Ulcer because of the rapid deterioration and the appearance of the wound. Physician T said the staff informed him that all preventative care, including offloading, was being provided and still her wound deteriorated. The surveyor informed Physician T of her observations of R #1's positioning for the past three days. Physician T said I was not told that, I was told they were offloading her. The surveyor informed Physician T of the staff transferring R #1 from her wheelchair to a couch was included in their offloading techniques. Physician T said 10 seconds or even one minute is not enough time to relieve pressure to an area, especially an impaired area. Physician T stated prolonged pressure could contribute to a pressure ulcer worsening but could not say definitively at this time that is what happened to R #1's wound. Physician T said R #1 was not in the active dying process and confirmed R #1 was being provided with skilled Physical, Occupational, and Speech Therapy. Interview with the Director of Rehabilitation (DOR) on 03/31/17 at 11:28 a.m. revealed R #1 received speech therapy five days a week for approximately 40-50 minutes. The DOR said R #1 remained seated in her wheelchair as she received her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0314 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 13) therapy. The DOR confirmed R #1 was not offloaded off her buttocks at any time during her therapy session. Interview with the Occupational Therapy Assistant (OTA) on 03/31/17 at 11:31 a.m. revealed R #1 received occupational therapy five days a week. The OTA stated R #1's therapy included grooming and hygiene, upper body dressing, dynamic sitting during activity of daily living care, and transfers. The OTA said the longest she had gotten R #1 to stand was three minutes, on a good day, which was rare. The OTA said the majority, if not all, of the therapy was done with R #1 in a sitting position. Interview with the Physical Therapy Assistant (PTA) on 03/31/17 at 11:33 a.m. revealed R #1 received physical therapy five times a week. The PTA said the longest he had gotten R #1 to stand was 20 minutes but those 20 minutes included several sitting breaks. The PTA said R #1 did not stand daily and it depended on her cognition each day. The PTA said the majority of R #1's therapy was done sitting in her wheelchair. According to the National Pressure Ulcer Advisory Panel website (http://www.npuap.org/resources/educational-and-clinical-resources/pressure-injury-staging-illustrations/) searched on 04/05/17 revealed: Pressure Injury Prevention Points: Risk Assessment: 1 Consider bedfast and chairfast individuals to be at risk for development of pressure injury. 2 Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury as soon as possible (but within 8 hours after admission). 3 Refine the assessment by including these additional risk factors: A. Fragile skin B. Existing pressure injury of any stage, including those ulcers that have healed or are closed C. Impairments in blood flow to the extremities from vascular disease, diabetes or tobacco use D. Pain in areas of the body exposed to pressure . 5 Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface. If the risk is from malnutrition, address those problems. Skin Care: .Avoid positioning an individual on an area of [DIAGNOSES REDACTED] or pressure injury Repositioning and Mobilization: 1 Turn and reposition all individuals at risk for pressure injury, unless contraindicated due to medical condition or medical treatments. 2 Choose a frequency for turning based on the support surface in use, the tolerance of skin for pressure and the individual's preferences. 3 Consider lengthening t/e turning schedule during the night to allow for uninterrupted sleep/ 4 Turn the individual into a 30-degree side lying position, and use your hand to determine if the sacrum is off the bed 5 Avoid positioning the individual on body areas with pressure injury. 6 Ensure that the heels are free from the bed. 7 Consider the level of immobility, exposure to shear, skin moisture, perfusion, body size and weight of the individual when choosing a support surface. 8 Continue to reposition an individual when placed on any support surface. 9 Use a breathable incontinence pad when using microclimate management surfaces. 10 Use a pressure redistributing chair cushion for individuals sitting in chairs or wheelchairs. 11 Reposition weak or immobile individuals in chairs hourly Observation of R #1 on 04/13/17 at 10:10 a.m. revealed R #1 was asleep in bed on an inflated air mattress. R #1 had white compression stockings on each leg; R #1's heel rested on her bed. R #1 did not have on any pressure relieving devices on her feet nor any pillows under her feet. Prevalon boots were not visible anywhere in her room. Interview with LVN A on 04/13/17 at 10:42 a.m. revealed R #1's sacral wound developed E.Coli (Escherichia Coli: a bacteria that normally lives in the intestines) in the wound. LVN A said R #1 likely got E.Coli in her wound from her urine or feces contaminating the wound. LVN A said R #1 had lost approximately five pounds in one week from 04/01/17-04/07/17. LVN A stated it was a possibility that R #1 was not given her bolus feedings as ordered through her [DEVICE] because out of 26 cans of enteral feeding R #1 had in her room, only three cans were missing within that one week. LVN A said she informed the ADON of R #1's weight loss. Record review of R #1's April 2017 Medication Review Report documented Vital 1.5 bolus feeding/ one can after meals PRN if eats less than 50% of meal .Start date 01/13/17. Record review of R #1's Weight Summary Report dated 04/13/17 documented 03/27/17 = 105.0 pounds; 04/06/17 = 101.5 pounds; 04/11/17 = 98.0 pounds .Height 62.0 inches Ideal Body Weight: 110.0 pounds. Record review of R #1's April 2017 Medication Administration Record [REDACTED].Start date: 03/27/17. The MAR indicated [REDACTED]. There were no entries documented of percentage of food eaten or bolus feeding given or not, for the entire day of 04/03/17, for lunch or supper on 04/04/17, for the entire day on 04/05/17 or for supper on 04/06/17. Observation of R #1 on 04/13/17 at 12:31 p.m. revealed R #1 was asleep in her bed, on an air mattress. R #1's feet rested on the mattress. R #1 did not have any pressure relieving devices on her feet nor pillows under her feet. Prevalon boots were not visible anywhere in her room. CNA F entered the room and attempted to awaken R #1 to eat. R #1 refused. CNA F said he was not sure if R #1 was suppose to wear Prevelon boots. CNA F said he recalled R #1 using Prevalon boots sometime last week but did not know what happened to them. CNA F looked throughout R #1's room and found the Prevalon boots in her closet. Upon the surveyor's request, CNA F removed R #1's white compression stockings and presented R #1's feet; R #1 had dark brown and light marroon discoloration to three seperate areas of her left heel. Interview with LVN A on 04/13/17 at 12:37 p.m. revealed she stated R #1 should be wearing her Prevalon boots whenever she was in bed. LVN A said R #1 could not put the Prevalon boots on herself. LVN A said the nursing staff were responsible for ensuring R #1 had the Prevalon boots on when she was in bed. LVN A said she was not aware of R #1 having any pressure areas on her feet. LVN A said she did not know if R #1 had her Prevalon boots on. Interview with Physician T on 04/13/17 at 1:00 p.m. revealed this surveyor explained to Physicain T her observations of R #1 not being offloaded off her sacrum, not being provided with her Prevelon boots to offload her heels, the CNA not aware of R #1's order when to wear her Prevalon boots, of the seven pound weight loss R #1 had within 15 days due to possibly not receiving her bolus feedings as ordered, and R #1 developing new wounds on her left heel. Physician T said he was not aware of R #1 having any new pressure areas. Physician T said Not maintaining adequate nutrition and not providing offloading to pressure areas can contribute to lack of healing of pressure ulcers and development of new pressure ulcers. Physician T stated he was aware R #1 did not eat much of her meals therefore that was why he ordered the bolus feedings. Physician T did not provide an answer when asked if R #1's pressure ulcers could have been avoided but said This did not help. Physician T said R #1 was not in the terminal state. Physician T said he was going to order R #1 scheduled bolus enteral feedings. Interview with the ADON on 04/13/17 at 1:20 p.m. revealed she stated that the Treatment Nurse (LVN L) had to leave. The ADON said she was available to assess R #1. The ADON stated she was not aware of R #1 having any pressure areas to her feet.The surveyor accompanied the ADON into R #1's bedroom. There were two blue Prevalon boots on R #1's wheelchair. R #1 was lying in bed on her right side with her eyes closed. The ADON said R #1 probably took the boots off when asked if R #1 should be wearing the boots. Upon the surveyor's request, the ADON assessed R
F 0328 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that respiratory care services provided by the facility, as outlined in the comprehensive care plan (Physician Orders), met professional standards of practice, for two Residents (R #4 and R #14) of three residents reviewed with orders for continuous oxygen and three residents (R #4, R

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0328 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 14) #17, and R #19) of seven residents reviewed for oxygen concentrator filter and oxygen tubing maintenance. 1.) The facility staff did not follow R #4's Physician order [REDACTED]. R#4's oxygen concentrator setting was observed at 2 and 2.5 LPM on three occasions on [DATE]-[DATE], and during transfer to the shower room when R #4 was provided with no oxygen. 2.) The facility did not ensure that R #14 wore her oxygen during ambulation, she became short of breath and she fell , fracturing her right hip and hitting her head. The facility did not follow R #14's Physician order [REDACTED]. R #14 expired on [DATE], in the facility. 3.) The facility did not ensure R #4's most current oxygen therapy order of continuous Oxygen at 3 liters per nasal cannula was accurate on her Treatment Administartion Record and the oxygen therapy was consistently monitored. 4.) The facility did not ensure the oxygen tubings were changed weekly, as per the facility's policy and oxygen concentrator filters remained clean for R #4, R #17, and R #19. The above failures resulted in an Immediate Jeopardy (IJ) situation on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a potential for more than actual harm with a scope identified as pattern. The facility was continuing to monitor to ensure continued implementation of their plan of removal. This failure could place 22 residents who required oxygen therapy at risk for shortness of breath and respiratory distress. Findings included: R #4: R #4's Face Sheet dated [DATE] documented a [AGE] year-old female admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. R #4's [DATE] Treatment Administration Record (TAR) documented O2 (Oxygen) via NC (nasal cannula) @ (at) 2LPM as needed for SOB. Start date: [DATE]. R #4's physician's orders [REDACTED].@ 3 LPM via NC continuously. R #4's Care Plan dated [DATE] documented (R #4) exhibits a risk for complications of infection related to increased risk of reoccurence of aspiration pneumonia .Approaches: .O2 as ordered. R #4's Significant Change MDS dated [DATE] documented R #4: -Rarely made self understood and rarely understood others. -Had short and long-term memory problems and had severely impaired cognitive skills for daily decision making. -Had an active [DIAGNOSES REDACTED]. -Received oxygen therapy while not a resident and while a resident at the facility. Observation of R #4 on [DATE] at 8:50 a.m. revealed R #4 was sleeping and was receiving O2 @ 2 LPM via NC. Observation of R #4 on [DATE] at 10:51 a.m. revealed R #4 was receiving O2 @ 2.5 LPM per NC. At 10:54 a.m., Licensed Vocational Nurse (LVN) I and Certified Nurse Aides H and J assisted to transfer R #4 from the bed to the Geriatric chair. During this time, CNA H removed R #4's nasal cannula, leaving R #4 without any oxygen administration. Both CNAs escorted R #4 to the shower room, without any oxygen therapy. At 11:33 a.m., R #4 was escorted back to her bedroom in the Geriatric chair and transferred to bed with the assistance of LVN I and CNAs H and J. Once R #4 was in bed, LVN I replaced R #4's nasal cannula in R #4's nares at 11:45 a.m The oxygen concentrator was set at 2.5 LPM. -R #4 was not provided with oxygen therapy from 10:51 a.m.- 11:45 a.m. Observation of R #4 on [DATE] at 11:30 a.m. revealed R #4 was lying in bed receiving O2 @ 2.5 LMP via NC. LVN K entered the room and said R #4 had continuous O2 @ 3LPM ordered when asked how much oxygen R #4 should be receiving. Upon the surveyor's request, LVN K inspected R #4's oxygen concentrator and stated It is set at 2.5 liters, it should be at 3 liters. LVN K adjusted R #4's oxygen concentrator to 3 LPM and then checked R #4's oxygen saturation which was 92%. LVN K stated LVN I was currently R #4's nurse. Interview with LVN I on [DATE] at 11:35 a.m. revealed she stated R #4 was ordered to receive continuous O2 @3LPM via NC. LVN I was informed of R #4 only receiving O2 @ 2.5 LPM on [DATE] and [DATE]. At this time LVN K approached LVN I and the surveyor that R #4's concentrator was set at 2.5 LPM but was adjusted to 3LPM. LVN I verified she had not verified that R #4's oxygen concentrator was set at 3 liters. LVN I explained R #4 used to receive O2 at 2.5 LPM but her order was recently changed to 3 LPM. LVN I reviewed R #4's Treatment Administration Record and said It still say's 2 liters as needed, that's not right. After LVN I reviewed R #4's physician's orders [REDACTED]. The new order was not transcribed to the record, I will do it immediately. LVN I was informed of the surveyor's observation of R #4 not receiving any oxygen on [DATE] while being prepared and escorted to the shower room; LVN I verified she witnessed R #4 without any oxygen in the shower room then said R #4 should have had the oxygen since her order was to receive oxygen continuously. LVN I stated R #4 should have been provided with a portable oxygen tank. LVN I said she took responsibility for not ensuring R #4 had oxygen on and then said each nurse caring for R #4 was responsible to ensure R #4 received continuous oxygen. LVN I stated the procedure was that any nurse that received a new order, transcribed that order to the Medication Administration Record. LVN I said each nurse caring for R #4 should have referred to the Treatment Administration Record to document the prescribed treatment administered but that was not done. R #14: Review of the Admission Record (closed record) dated [DATE] revealed R#14 was initially admitted on [DATE] and readmitted on [DATE]. R#14's [DIAGNOSES REDACTED]. R#14 was [AGE] years old. R #14 expired on [DATE], in the facility. Review of R#14's Quarterly Minimum Data Set ((MDS) dated [DATE] revealed she was clearly able to understand others and had good ability to express her ideas and wants. R#14 had no cognitive deficits and scored 15 out of 15 points on the Brief Interview for Mental Status (BIMS). R#14 had no mood or behavior problems. R#14 was able to walk independently using a walker in her room or corridor with supervision, could dress herself, toilet herself, but required physical help in part of the bathing activity with the help of one person. R#14 was not steady in her balance during transitions and walking but was able to stabilize herself without staff assistance. R#14 was continent of bowel and bladder. R#14 had frequent pain and was on scheduled pain medication. R#14 had shortness of breath or trouble breathing with exertion, when sitting at rest and when lying flat. R#14 received oxygen therapy. Review of R#14's Care Plan included the following: R#14 requires assistance/is dependent for ADL (Activities of Daily Living) care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: SOB (shortness of breath) with exertion secondary to [MEDICAL CONDITION]. Interventions included R#14 was independent with bed mobility and with transfers. There were no other interventions listed. Initiated [DATE] and revised [DATE]. R#14 is at nutritional risk and may gain or lose weight due to fluid retention as evidenced by [MEDICAL CONDITION] to lower extremities. Interventions included evaluating for proper consistency of diet, honoring food preferences within meal plan, weighing weekly and alerting dietitian and physician to any significant loss or gain, monitoring for changes in nutritional status, and monitoring intake at all meals. Initiated [DATE]. No interventions were noted regarding elevating BLE when [MEDICAL CONDITION] was present. R#14 has [MEDICAL CONDITION]. Interventions included administering oxygen as ordered/indicated, evaluating breath sounds and respiratory function for rate, rhythm, depth, rhonchi, wheezes q (every) shift and with a change of condition, notify physician of changes from baseline; observe patient at rest and exertion, notify physician of increased weakness and fatigue, and observe for worsening SOB, notify physician if unrelieved or new SOB at rest. Initiated [DATE] with no updates. Review of R#14's Order Summary Report printed on [DATE] for the date range [DATE] to [DATE] revealed the following physician orders [REDACTED]. [DATE]: [MEDICATION NAME] 2 puffs inhale two times a day related to [MEDICAL CONDITION] [DATE]: Oxygen at 2L(liters)/min (minute) via nasal cannula continuously, every shift related to [MEDICAL CONDITION] [DATE]: [MEDICATION NAME] ER Extended Release 30 mg two times daily for pain [DATE]: Duo Neb .5 mg (milligram)/3 mg one vial with Nebulizer every six hours as needed [DATE]: [MEDICATION NAME] Liquid 100 mg/5ML Give 10 ml by mouth every 6 hours as needed for cough [DATE]: Check O2 (oxygen) daily and prn (as needed) every day shift for dyspnea. [DATE]: [MEDICATION NAME] Solution XXX,[DATE].5 (3) mg/3ML (milliliters) 1 vial inhale orally every 6 hours related to [MEDICAL CONDITION] [DATE]: Daliresp Tablet 500 mcg (micrograms) Give 1 tablet by mouth one time a day related to [MEDICAL CONDITION]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	**04/18/2017**

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 0328

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 15)
[DATE]: [MEDICATION NAME] Tablet 20 mg once daily for [MEDICAL CONDITION]
Review of Interdisciplinary Team Notes dated [DATE] revealed After speaking with nurse verified that resident is on continuous O2 at 2 L/M per NC (two liters of oxygen per nasal canula).
Review of R#14's Treatment Administration Record (TAR) for February, 2017 revealed the following oxygen levels when they were checked during the day shift 8:00 a.m. to 4:00 p.m.:
[DATE]: 93
[DATE]: 95
[DATE]: 95
[DATE]: 93
[DATE]: 93
[DATE]: 96
[DATE]: 94
Review of Progress Notes from R#14's facility record revealed the following:
[DATE]: R#14 was found on floor in front of her recliner. Cause of fall was slippery socks. Socks changed out.
[DATE]: R#14 with increased occurrence of shortness of breath/cough. Administered nebulizer treatment with little results observed. Oxygen inspected and working properly. Oxygen sats = 84% and toes cyanotic. Oxygen increased to 3.5L via nasal canula. Oxygen sats were 90% after oxygen adjustment.
[DATE]: R#14 slipped while ambulating to the restroom in her room. No injury sustained. Root cause was R#14 was wearing inappropriate footwear.
[DATE]: Family member of R#14 expressed concern that R#14 had swelling in bilateral extremities (BLE). Nurse noted 2+ [MEDICAL CONDITION]. Nurse notified physician and physician gave no new orders but will see R#14 on [DATE].
[DATE]: physician progress notes [REDACTED]. Referral to Pulmonologist was pending since [DATE]. Cancel that referral and refer R#14 to a different physician. BLE Venous Doppler (blood flow test) ordered, as well as chest xray, an echocardiogram, and labs. For [MEDICAL CONDITION], change [MEDICATION NAME] 60 mg QD (daily) to [MEDICATION NAME] 60 mg BID
(twice daily) and monitor fluid status.
Review of Telephone Physician order [REDACTED].
Review of chest xray report dated [DATE] revealed R#14 had mild [MEDICAL CONDITIONS].
Review of Progress Notes from R#14's facility record revealed the following:
[DATE]: Results from Ultrasound and Venous Doppler were negative at this time.
[DATE] 02:25: R#14 resting quietly in bed with head of bed raised for comfort. Oxygen via nasal canula in place at this time. 3+ [MEDICAL CONDITION] to BLE noted. No cough observed or reported. Seems to tolerate increased [MEDICATION NAME]
well. Denies pain.
[DATE] 15:09: Nurse Practitioner (NP) Progress Note. NP seeing R#14 due to episode of [MEDICAL CONDITION] with sats dropping
to 85%. Staff report she was walking to the bathroom without her oxygen and became very short of breath. ,[DATE]+ [MEDICAL CONDITION] to BLE. Chest xray showed mild [MEDICAL CONDITION]. [MEDICATION NAME] increased to 80 mg BID X 3days, then
resume 60 mg BID. Prognosis: Guarded, worse today. Today with episode of [MEDICAL CONDITION].
[DATE]: Facility staff meeting, reviewed R#14's condition. Nursing, Social Services, Dietary Manager, ADON, and Administrator present. R#14 has gained 11 pounds in 30 days. R#14 has 2+ [MEDICAL CONDITION] to BLE, is sedentary and compliant with elevating her lower extremities. Started on weekly weights X 4 weeks to monitor fluid balance.
[DATE] 10:37: Referral to Pulmonologist. Expected to be one to two weeks before appointment can be made but it would be made as soon as possible.
[DATE] 12:25: physician progress notes [REDACTED]. Yesterday with episode of [MEDICAL CONDITION]. Follow up in a few days
around ,[DATE].
[DATE] 12:16: R#14 had an unplanned transfer.
[DATE] 17:55: Change in Condition. Per CNA F, R#14 was standing awaiting shower and fell against door, hitting head, arm and hip on floor upon landing. R#14 oxygen saturation 82 on room air at time of incident and 95% on 31 NC (nasal canula) upon return to room. Observations included labored breathing, shallow breathing crackles/rales present, right upper, right lower, left upper, left lower pitting right LE [MEDICAL CONDITION], pitting left LE [MEDICAL CONDITION], lower body right side weakness.
Review of hospital History and Physical revealed R#14 was admitted to the hospital on [DATE] at 18:21. Review of R#14's present illness revealed she had [MEDICAL CONDITION] from diastolic dysfunction [MEDICAL CONDITION], hypertensive [MEDICAL
CONDITION], type 2 diabetes, chronic [MEDICAL CONDITION] pacemaker defibrillator, dementia, history of [MEDICAL CONDITION]
(rapid heart rate), [MEDICAL CONDITION], left carotid endarterectomy (surgery on neck artery), depression, history of back surgery, hysterectomy, and rotator cuff injury.
Review of hospital Assessment and Plan dated [DATE] revealed R#14 had Pneumonia, right femoral neck fracture, [MEDICAL CONDITIONS] with exacerbation, and Chronic [MEDICAL CONDITION].
In an interview on [DATE] at 11:45 a.m., CNA E said on [DATE] she assisted R#14 out of her room to go to the shower room. CNA E said R#14 complained of being a little dizzy when she opened the shower room door and R#14 fell to the side. CNA E said R#14 fell right inside the shower room by the door. CNA E said R#14 said she was dizzy and could not breathe. CNA E said R#14 used her regular walker with a portable oxygen tank on it but she was not using oxygen when she was walking. CNA E said she had showered R#14 before and R#14 usually only needed help with washing her back and drying off. CNA E said R#14 usually had her portable oxygen on the other side of the wall from the shower and she wore the nasal canula in the shower. CNA E said R#14 told her she did not need her oxygen and sometimes did not wear her oxygen. CNA E said she was not given instructions about whether R#14 needed to wear her oxygen all of the time but she knew R#14 could not be left alone. CNA E said they just walked two doors down from R#14's room to the shower room when R#14 fell .
In an interview at 11:55 a.m. on [DATE], Family Member (FM) BB, who also resided in the facility, said he was receiving therapy when R#14 fell on [DATE]. FM BB went to check on R#14 and found her sitting in a chair in bad pain. FM BB said R#14 told him she got out of her wheelchair and walked into the bathroom and fell . R#14 had a big knot on the right side of her head and broke the knob off of her hip. FM BB said R#14 returned to the facility after her hip was repaired, and passed away as he was talking to her on [DATE].
In an interview on [DATE] at 1:00 p.m., FM CC, a family member of R#14, said R#14 always had her oxygen on when he visited her, and when R#14 left the facility, she was always using her portable oxygen
In an interview at 10:10 a.m. on [DATE] with CNA E, when asked if she had asked R#14 to put her oxygen on before they walked down the hall toward the shower room on [DATE], CNA E said she did not ask R#14 to put on her oxygen because she did not want to pressure her to wear her oxygen. CNA E said sometimes R#14 wore her oxygen and sometimes she did not wear it.
In an interview at 10:20 a.m. on [DATE], the Assistant Director of Nurses (ADON), when asked how often R#14 wore her oxygen, said R#14 went without her oxygen sometimes and probably wore her oxygen about 50% of the time. The ADON said R#14 would go
around the building without it sometimes. Surveyor asked the ADON if there was any change in R#14's breathing and need for oxygen the week before she fell , and the ADON replied that she did not know of any change.
In an interview with the Administrator on [DATE] at 10:10 a.m., the Administrator said she did not report the incident with R#14's fall on [DATE] because it was a witnessed fall. The Administrator said they talked with staff and determined it was not a reportable incident.
Review of Event Summary Report of incident with R#14 dated [DATE] at 11:30 a.m. revealed R#14 sustained an abrasion, bruise, fracture and skin tear. Emergency Medical was called and R#14 was transferred to the hospital at 12:15 p.m. Circumstances of the event and immediate actions taken: Resident (R#14) amb (ambulated) 30 ft (feet) to shower room. became dizzy and fell . CNA reported immediately to LVN who assessed. O2 Sat at 85%. Resident c/o (complained of) pain to head and right arm, skin tear noted. Neuro check complete and WNL (within normal limits). Full ROM (range of motion) to all extremities. Resident assisted back to room and requests to sit in recliner. O2 applied, SAT return to 95% (in less than) 1 min.
(minute). Skin Tear cleansed and covered. The fall was related to ambulation status, resident was weak and stated she felt dizzy once arriving to shower area. R#14 had a change of condition in the last seven days with 3+ [MEDICAL CONDITION] to bilateral feet, with [MEDICATION NAME] increased to 80 mg. Current medication that may be causative to the fall included antihypertensives, diuretics, and narcotics. R#14 was administered [MEDICATION NAME] ER Tablet Extended Release 30 mg within eight hours prior to the fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0328 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 16) Review of Event Summary Report of incident with R#14 dated [DATE] revealed root cause to be Resident oxygen saturation decreased and caused resident become dizzy. O2 at 2L ordered continuous, but resident refuses to wear O2 while in bathroom in room and while showering. CNA was unable to effectively catch resident in time to prevent fall. Corrective actions included further education on use of oxygen continuous, standby assistance and s/s (signs/symptoms) of possible complications related to oxygen dependent residents. Resident needs to use her portable oxygen during bathing process to prevent desaturation. Resident c/o pain to right hip over one hour after being in chair and was sent out to hospital with a right [MEDICAL CONDITION]. Review of Witness Statements dated [DATE], attached to the facility Risk Management System report, revealed the following: I, (CNA E) did observe on [DATE] at 10:20 a.m. I went to (R#14's) room and told her it's her shower day. Let's go get your shower. She said okay. I have my clothes and stuff together lets go. I was walking her to the shower room. We opened the door. Right when she was entering the bathroom, (R#14) stood very still then she lost balance and fell over on the floor. I tried to catch her but she fell too quickly. She ended up falling on her shoulder and hit her head. I, (CNA G), did observe on (blank) at (blank). Have witnessed (R#14) to refuse to use her oxygen to the restroom or the shower room. On occasion. I, (CNA H), did observe on (blank) at (blank). In the past I have known (R#14) not to wear her o2 to bathroom or shower room. The facility's Oxygen: Transport of Patient on Continuous Oxygen Policy dated [DATE] documented The center will provide full (oxygen level at time of departure), portable oxygen equipment (concentrator, compressed oxygen, liquid portable oxygen) for patients requiring continuous oxygen .Portable oxygen will be set up by a licensed nurse, respiratory therapist, or rehabilitation therapist as appropriate. The duration begins . or allows for travel time to the destination where capability to continue to deliver oxygen exists. The facility's Oxygen Concentrator Procedure dated [DATE] documented 1. Verify order .11. Set liter flow per order. 12. Attach prescribed oxygen delivery device and apply oxygen delivery to the resident . R #17: R #17's [DATE] physician's orders [REDACTED].Oxygen at 3 LPNC continuously- start date: [DATE]. R #17's [DATE] TAR indicated the order for oxygen at 3 LPNC but did not indicate when her oxygen tubing should have been changed. Observation of R #17 on [DATE] at 9:48 a.m. revealed she received oxygen at 3 liters per nasal cannula. R #17's oxygen tubing was dated [DATE]. On [DATE] at 9:50 a.m., the Administrator was informed an IJ situation was identified due to the above failures. Observation of R #16 on [DATE] at 9:51 a.m. revealed she received oxygen at 3 liters per nasal cannula. R #16's oxygen concentrator filter had white dust covering the filter. R #16's oxygen tubing was dated [DATE]. R #19: R #19's Face Sheet dated [DATE] documented a [AGE] year-old female asmitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. R #19's admission orders [REDACTED]. Observation of R #19 on [DATE] at 9:54 a.m. revealed she received oxygen at 3 liters per nasal cannula. R #19's oxygen tubing was not dated. Interview with LVN U on [DATE] at 10:14 a.m. revealed she did not know how many liters of oxygen R #19 should be receiving. LVN U reviews R #19's [DATE] Medication Administration Record [REDACTED]. I have to check her orders. LVN U consulted with LVN K then LVN K reviewed R #19's physician's orders [REDACTED]. On [DATE] at 11:08 a.m., LVN K informed the surveyor that she received orders for R #19 and provided a copy of the orders. R #19's physician's orders [REDACTED].@ 2LPNC PRN (as needed) for saturation level less than 90% for [DIAGNOSES REDACTED].#19's oxygen should have retrieved anorder from her physician for the oxygen. R #18: R #18's [DATE] physician's orders [REDACTED]. Review of R #18's [DATE] TAR indicated her oxygen concentrator filter was only cleaned on [DATE]. The TAR contained a signature on [DATE], indicating that the oxygen tubing was changed on that day. -However, observation on [DATE] revealed R #18's tubing was dated [DATE]. Observation of R #18 on [DATE] at 9:57 a.m. revealed she received oxygen at 4 liters per nasal cannula. R #18's oxygen concentrator filter was covered with white dust. R #18's oxygen tubing was dated [DATE]. Interview with LVN U on [DATE] at 10:09 a.m. revealed she stated she had recently started working in the facility approximately one week ago. LVN U said oxygen tubing should be changed weekly but did not know what the facility's policy and procedure was or who was responsible for cleaning them. LVN U stated she did not know anything about the maintenance of the filters. Interview with LVN I on [DATE] at 10:12 a.m. revealed she stated oxygen tubing should be changed and dated weekly, at the same time the concentrator filters were cleaned. LVN I said this was scheduled on Sundays and the night shift was responsible for ensuring it was done. LVN I said each resident's Treatment Administration Record should have address the cleaning of filters and changing of oxygen tubing. On [DATE] at 5:59 p.m., the facility was notified of the acceptance of the final Plan of Removal (POR). The final Plan of Removal documented: This Plan of Removal is in response to the alleged identification of Immediate Jeopardy communicated by the survey team on [DATE] during a return visit prompted by the annual survey with exit date of [DATE] at (the facility). The alleged Immediate Jeopardy findings were identified in the following areas: -Quality of Care -Neglect The facility respectfully submits this Plan of Removal (POR) pursuant to Federal and State regulatory requirements. Submission of this Letter of Credible Allegation does not constitute an admission or agreement of the facts alleged or the conclusions set forth in the verbal and written notice of Immediate Jeopardy and/or any subsequent Statement of Deficiencies. Corrective Action and Identification: Review of orders identified 22 of 72, residents as having orders for Oxygen. This facility has put in place immediate corrective action as evidenced by: 1. On [DATE], nursing administration provided education on abuse and neglect to staff members. On [DATE], nursing administration reeducated staff members on abuse and neglect. 2. On [DATE] residents on oxygen therapy assessed and compliance with orders verified by nursing administration. 3. On [DATE], a complete audit of residents using oxygen was conducted by nursing administration and care plans were reviewed and revised accordingly. 4. On [DATE], nursing administration provided education to nursing staff regarding use of oxygen and maintenance of filter and tubing. 5. On [DATE], the MAR indicated [REDACTED]. MAR indicated [REDACTED]. 6. On [DATE] Kardexes were updated to reflect those residents receiving oxygen with the verbiage 'respiratory therapy'. A Kardex is a tool that is used by the CNAs and nursing to communicate what type of care the resident needs from the CNA perspective. The Kardex is located in the CNA electronic tablet that is used to document resident care and provides information regarding resident care and needs specific to the CNA level. It is the equivalent of a care plan. Examples of items on a Kardex are mobility, transfer, eating and oxygen status. 7. On [DATE], Kardexes were updated to reflect those residents that are on oxygen with the verbiage 'Continuous Oxygen therapy' or 'PRN oxygen therapy'. 8. On [DATE], nursing staff educated regarding the MAR updates that reflect the tubing and filter changing and the oxygen tubing/filter maintenance process. The tubing will be changed on Sunday by the charge nurse on the ,[DATE] shift. Charge nurse to remove and replace old tubing and date new tubing. Remove old filter and replace with new filter. Humidification bottles are to be removed and replaced as needed. Humidification bottles will be dated each time they are replaced. 9. CNAs on [DATE] received education provided regarding the updated Kardex that reflects the verbiage, 'Continuous Oxygen therapy' or 'PRN oxygen therapy'.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0328 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 17) 10. CNAs on [DATE] received education to alert charge nurses or nurse managers on all resident oxygen use refusals and changes of condition for appropriate intervention and documentation. Example: If the resident refuses oxygen the CNA will alert the charge nurse so that the charge nurse can come assess and speak to the resident to explain the importance of using the oxygen as ordered and check the residents oxygen saturation levels, level of consciousness, nail beds and fingers for cyanosis and encourage the resident to comply with the oxygen as ordered. The nurse will be sure to document the resident's status and concerns and communicate this to nurse management, the attending MD and family if needed. Charge nurse and CNA will ensure that resident is safe from falls or other injury related to refusal of oxygen. Changes of condition related to respiratory distress such as shortness of breath, dusky nail beds, increase in confusion, drowsiness CNA to alert charge nurse, charge nurse to perform respiratory assessment of resident including but not limited to oxygen saturation levels, vital signs, lung sounds and intervene and notify as appropriate, and document findings and outcomes. 11. Care Plans were reviewed and revised to ensure they reflect the current oxygen therapy orders. Care plans will be updated [DATE]. 12. Nursing staff to receive the above education before returning to the floor. The Administrator and other consultants re-assessed residents who were identified by the facility as having a need for oxygen thereapy Through this process, on [DATE], the facility provided an updated list of those residents on oxygen therapy. Four residents were identified as having physician orders [REDACTED]. The surveyors confirmed the Plan of Removal had been implemented sufficiently to remove the Immediate Jeopardy by: -eight CNA's were interviewed and confirmed they had been trained as to which residents required oxygen therapy, and could identify them. -five nurses were interviewed and said they had been trained as to which residents were identified with use of oxygen therapy, and could identify them. The nurses said they received instruction and were able to state and retrieve the current physician's orders [REDACTED]. -The updated resident Kardex's and Treatment Administration Record for all residents with ordered oxygen therapy were reviewed and it was found they contained the order for oxygen and when the oxygen tubing were to be changed and when the oxygen filter was to be cleaned. On [DATE] at 2:54 p.m., the Administrator and the Regional Vice President were informed the IJ was removed. However, the facility remained out of compliance at a severity of the potential for more than actual harm with a scope identified as pattern. The facility was continuing to monitor to ensure assessments and interventions for oxygen therapy were accurate for all residents. Review of List of Patients on Oxygen dated [DATE] and received on [DATE] identified four residents as requiring continuous oxygen; one resident as requiring continuous oxygen at night, and 17 residents requiring oxygen as needed, for a total of 22 residents requiring oxygen therapy.
F 0353 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have sufficient staff to care for residents on the 100, 200 and 300 halls to enable these residents to reach their highest practicable level of well-being. The facility did not have a sufficient number of Certified Nursing Assistants (CNAs) on the 2:00 p.m. to 10:00 p.m. and 10:00 p.m. to 6:00 a.m. shifts to meet the needs of residents who resided on the 100, 200 and 300 halls. This failure could affect the quality of care and quality of life of 55 residents by having too few licensed staff to respond to their needs, and by having CNAs who were stressed from working double shifts to provide care when needed. The findings were: 100/200 Hall Staffing Observation at 11:00 p.m. on 04/13/17 revealed three staff members working on the 100 and 200 Halls. These included LVN N, LVN O, and CNA P. Observation of CNA P from 11:00 p.m. to 12:00 p.m. revealed she was going back and forth between the 100 Hall, which was a locked unit for female residents with [MEDICAL CONDITION]/Dementia, and the 200 Hall, assisting residents with positioning, incontinent care, and hydration. There were 49 residents on the 100 and 200 halls according to the list of residents provided by the facility on 03/28/17. Observation of LVN O from 11:00 p.m. to 1:30 p.m. revealed she was passing medications most of this time on the 200 Hall. In an interview at 11:15 p.m. on 04/13/17, LVN N said she was working the 10 p.m. to 6 a.m. shift in the 100 hall because they did not have coverage (staff to work). LVN N said six of the 18 residents who resided in the unit for Alzheimer's/Dementia females were dependent on staf to be repositioned, and 14 of the residents in that unit were incontinent. LVN N said two residents required two persons to assist them with repositioning and incontinent care. LVN N said R#23 was up all night on 04/12/17 and finally went to bed early in the morning. LVN N said her duties included completing monthly summaries on residents, doing a bowel log, filing, completing the 24 hour report, and passing 6:00 a.m. medications. LVN N said she assisted CNA P with residents who needed two person positioning and incontinent care. In an interview at 11:45 p.m. on 04/13/17, LVN O said she always worked the late shift (10:00 p.m. to 6:00 a.m.). LVN O said she passed medications on the 200 hall. LVN O said all residents were on a rotation for incontinent care and repositioning closer to the three hour mark. LVN O said two residents required two people to assist with positioning and she needed to grab someone from another hall to help the CNA with positioning them. LVN O said two CNAs were scheduled to work the 10:00 p.m. to 6:00 a.m. shift but one of them called in at the last minute and said that they could not come in. In an interview on the 100 hall secure unit at 12:20 a.m. on 04/14/17, LVN N said residents in the secure unit were changed at 9:00 p.m. and she was waiting on CNA P to assist her with a resident who needed two persons to provide care. LVN N said there were three residents in the secure unit who required two person assist with positioning and incontinent care. In an interview and observation at 12:30 a.m. on 04/14/17, CNA P said during the night all residents were checked and at one point all residents on the 100 hall secure unit were incontinent. CNA P was observed to walk R#23, who was walking around the unit, into the activities area and give her a glass of water. Review of a list of residents on the 100 hall prepared by the ADON on 04/14/17 revealed there were four residents who were incontinent. In an interview with the ADON at 12:30 a.m. on 04/14/17 surveyor showed her the list of four incontinent residents on the 100 hall, and advised her that LVN N identified 14 residents as being incontinent. The ADON said most of the residents on the 100 hall were assisted to the toilet. The ADON said it was rare that the facility would be short-handed and rare that CNAs would not show up for their shift. In an interview at 12:40 a.m. on 04/14/17, the ADON said there were no safety issues regarding staffing and there were enough staff members to care for the residents. The ADON said there was no system to staff the facility according to the accuity of the residents. The ADON said the facility looked at new residents to see if they could meet the needs of those residents with the current staff. The ADON said some behaviors require one to one supervision at the hospital. To be accepted at the facility, new residents had to be free of one to one supervision for 24 hours at the hospital. In an interview on 04/14/17 at 12:50 a.m., the ADON said if two staff members were in a room with a resident in the 100 hall secure unit, rendering care to that resident, and other residents in the secure unit were up walking around, the CNA or nurse would come out and get help to watch the resident who was walkinig. The ADON said the directive to come out and get assistance had been given to the nurse and CNA on the secure unit on the 100 hall. Observation of residents and staffing on the 100 hall secure unit on 04/14/17 from 12:20 a.m. to 12:40 a.m. revealed R#23 was walking around the unit and LVN N and CNA P went into R#25's room and closed the door to assist R#25 with incontinent care and positioning. Observation at 12:30 a.m. on 04/14/17 revealed only one other staff member, LVN O, available to assist LVN N and CNA P with monitoring R#23 was LVN O, and if LVN O came into the secure unit to assist with R#23, residents on the 200 hall would be left unsupervised. Review of R#23's face sheet dated 02/17/17 revealed she was admitted to the facility on [DATE] and readmitted on [DATE]. Her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	**04/18/2017**

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 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 18) [DIAGNOSES REDACTED]. R#23 was [AGE] years old. Review of R#23's Quarterly MDS (Minimum Data Set) dated 02/07/17 revealed her balance was not steady but she could stabilize without staff assistance. R#23 had a fall without injury in the last three months. Review of R#23's Care Plan revised on 03/28/17 revealed R#23 was at risk for falls due to impaired mobility, sporadic confusion and an actual fall without injury on 03/14/17. Interventions included assisting R#23 with ambulation providing a rolling walker. In an interview on 04/14/17 at 12:30 p.m., LVN Q said R#23 had a fall this morning. LVN Q said she was assisting other residents and found R#23 on the floor in front of the door to the bathroom in her room. LVN Q said R#23 did not appear to be injured but was on close watch to be sure. Review of R#25's Face Sheet dated 04/14/17 revealed she was admitted to the facility on [DATE]. R#25's [DIAGNOSES REDACTED]. R#25 was [AGE] years old. Review of R#25's Quarterly MDS dated [DATE] revealed she had severe cognitive impairment, and required extensive assistance with bed mobility and transfer wiht the help of two plus persons. R#25 was totally dependent on others for walking and required extensive assistance with toileting and hygiene with the help of two plus persons. Review of R#25's Care Plan dated 03/22/17 revealed she was resistant to care and required staff to approach her in a calm, unhurried manner and reassure her when needed. She required a consistent, trusted caregiver and structured daily routine when possible. Staff were required to anticipate all of her needs due to her inability to verbalize them. R#25 was at risk for injury related to falls and skin tears secondary to frail skin due to impaired mobility and lack of safety awareness. Interventions included monitoring for and assisting with toileting needs. R#26 (200 Hall) Review of R#26's Face Sheet dated 04/14/17 revealed he was admitted to the facility on [DATE]. R#26's [DIAGNOSES REDACTED]. R#26 was [AGE] years old. Review of R#26's Annual MDS dated [DATE] revealed he scored 15 points on the BIMS, indicating he was cognitively intact. R#26 was independent with supervision with most of his activities of daily living but used a wheelchair and could not walk. In an interview on 04/14/17 at 11:45 a.m., R#26 said there was a constant shortage of staff and never enough CNAs on his hall. R#26 said he could do most activities of daily living without much assistance but needed help to make his bed due to limited use of one arm. R#26 said he needed help to straighten his bed during the two to ten shift and occasionally someone would assist him. R#26 said he could hear call lights going off and not being answered during the two to ten shift. R#26 said he ate dinner in the dining room and staff would bring in residents early into the dining room, between 4:00 p.m. and 4:30 p.m., dump them and leave them unsupervised. R#26 said some of the CNAs were immature and talked like they were in high school. R#26 said this nursing home was his home and he expected maturity in the way the staff took care of him. R#5 (300 Hall) Review of R#5's Admission Record dated 03/29/17 revealed he was admitted to the facility on [DATE]. R#5's [DIAGNOSES REDACTED]. R#5 was [AGE] years old. Review of R#5's Annual Minimum Data Set ((MDS) dated [DATE] revealed he had moderate difficulty hearing others but could usually understand others and could usually make himself understood. R#5 had severe cognitive impairment but had no behavior concerns. R#5 needed supervision with the help of one person to transfer from bed to chair but did not walk. R#5 used a wheelchair to move around the facility. R#5 required limited assistance with dressing, supervision with toileting, and extensive assistance with personal hygiene. R#5 required physical help with one person's assistance with bathing and was unsteady in his balance but could stabilize without staff assistance. R#5 had occasional urinary incontinence but had no bowel incontinence. Review of R#5's Care Plan dated 10/13/16 revealed he required assistance at times for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, toileting related to Dx (diagnosis) of Dementia. Interventions included providing R#5 with extensive assistance of one for bathing and with set-up, limited assist of one for personal hygiene. There was no care plan related to R#5 resisting or refusing ADL care. R#5 was occasionally incontinent of bowel. Review of R#5's Care Plan dated 01/06/15 revealed he had difficulty recalling recent events. Interventions included asking R#5 about preferences throughout the day and to validate his thoughts/feelings when confused or anxious. There was no care plan intervention related to R#5's refusal of ADL care due to his dementia or pain. On initial tour on 03/28/17 at 9:20 a.m., when asked how he was doing, R#5 said I haven't had a bath in days. When asked if he could remember when he last had a bath, R#5 did not replly. R#5 was lying in bed with his covers up to his chin. R#5 had some facial hair stubble on his chin and jaw area. In an interview on 03/28/17 at 12:20, Family Member (FM) AA said there was a shortage of staff at the facility especially on the evening and night shift. FM AA said she visited R#5 in the evening and sometimes noticed R#5 needed a shower and shave, but when she asked a CNA to bathe R#5, they would sometimes reply, No showers tonight. We're short handed. FM AA said R#5 did not like to shower and got confused about time and needed to be approached at different times to get him to shower. FM AA said sometimes R#5's hair smelled dirty. Review of the 300 Hall Shower Schedule (undated) revealed R#5 was scheduled for a bath on Tuesdays, Thursdays and Saturdays during the 6:00 a.m. to 2:00 p.m. shift. Review of the POC (Plan of Care) Legend Report dated 03/29/17 revealed the following codes for the ADL Activity Log: Code 99: Resident not available. Code 98: Resident refused. Code 97: Not applicable. Review of the ADL Activity Log for February, 2017 and March, 2017, revealed the following schedule of bathing for R#5: February, 2017: 02/02/17 (Thursday) : Shower at 1058 02/04/17 (Saturday): Blank 02/07/17 (Tuesday): Shower at 1435 02/09/17 (Thursday): Shower at 1142 02/11/17 (Saturday): Code 97 (not applicable) 02/12/17 (Sunday): Code 97 (not applicable) 02/14/17 (Tuesday): Code 99 (not available) 02/16/17 (Thursday): Code 97 (not applicable) 02/18/17 (Saturday): Shower at 1359 02/20/17 (Monday): Shower at 2150 02/21/17 (Tuesday): Shower at 1311 02/23/17 (Thursday): Shower at 1249 02/25/17 (Saturday): Code 98 (refused) 02/26/17 (Sunday): Code 97 (not applicable) 02/28/17 (Tuesday): Shower at 1359 March 2017 03/02/17 (Thursday): Code 98 (refused) 03/04/17 (Saturday): Shower at 1300 03/07/17 (Tuesday): Shower at 1359 03/09/17 (Thursday): Shower at 1141 03/11/17 (Saturday): Shower at 1306 03/14/17 (Tuesday): Shower at 1127 03/16/17 (Thursday): Code 98 (refused) 03/18/17 (Saturday): Code 98 (refused) 03/21/17 (Tuesday): Code 98 (refused) 03/23/17 (Thursday): Code 97 (not applicable) 03/25/17 (Saturday): Shower at 1311 03/28/17 (Tuesday): Code 98 (refused)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 19) In an interview at 1:50 p.m. on 03/29/17, Nurse Practice Educator (NPE) B said she did not know why Certified Nursing Assistants (CNAs) would mark not applicable in the computer system on some of the days that R#5 was scheduled for a bath. NPE B said CNAs should tell the charge nurse if R#5 refused showers and the charge nurse should enter a nurses note into the Progress Notes regarding R#5's refusal of a bath. Review of Progress Notes for February, 2017 and March, 2017 revealed only one note related to R#5 refusing showers: 02/26/17: (R#5) refused shower on 02/25/17. Was asked again this shift and again refused. Multiple attempts made. R#13 (300 Hall) In an interview on 03/29/17 at 4:30 p.m., R#13, who resided on the 300 Hall, said sometimes CNAs were stressed and overworked and may have talked with residents in a harsh tone of voice. R#13 said he laughed off the situation because he knew those employees had a lot to do. Confidential Interviewees In a confidential interview on 03/29/17 at 3:30 p.m. with six Confidential Interviewees (CIs): - CI 1 said there was a problem with the facility not having nearly enough staff. CI 1 said sometimes employees had to work 16 hours straight and some staff had been quitting because of the long hours. CI 1 said it was difficult to allow someone to assist with personal care if they did not know you; CI 1 said there was no continuity of care for residents. -CI 2 said call lights were not answered especially from 6:00 p.m. to 8:00 p.m. at night. Two CIs said there were residents in the facility who screamed a lot, or called for help frequently. These CIs said it disturbed them to hear the residents call out all the time, and they wondered if any of the CNAs or nurses responded to them. Review of Daily Position Sheets for March, 2017, which showed the schedule of CNAs and nurses, revealed on 03/08/17 and 03/16/17 there were two CNA's who worked the 10 p.m. to 6 a.m. shift. In an interview with the Administrator on 03/31/17 at 11:10 a.m. she stated staffing CNAs was always an issue. The Administrator further stated at times nurses will work as CNAs on the over night shift. On 04/14/17 at 11:10 a.m., observation revealed R#18 was sitting up in a chair and her call light was approximately four feet away from her tied to the bed rail. Surveyor asked R #18 if she could reach her call light and R #18 said no. R #18 said the staff told her she probably would not receive her shower today because she was told it was a State Holiday. On 04/14/17 at 11:15 a.m., interview with R #19 said sometimes it took up to 4 hours for anyone to respond to the call light. Surveyor asked R #19 how she was able to account for the time. R #19 said, See that clock on the wall? Does it say 11:15 a.m.? R #19 said she had to activate her call light for her room-mate (R #18) because many times her room-mate was unable to find her call light. R #19 said the staff would answer the call light, cut the light off then say they will be right back. R #19 said the staff forget to come back. On 04/14/17 at 12:19 p.m., interview with R #17 said the facility did not have enough staff to help all the residents with care. R #17 said sometimes it took between 15 minutes to 1 hour and 45 minutes to answer her call light. R #17 said at times she had to yell out for help. R #17 said it made her feel like a piece of furniture. R #17 said many times the aides will come into the room and cut off the call light and tell her that they will be right back, but that was never the case. R #17 said she gets that answer a lot around here. Review of CMS Form 672 dated 03/28/17 revealed 48 residents in the facility needed the assistance of one or two staff with bathing; 50 residents required the assistance of one or two staff with transferring; and 55 residents required the assistance of one or two staff with toilet use. 22 residents were dependent on staff for bathing; 9 residents were dependent on staff for transferring; and 10 residents were dependent on staff for toilet use. 32 residents were occasionally or frequently incontinent of bladder and 21 residents were occasionally or frequently incontienent of bowel.
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 establish and maintain an Infection Control Program with a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents to prevent the spread of infections, to include hand hygiene procedures to be followed by staff involved in direct resident contact for one Resident (R #4) of three residents observed receiving resident personal care. Certified Nurse Aides (CNAs) H and J did not perform handwashing for at least 20 seconds, according to the facility's policy and procedure, while assisting R #4 with personal care. This failure could place 55 residents identified as needing one to two person assistance for activities of daily living (ADL) at risk for exposure to infections. The findings included: The facility's Hand Hygiene policy and procedure dated 11/28/16 documented .Hand Hygiene techniques: To wash hands with soap and water: Wet hands with warm water, apply soap to hands, and rub hands vigorously outside the stream of water for 20 seconds covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel . R #4's Face Sheet dated 12/06/16 documented a [AGE] year-old female admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. R #4's Significant Change MDS dated [DATE] documented R #4: -Rarely made self understood and rarely understood others. -Had short and long-term memory problems and had severely impaired cognitive skills for daily decision making. -Was totally dependent with two staff physical assistance for bed mobility, transfers, dressing, and personal hygiene. -Had an active [DIAGNOSES REDACTED]. -Received oxygen therapy while not a resident and while a resident at the facility. Observation of R #4 on 03/29/17 at 8:50 a.m. revealed R #4 was sleeping and was receiving O2 @ 2 LPM via NC. Observation of R #4 on 03/29/17 at 8:53 a.m. revealed R #4 layed in her bed in a face up position with her eyes closed. CNAs H and J entered R #4's room and explained to R #4 that they were going to provide incontinent care. CNA H began washing her hands and scrubbed her hands with soap for a total of 11 seconds, before rinsing. Then, CNA J washed her hands and scrubbed her hands with soap for a total of 10 seconds, before rinsing. After both CNAs completed performing incontinent care on R #4, they each doffed their gloves and again separately washed their hands. CNA J scrubbed her hands with soap for a total of five seconds, before rinsing. CNA H scrubbed her hands with soap for a total of 11 seconds, before rinsing. Simultaneous interview with CNAs H and J on 03/29/17 at 11:38 a.m. revealed they stated they were trained to wash their hands for a total of 30 seconds. CNA H said they were told to sing the Happy Birthday song twice while scrubbing their hands with soap. Each CNA said they did not count or sing while washing their hands during both observations. Observation of R #4 on 03/29/17 at 10:54 a.m. revealed CNAs H and J were preparing R #4 for a transfer from her bed to the Geriatric chair and a shower. CNA J scrubbed her hands with soap for 11 seconds, before rinsing. CNA H scrubbed her hands with soap for 11 seconds, before rinsing. Interview with the Assistant Director of Nurses (ADON) on 03/31/17 at 9:31 a.m. revealed she was informed of the observations of CNAs H and J. The ADON confirmed all staff were trained to scrub their hands with soap for a total of 20 seconds before rinsing. The facility's Medicare and Medicaid Services Form 672 documented 55 residents requiring assistance of one or two staff for ADL care.
F 0498 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that nurse aides show they have the skills and techniques to be able to care for residents' needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure nurse aides were able to demonstrate skills and techniques necessary to care for residents' needs, for one Resident (R #4) of three residents observed receiving personal care, in that: Certified Nurse Aides (CNAs) H and J did not perform handwashing for at least 20 seconds, according to the facility's policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455974	A. BUILDING _____ B. WING _____	04/18/2017

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 0498 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 20) and procedure, while assisting R #4 with personal care. This failure could place 55 residents identified as needing one to two person assistance for activities of daily living (ADL) at risk for exposure to infections. The findings included: R #4's Face Sheet dated 12/06/16 documented a [AGE] year-old female admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. R #4's Significant Change MDS dated [DATE] documented R #4: -Rarely made self understood and rarely understood others. -Had short and long-term memory problems and had severely impaired cognitive skills for daily decision making. -Was totally dependent with two staff physical assistance for bed mobility, transfers, dressing, and personal hygiene. -Had an active [DIAGNOSES REDACTED]. -Received oxygen therapy while not a resident and while a resident at the facility. Observation of R #4 on 03/29/17 at 8:50 a.m. revealed R #4 was sleeping and was receiving O2 @ 2 LPM via NC. Observation of R #4 on 03/29/17 at 8:53 a.m. revealed R #4 layed in her bed in a face up position with her eyes closed. CNAs H and J entered R #4's room and explained to R #4 that they were going to provide incontinent care. CNA H began washing her hands but only scrubbed her hands with soap for a total of 11 seconds, before rinsing. Then, CNA J washed her hands but only scrubbed her hands with soap for a total of 10 seconds, before rinsing. After both CNAs completed performing incontinent care on R #4, they each doffed their gloves and again separately washed their hands. CNA J scrubbed her hands with soap for a total of five seconds, before rinsing. CNA H scrubbed her hands with soap for a total of 11 seconds, before rinsing. Simultaneous interview with CNAs H and J on 03/29/17 at 11:38 a.m. revealed they stated they were trained to wash their hands for a total of 30 seconds. CNA H said they were told to sing the Happy Birthday song twice while scrubbing their hands with soap. Each CNA said they did not count or sing while washing their hands during both observations. Observation of R #4 on 03/29/17 at 10:54 a.m. revealed CNAs H and J were preparing R #4 for a transfer from her bed to the Geriatric chair and a shower. CNA J scrubbed her hands with soap for 11 seconds, before rinsing. CNA H scrubbed her hands with soap for 11 seconds, before rinsing. Interview with the Assistant Director of Nurses (ADON) on 03/31/17 at 9:31 a.m. revealed she was informed of the observations of CNAs H and J. The ADON confirmed all staff were trained to scrub their hands with soap for a total of 20 seconds before rinsing. The facility's Hand Hygiene policy and procedure dated 11/28/16 documented .Hand Hygiene techniques: To wash hands with soap and water: Wet hands with warm water, apply soap to hands, and rub hands vigorously outside the stream of water for 20 seconds covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel . The facility's Medicare and Medicaid Services Form 672 documented 55 residents requiring assistance of one or two staff for ADL care.
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 failed to maintain clinical records in accordance with accepted professional standards of practice, that were complete and accurately documented, for one Resident (R#4), of 15 residents whose records were reviewed. The facility did not ensure R #4's most current oxygen therapy order of continuous Oxygen at 3 liters per nasal cannula was accurately documented on her Treatment Administartion Record. This failure could place all three residents on continuous oxygen therapy and seven residents receiving respiratory treatments at risk for shortness of breath and respiratory distress. The findings included: R #4's Face Sheet dated 12/06/16 documented a [AGE] year-old female admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. R #4's March 2017 Treatment Administration Record documented O2 (Oxygen) via NC (nasal cannula) @ (at) 2LPM as needed for SOB. Start date: 01/22/16. R #4's physician's orders [REDACTED].@ 3 LPM via NC continuously. R #4's Care Plan dated 03/08/17 documented (R #4) exhibits a risk for complications of infection related to increased risk of reoccurence of aspiration pneumonia .Approaches: .O2 as ordered. R #4's Significant Change MDS dated [DATE] documented R #4: -Rarely made self understood and rarely understood others. -Had short and long-term memory problems and had severely impaired cognitive skills for daily decision making. -Had an active [DIAGNOSES REDACTED]. -Received oxygen therapy while not a resident and while a resident at the facility. Observation of R #4 on 03/29/17 at 8:50 a.m. revealed R #4 was sleeping and was receiving O2 @ 2 LPM via NC. Observation of R #4 on 03/29/17 at 10:51 a.m. revealed R #4 was receiving O2 @ 2.5 LPM per NC. At 10:54 a.m., Licensed Vocational Nurse (LVN) I and Certified Nurse Aides H and J assisted to transfer R #4 from the bed to the Geriatric chair. During this time, CNA H removed R #4's nasal cannula, leaving R #4 without any oxygen administration. Both CNAs escorted R #4 to the shower room, without any oxygen therapy. At 11:33 a.m., R #4 was escorted back to her bedroom and transferred to bed with the assistance of LVN I and CNAs H and J. Once R #4 was in bed, LVN I replaced R #4's nasal cannula in R #4's nares. The oxygen concentrator was set at 2.5 LPM. Observation of R #4 on 03/30/17 at 11:30 a.m. revealed R #4 was lying in bed receiving O2 @ 2.5 LMP via NC. LVN K entered the room and said R #4 had continuous O2 @ 3LPM ordered when asked how much oxygen R #4 should be receiving. Upon the surveyor's request, LVN K inspected R #4's oxygen concentrator and stated It is set at 2.5 liters, it should be at 3 liters. LVN K adjusted R #4's oxygen concentrator to 3 LPM and then checked R #4's oxygen saturation which was 92%. LVN K stated LVN I was currently R #4's nurse. Interview with LVN I on 03/30/17 at 11:35 a.m. revealed she stated R #4 was ordered to receive continuous O2 @3LPM via NC. LVN I was informed of R #4 only receiving O2 @ 2.5 LPM on 03/29/17 and 03/30/17. At this time LVN K approached LVN I and the surveyor that R #4's concentrator was set at 2.5 LPM but was adjusted to 3LPM. LVN I verified she had not verified that R #4's oxygen concentrator was set at 3 liters. LVN I explained R #4 used to receive O2 at 2.5 LPM but her order was recently changed to 3 LPM. LVN I reviewed R #4's Treatment Administration Record and said It still say's 2 liters as needed, that's not right. After LVN I reviewed R #4's physician's orders [REDACTED]. The new order was not transcribed to the record, I will do it immediately. LVN I was informed of the surveyor's observation of R #4 not receiving any oxygen on 03/29/17 while being prepared and escorted to the shower room; LVN I verified R #4 did not have any oxygen provided during that time and she should have since her order was to receive oxygen continuously. LVN I stated R #4 should have been provided with a portable oxygen tank. LVN I said she took responsibility for not ensuring R #4 had oxygen on and then said each nurse caring for R #4 was responsible to ensure R #4 received continuous oxygen. LVN I stated the procedure was that any nurse that received a new order, transcribed that order to the Medication Administration Record. LVN I said each nurse caring for R #4 referred to the Treatment Administration Record to document the prescribed treatment administered. Review of CMS Form 672 dated 03/28/17 revealed 7 residents were receiving respiratory therapy. The facility's list of residents receiving continuous oxygen identified three residents.