| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE & | | | PRINTED:8/17/2017 FORM APPROVED OMB NO. 0938-0391 |
|---|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 455974 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/18/2017 |
| NAME OF PROVIDER OF SU OAK CREST NURSING CEN | PPLIER | STREET ADI 1902 FM 3036 ROCKPORT | |
| For information on the nursing | home's plan to correct this deficient | cy, please contact the nursing home or the state s | |
| (X4) ID PREFIX TAG | · · · | EFICIENCIES (EACH DEFICIENCY MUST E | |
| F 0174 | Provide access to a telephone for | resident to use in private. | |
| Level of harm - Potential for minimal harm | overheard. | w, the facility failed to provide a place for 74 res | Ũ |
| Residents Affected - Many | phone had a cord and was attache This failure could affect 74 resider individuals and entities within and The findings were: In a confidential interview on 03/2 available for residents to use was no privacy in making phone calls to a place that would be more priv Observation of the resident's phon was attached to the wall jack with In an interview on 03/30/17 at 3:5 Vocational Nurse (LVN) A and N area across from the nurses statio and NPE B answered the 300 hall | tts quality of life by preventing them from havin l external to the facility. 9/17 at 3:30 p.m., six Confidential Interviewees in a common area on the 200 hall across from th from the resident's phone because it was not a co rate. e on 03/30/17 at 8:45 a.m. revealed it was locate a cord. Five residents were sitting around the te 5 p.m., when asked where the telephone for the r | g privacy when making phone calls to (CIs) said the telephone that was made en urses station. The CIs said there was ordless phone and they could not take it d in the common area of the 200 hall and lephone in the common area. residents to use was located, Licensed ts telephone was on the 200 hall in the common d access to a residents phone and LVN A common area. |
| F 0223 | others. | ouse, physical punishment, and being separate | |
| Level of harm - Immediate jeopardy | Based on interview and record rev | S HAVE BEEN EDITED TO PROTECT CONI iew, the facility failed to ensure that three Resid neglect, was free from neglect, in that: | |
| Residents Affected - Some | The facility staff did not follow R | #4's Physician order [REDACTED]. R#4's oxy n [DATE]-[DATE], and during transfer to the sl | |
| | fracturing her right hip and hitting expired on [DATE], in the facility The facility did not ensure R #4's accurate on her Treatment Admin The facility did not ensure R #4's incomplete the accurate of the accurate of the accurate filters remained clean for R #4, R The above failures resulted in an I facility remained out of complian facility was continuing to monitor This failure could place 22 resider R #1's Stage 2 coccyx pressure ul pressure ulcer by [DATE]. The fa every two hours on two separate of the facility did not ensure R #1 w developed three separate Deep Ti surveyor's injury. The facility's Assistant Director of each wound. The above failures resulted in an I facility remained out of complian monitor to ensure continued impl These failures could affect four re them at risk for developing new p The findings included: R #4's [DATE]. Treatment Admini for SOB. Start date: [DATE]. R #4's Care Plan dated [DATE] d R #4's Significant Change MDS d exarely made self understood and -Had short and long-term memory -Had an active [DIAGNSES RE -Received oxygen therapy while n Observation of R #4 on [DATE] a Vocational Nurse (LVN) I and Co During this time, CNA H remove | nost current oxygen therapy order of continuous istartion Record and the oxygen therapy was coi gen tubings were changed weekly, as per the fac #17, and R #19. mmediate Jeopardy (IJ) situation on [DATE]. W ce at a potential for more than actual harm with a to ensure continued implementation of their pla ts who required oxygen therapy at risk for short cer discovered on [DATE], acquired in the facili cility did not provide R #1 with pressure relief (lays. ore her Prevelon Boots (pressure relieving devic ssue Injuries (DTI) on her left heel that the facili 'Nurses (ADON) inaccurately identified R #1's I mmediate Jeopardy (IJ) situation on [DATE]. W ce at actual harm with a scope identified as patte ementation of their plan of removal. idents with pressure ulcers and 53 residents rec ressure ulcers or a decline in existing pressure u ocumented a [AGE] year-old female admitted to stration Record (TAR) documented O2 (Oxyger TED].@ 3 LPM via NC continuously. itemed (R #4) exhibits a risk for complication nia. Approaches: .O2 as ordered. ated [DATE] documented R #4: rarely understood others. | nysician order [REDACTED]. R #14 coxygen at 3 liters per nasal cannula was nsistently monitored. cility's policy and oxygen concentrator while the IJ was removed on [DATE], the a scope identified as pattern. The un of removal. ness of breath and respiratory distress. ty, steadily worsened to an unstageable offloading) off her buttocks at least es for the feet) as ordered. R #1 ty was not aware of, until the DTI's as calluses and incorrectly measured while the IJ was removed on [DATE], the err. The facility was continuing to eiving preventative skin care and place lears. b the facility on [DATE] with the [DIAGNOSES th) via NC (nasal cannula) @ (at) 2LPM as needed ns of infection related to increased risk of skills for daily decision making. receiving O2 @ 2 LPM via NC. 2.5 LPM per NC. At 10:54 a.m., Licensed R #4 from the bed to the Geriatric chair. o yoygen administration. Both CNAs escorted R |
| LABORATORY DIRECTOR'S REPRESENTATIVE'S SIGNA | | TITLE | (X6) DATE |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| NAME OF PROVIDER OF SU | 455974 IPPLIER | STREET ADDRE | ESS, CITY, STATE, ZIP | | |
| DAK CREST NURSING CEN | CREST NURSING CENTER 1902 FM 3036 ROCKPORT, TX 78382 | | | | |
| | | cy, please contact the nursing home or the state surv | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFORI | DEFICIENCIES (EACH DEFICIENCY MUST BE I MATION) | PRECEDED BY FULL REGULATORY | | |
| F 0223 | (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 | | |
| Level of harm - Immediate jeopardy | nasal cannula in R #4's nares at 1 | 1:45 a.m The oxygen concentrator was set at 2.5 LP en therapy from 10:51 a.m 11:45 a.m. | | | |
| Residents Affected - Some | room and said R #4 had continuo surveyor's request, LVN K inspec | tt 11:30 a.m. revealed R #4 was lying in bed receivir us O2 @ 3LPM ordered when asked how much oxy cted R #4's oxygen concentrator and stated It is set a yeen concentrator to 3 LPM and then checked R #4' | gen R #4 should be receiving. Upon the t 2.5 liters, it should be at 3 | | |
| | surveyor's request, LVN K inspec liters. LVN K adjusted R #4's oxi stated LVN I was currently R #4' Interview with LVN I on [DATE] I was informed of R #4 only rece surveyor that R #4's concentrator #4's oxygen concentrator was set changed to 3 LPM. LVN I reviewed I will do it immediately. LVN I way being prepared and escorted to th then said R #4 should have had th been provided with a portable ox, said each nurse caring for R #4 w that any nurse that received a new nurse caring for R #4 should have administered but that was not dor R #14: Review of the Admission Record [DATE]. R#14's [DIAGNOSES I Review of R#14's Quarterly Mini good ability to express her ideas : Interview for Mental Status (BIM walker in her room or corridor wi the bathing activity with the help able to stabilize herself without s on scheduled pain medication. R ⁴ when lying flat, R#14 received o Review of R#14's Care Plan inclu R#14 requires assistance/is depen- dressing, eating, bed mobility, tra secondary to [MEDICAL COND were no other interventions listed R#14 is at nutritional risk and mar extremities. Interventions listed R#14 has [MEDICAL CONDITION] was J R#14 has [MEDICAL CONDITION] was Review of R#14's Order Summar orders [REDACTED]. [DATE]: [MEDICATION NAME [DATE]: [Oxygen a 2L(liters)/mii [DATE]: [MEDICATION NAME [DATE]: [Coygen 2L(DATION NAME [DATE]: [MEDICATION NAME | ted R #4's oxygen concentrator and stated It is set a gen concentrator to 3 LPM and then checked R #4's s nurse. at 11:35 a.m. revealed she stated R #4 was ordered was set at 2.5 LPM on [DATE] and [DATE]. At th was set at 2.5 LPM to the was adjusted to 3LPM LV1 at 3 liters. LVN I explained R #4 used to receive OF red R #4's Treatment Administration Record and sai #4's physician's orders [REDACTED]. The new on is informed of the surveyor's observation of R #4 no e shower room; LVN I verified she witnessed R #4 + ne oxygen since her order was to receive oxygen con- ygen tank. LVN I said she took responsibility for no as responsible to ensure R #4 received continuous o order, transcribed that order to the Medication Adr e referred to the Treatment Administration Record to be end was set (MDS) dated [DATE] revealed R#14 was in REDACTED]. R#14 was [AGE] years old. R #14 ex- ind wants. R#14 had no cognitive deficits and score (S). R#14 had no mood or behavior problems. R#14 th supervision, could dress herself, toile therself, bu of one person. R#14 was not steady in her balance of the sistance. R#14 was not steady in her balance of the following: dent for ADL (Activities of Daily Living) care in ba ansfer, locomotion, toileting related to: SOB (shortne TTION]. Interventions included R#14 was independ d evaluating for proper consistency of diet, honoring, titian and physician to any significant loss or gain, ri 11 meals. Initiated [DATE]. No interventions were nor resent. DN]. Interventions included administering oxygen as y Report printed on [DATE] for the date range [DATE]. So DB, notify physician if unrelieved or new SOB a y Report printed on [DATE] for the date range [DATE]. E Extended Release 30 mg two times daily for p m//3 mg one vial with Nebulizer every six hours as 1 Liquid 100 mg/SML Give 10 ml by mouth every (y and prn (as needed) every day shift for dyspnea. 2 Solution XXX,[DATE].5 (3) mg/3ML (milliliters), g (micrograms) Give 1 tablet by mouth one time a da 2 Tab | a 2.5 liters, it should be at 3 a sort of a sort of the s | | |
| | [DATE]: 94 Review of Progress Notes from R [DATE]: R#14 was found on floo [DATE]: R#14 with increased occ observed. Oxygen inspected and | #14's facility record revealed the following: r in front of her recliner. Cause of fall was slippery s urrence of shortness of breath/cough. Administered working properly. Oxygen sats = 84% and toes cyar | nebulizer treatment with little results | | |
| | inappropriate footwear. [DATE]: Family member of R#14 [MEDICAL CONDITION]. Nurs [DATE]: physician progress notes refer R#14 to a different physicia echocardiogram, and labs. For [N NAME] 60 mg BID (twice daily) and monitor fluid st | ulating to the restroom in her room. No injury sustain expressed concern that R#14 had swelling in bilate se notified physician and physician gave no new ord (REDACTED]. Referral to Pulmonologist was pen n. BLE Venous Doppler (blood flow test) ordered, a (EDICAL CONDITION], change [MEDICATION] atus. | eral extremities (BLE). Nurse noted 2+ lers but will see R#14 on [DATE]. Iding since [DATE]. Cancel that referral and as well as chest xray, an | | |
| | Review of Progress Notes from R [DATE]: Results from Ultrasound [DATE] 02:25: R#14 resting quie | rder [REDACTED]. [DATE] revealed R#14 had mild [MEDICAL CON #14's facility record revealed the following: and Venous Doppler were negative at this time. tly in bed with head of bed raised for comfort. Oxyg N] to BLE noted. No cough observed or reported. S | gen via nasal canula in place at this | | |
| | well. Denies pain. [DATE] 15:09: Nurse Practitioner dropping | (NP) Progress Note. NP seeing R#14 due to episod | | | |
| | | C | , | | |

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| NAME OF PROVIDER OF SU | 455974 IPPLIER | STREET ADDR | RESS, CITY, STATE, ZIP | |
| OAK CREST NURSING CEN | NTER | 1902 FM 3036 ROCKPORT, 7 | FX 78382 | |
| | | cy, please contact the nursing home or the state sur | | |
| | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| | home's plan to correct this deficient SUMMARY STATEMENT OF E OR LSC IDENTIFYING INFORM (continued from page 2) CONDITION] to BLE. Chest xra 3days, then resume 60 mg BID. Prognosis: G [DATE]: Facility staff meeting, re Administrator present. R#14 has j compliant with elevating her lows (DATE] 10:37: Referral to Pulmo as soon as possible. [DATE] 12:25: physician progress days around ,[DATE]. [DATE] 12:16: R#14 had an unpl [DATE] 17:55: Change in Conditi hip on floor upon landing. R#14 or return to room. Observations incl lower, left upper, left lower pittin side weakness. Review of hospital History and PF present illness revealed she had [] [MEDICAL CONDITION], type 2 diabetes, ci CONDITION] (rapid heart rate), [MEDICAL CO surgery, hysterectomy, and rotato Review of hospital Assessment an CONDITIONS] with exacerbatio In an interview on [DATE] at 11:2 CNA E said R#14 complained of said R#14 used her regular wakke E said she had showerd R#14 be usually had her portable oxygen C CNA E said R#14 told her she dit instructions about whether R#14 said hey just walked two doors d In an interview on [DATE] at 11:2 ci CNA E said R#14 told her she dit instructions about whether R#14 said hey just walked two doors d In an interview on [DATE] at 1:2 ci CNA E said R#14 told her she dit instructions about whether R#14 said hey just walked two doors d In an interview on [DATE] at 1:2 ci ci c | [ROCKPORT, 7 cy, please contact the nursing home or the state sur DEFICIENCIES (EACH DEFICIENCY MUST BE MATION) y showed mild [MEDICAL CONDITION]. [MED uarded, worse today. Today with episode of [MED viewed R#14's condition. Nursing, Social Services gained 11 pounds in 30 days. R#14 has 2+ [MEDIG er extremities. Started on weekly weights X 4 weel nologist. Expected to be one to two weeks before a s notes [REDACTED]. Yesterday with episode of [anned transfer. on. Per CNA F, R#14 was standing awaiting show oxygen saturation 82 on room air at time of inciden uded labored breathing, shallow breathing crackles g right LE [MEDICAL CONDITION], pitting left hysical revealed R#14 was admitted to the hospital MEDICAL CONDITION] from diastolic dysfuncti hronic [MEDICAL CONDITION] pacemaker defi DNDITION], left carotid endarterectomy (surgery o r cuff injury. d Plan dated [DATE] revealed R#14 had Pneumor n, and Chronic [MEDICAL CONDITION]. I5 a.m., CNA E said on [DATE] she assisted R#14 being a little dizzy when she opened the shower ro wer room by the door. CNA E said R#14 said she r with a portable oxygen tank on it but she was not fore and R#14 usually only needed help with wash n the other side of the wall from the shower and sl 1 not need her oxygen and sometimes did not wear needed to wear her oxygen all of the time but she cown from R#14's room to the shower room when I DATE], Family Member (FM) BB, who also reside E]. FM BB went to check on R#14 and found her s chair and walked into the bathroom and fell . R#14 r hip. FM BB said R#14 returned to the facility aff | rvey agency. B PRECEDED BY FULL REGULATORY PICATION NAME] increased to 80 mg BID X DICAL CONDITION]. s, Dietary Manager, ADON, and CAL CONDITION] to BLE, is sedentary and ks to monitor fluid balance. appointment can be made but it would be made [MEDICAL CONDITION]. Follow up in a few //rer and fell against door, hitting head, arm and at and 95% on 31 NC (nasal canula) upon s/rales present, right upper, right LE [MEDICAL CONDITION], lower body right on [DATE] at 18:21. Review of R#14's ion [MEDICAL CONDITION], hypertensive ibrillator, dementia, history of [MEDICAL on neck artery), depression, history of back nia, right femoral neck fracture, [MEDICAL 4 out of her room to go to the shower room. bom door and R#14 fell to the side. CNA E was dizzy and could not breathe. CNA A ing her back and drying off. CNA E said R#14) he wore the nasal canula in the shower. 'her oxygen, CNA E said she was not given knew R#14 could not be left alone. CNA E R#14 fell . de in the facility, said he was receiving sitting in a chair in bad pain. FM BB said R#14 had a big knot on the right side of her ter her hip was repaired, and passed #14 always had her oxygen on when he visited R#14 to put her oxygen on before they walked 14 to put on her oxygen because she did not ygen and sometimes she did not war it. when asked how often R#14 wore her oxygen, | |
| | oxygen the week before she fell. In an interview with the Administ R#14's fall on [DATE] because it not a reportable incident. Review of Event Summary Repor fracture and skin tear. Emergency of the event and immediate action fell . CNA reported immediately 1 arm, skin tear noted. Neuro check Resident assisted back to room ar (minute). Skin Tear cleansed and dizzy once arriving to shower are bilateral feet, with [MEDICATIO antihypertensives, diuretics, and r within eight hours prior to the fall Review of Event Summary Repor decreased and caused resident bee in room and while showering. CN included further education on use complications related to oxygen c prevent desaturation. Resident c/c right [MEDICAL CONDITION]. Review of Witness Statements dat I, (CNA G), did observe on [DATE shower. She said okay. I have my door. Right when she was enterin tried to catch her but she fell too o I, (CNA G), did observe on (blank shower room. On occasion. I, (CNA H), did observe on (blank shower room con cocasion. I, (CNA H), did observe on (blank shower for patients requiring continuous rehabilitation therapist as appropr capability to continue to deliver o The facility's Oxygen Concentrato Attach prescribed oxygen deliver. Review of the Facility Abuse Prof POLICY (Facility) will prohibit abuse, negl includes, but is not limited to, free restraint not required to treat the r through the following: -Screening of potential hires; -Training of employees (both new -Prevention of occurrences; | t of incident with R#14 dated [DATE] revealed roc come dizzy. O2 at 2L ordered continuous, but resid (A was unable to effectively catch resident in time of oxygen continuous, standby assistance and s/s (lependent residents. Resident needs to use her port. pain to right hip over one hour after being in chai ed [DATE], attached to the facility Risk Managem E] at 10:20 a.m. I went to (R#14's) room and told h clothes and stuff together lets go. I was walking h g the bathroom, (R#14) stood very still then she lo juickly. She ended up falling on her shoulder and 1) at (blank). Have witnessed (R#14) to refuse to us c) at (blank). In the past I have known (R#14) not tt of Patient on Continuous Oxygen Policy dated [DA c), portable oxygen equipment (concentrator, comp oxygen. Portable oxygen equipment (concentrator, comp oxygen exists. r Procedure dated [DATE] documented 1. Verify q y device and apply oxygen delivery to the resident ibition Policy, revised [DATE], revealed the follo ect, misappropriation of resident property, and exp edom from corporal punishment, involuntary seclu resident's medical symptoms. The Center will impl employees and ongoing training for all employees is or allegations which need investigation; regations; | ny change. said she did not report the incident with talked with staff and determined it was n. revealed R#14 sustained an abrasion, bruise, the hospital at 12:15 p.m. Circumstances feet) to shower room. became dizzy and to (complained of) pain to head and right ROM (range of motion) to all extremities. rn to 95% (in less than) 1 min. , resident was weak and stated she felt n days with 3+ [MEDICAL CONDTITON] to n that may be causative to the fall included I NAME] ER Tablet Extended Release 30 mg ot cause to be Resident oxygen saturation dent refuses to wear O2 while in bathroom to prevent fall. Corrective actions (signs/symptoms) of possible able oxygen during bathing process to ir and was sent out to hospital with a nent System report, revealed the following: er it's her shower day. Let's go get your et to the shower room. We opened the st balance and fell over on the floor. I hit her head. se her oxygen to the restroom or the o wear her o2 to bathroom or shower room. XTE] documented The center will provide full pressed oxygen, liquid portable oxygen) ed nurse, respiratory therapist, or e to the destination where order .11. Set liter flow per order. 12. wing: ploitation for all residents. This lsion, and any physical or chemical lement an abuse prohibition program | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YL1011

Facility ID: 455974

If continuation sheet Page 3 of 21

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| OAK CREST NURSING CEN | NTER | 1902 FM 303 ROCKPORT | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM | DEFICIENCIES (EACH DEFICIENCY MUST I | BE PRECEDED BY FULL REGULATORY |
| F 0223 | (continued from page 3) | MATION) | |
| Level of harm - Immediate | -Reporting of incidents, investigat Federal Definitions: | tions, and Center response to the results of their | investigations. |
| jeopardy | | f the Center, its employees, or service providers d physical harm, pain, mental anguish, or emotio | |
| Residents Affected - Some | | provide goods or services, including medical se | ervices that are necessary to avoid |
| | physical or emotional harm, pain, PURPOSE To ansure that Conter staff are doi | ing all that is within their control to prevent occu | propage of abuse mistrastment |
| | neglect, exploitation, involuntary for all patients. | seclusion, injuries of unknown source, exploitat | |
| | prohibit abuse, neglect, involunta | (CED), or designee, is responsible for operationary seclusion, injuries of unknown source, exploit, exploitation, or mistreatment, including injur | itation, and misappropriation of property. |
| | misappropriation of resident prop | | |
| | 5. Staff will identify eventssuch constitute abuseand determine t | as suspicious bruising of patients, occurrences, j he direction of the investigation. This also inclu- ident of suspected abuse perfect involuntary se | des patient-to-patient abuse. |
| | misappropriation of patient prope supervisor immediately. | ident of suspected abuse, neglect, involuntary se rty is to tell the abuser to stop immediately and it | report the incident to his/her |
| | and other officials in accordance 5.1.1.1 If the patient/resident sust | ains serious bodily injury, report no later than ty | wo (2) hours after forming the |
| | Upon receiving information con seclusion, injuries of unknown or | pected Crimes Under the Elder Justice Act (EJA cerning a report of suspected or alleged abuse, a igin, or misappropriation of property, the CED of | mistreatment, neglect, involuntary |
| | 6.1 Enter allegation into the Risk 6.2 Immediately, not to exceed 24 6.2.1 Online at report incident on | 4 hours, notify the Texas Department of Aging a | and Disability Services either: |
| | 6.2.2 By phone at [PHONE NUM | IBER], regardless of the day or time; select option 24 hours of an allegation of abuse that focuses | |
| | 6.7.2 clinical examination for sign 6.7.3 causative factors; and 6.7.4 Interventions to prevent furt | ns of injuries, if indicated; | |
| | 7.3 The CED or designee will rep 7.3.1 DADS Form 3613-A, Provi 7.3.2 Submit the investigation as 7.3.2.2.1 Texas Department of Ag | ort findings of all completed investigations with der Investigation Report follows: | nin five (5) working days utilizing: |
| | Consumer Rights and Services-C R #17: | omplaint Intake Unit | |
| | R #17's [DATE] TAR indicated the changed. | s [REDACTED].Oxygen at 3 LPNC continuous the order for oxygen at 3 LPNC but did not indica | ate when her oxygen tubing should have been |
| | tubing was dated [DATE]. On [DATE] at 9:50 a.m., the Adm | at 9:48 a.m. revealed she received oxygen at 3 linistrator was informed an IJ situation was identified at the structure of th | tified due to the above failures. |
| | concentrator filter had white dust R #19: | at 9:51 a.m. revealed she received oxygen at 3 l covering the filter. R #16's oxygen tubing was d | dated [DATE]. |
| | R #19's Face Sheet dated [DATE] REDACTED]. R #19's admission orders [REDAC | | to the facility on [DATE] with the [DIAGNOSES |
| | Observation of R #19 on [DATE] tubing was not dated. | at 9:54 a.m. revealed she received oxygen at 3 l | iters per nasal cannula. R #19's oxygen nany liters of oxygen R #19 should be receiving. |
| | LVN U reviews R #19's [DATE] with | Medication Administration Record [REDACTE | ED]. I have to check her orders. LVN U consulted |
| | On [DATE] at 11:08 a.m., LVN K #19's physician's orders [REDAC | #19's physician's orders [REDACTED]. (informed the surveyor that she received orders 'TED].@ 2LPNC PRN (as needed) for saturation ld have retrieved anorder from her physician for | n level less than 90% for [DIAGNOSES |
| | signature on [DATE], indicating -However, observation on [DATE] | s [REDACTED]. indicated her oxygen concentrator filter was only that the oxygen tubing was changed on that day.] revealed R #18's tubing was dated [DATE]. at 9:57 a.m. revealed she received oxygen at 4 1 | |
| | concentrator filter was covered w Interview with LVN U on [DATE approximately one week ago. LV | ith white dust. R #18's oxygen tubing was dated [] at 10:09 a.m. revealed she stated she had recen N U said oxygen tubing should be changed week | [DATE]. htly started working in the facility |
| | same time the concentrator filters responsible for ensuring it was do | at 10:12 a.m. revealed she stated oxygen tubing were cleaned. LVN I said this was scheduled or one. LVN I said each resident's Treatment Admin of oxygen tubing | n Sundays and the night shift was |
| | Removal documented: | ity was notified of the acceptance of the final Pla | . , |
| | [DATE] during a return visit pror Immediate Jeopardy findings wer -Quality of Care | se to the alleged identification of Immediate Jeo npted by the annual survey with exit date of [D/ e identified in the following areas: | |
| | Submission of this Letter of Cred | his Plan of Removal (POR) pursuant to Federal ible Allegation does not constitute an admission l and written notice of Immediate Jeopardy and/ | or agreement of the facts alleged or the |
| | Corrective Action and Identification Review of orders identified 22 of | on: 72, residents as having orders for Oxygen. ediate corrective action as evidenced by: | |
| | | | |

| STATEMENT OF DEVELOPMENT OF DEVELOPMENT OF DEVELOPMENT OF DEVELOPMENT OF DEVELOPMENT OF DEVELOPMENT OF DEVELOPMENT OF DEVELOPMENT OF DEVELOPMENT DEVELOPMENT OF DEVELOPMENT OF DEVELOPMENT DEVELOPMENT OF DEVELOPMENT OF DEVELO | DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | PRINTED:8/17/2017 FORM APPROVED | |
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| ADD BLAN DOT Displayment Displayment Displayment ADD BLAN DOT NUMMERS PROF ADDRESS, CITY, STATE, 200 DAK CHEN THREE TO DESCRIPTION PROF ADDRESS, CITY, STATE, 200 DAK CHEN THREE TO DESCRIPTION PROF ADDRESS, CITY, STATE, 200 DAK CHEN THREE TO DESCRIPTION PROF ADDRESS, CITY, STATE, 200 FORMATION TO DESCRIPTION DISPLAY, 200 FORMATION DISPLAY, 200 < | STATEMENT OF | (X1) PROVIDER / SUPPLIER | | | |
| CORRECTION NUMBER International system International system SAME OF PROVIDER OF NUMPLINE International system International system International system SAME OF PROVIDER OF NUMPLINE International system International system International system International system Veri Information on the mering home's plane to enret the Additionary plane content the marking home or the internationary agency. (A) ID PREINT AG SIMMARY SYSTEM SYS | | | | | |
| NAME OF PROVIDER OF SUPPLIER PROVIDER PROVIDER OF SUPPLIER PROVIDER OF SUPPLIER PROVIDER PROVIDER OF SUPPLIER PROVIDER PROVIDER OF SUPPLIER PROVIDER PRO | | NUMBER | | 04/10/2017 | |
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| OAS ID DRUTE YAG KIAMADAY STATEMENT OF EPTERTENCES (IACLI DEFICIENCY MUST BE FRICEDED BY FULL REGULATORY OR EXESTING INFORMED AND INFORMATION (INFORMATION) F1223 Continued. Transpige 4) Continued and the provide continued and region region and region and region and region and region and region an | For information on the nursing | home's plan to correct this deficien | | | |
| P223 Continued. In Page 4 Continu | | 1 | | | |
| Level of Hamm-Innuckie Level DATE: a complete audit of realistic strain on these and register to staff members. On [DATE]: moning detailer three and the solution of the solution of | | OR LSC IDENTIFYING INFOR | | | |
| joponty 2. On IDATE insidem on oxygen theory successed and Compliance with order verified by maring administration of the complex conducts by maring administration and core plans were constants by maring administration and core plans were constants by maring administration and core plans were constants by maring administration provide detection to maning staff regarding use or oxygen and maintenance of filer constants. The constant constant constant constants and core plans were constants by maring administration provide detection to maring staff regarding use oxygen and maintenance of filer constants. The constant constant constant constants and constants are constant constants. The constant constant constant constant constants are constant constants. The constant constant constant constants are constant constants. The constant constant constant constant constants. The constant constant constant constants are constant constants. The constant constant constant constant constants are constant constants. The constant constant constant constants are constant constants. The constant constant constant constants are constant constant constants. The constant constant constant constants are constant constants. The constant constant constant constants are constant constants. The constant constant constant constants are constant constant constants. The constant constant constant constant constants are constant constants. The constant constant constant constant constants are constant constants. The constant constant constant constants and regions. The constant constant constant constants are constant constant constants. The constant constant constant constant constants and regions. The constant | | 1. On [DATE], nursing administra | | taff members. On [DATE], nursing | |
| Residents Affected - Sem In reviewed and evolved accordingly. Co. [10, CHT2], the NARE indicated [REDACTED] MARE indicated [REDACTED] J. H. Hen of the Second accordingly. J. Difference of the Second accordingly in the Second according and the Second accordingly. J. Hen of Harms - Innucleal [REDACTED] MARE indicated [REDACTED] J. Hen of Harms - Innucleal [REDACTED]. J. Hen of Harms - Innucleal [REDACTED | | | | rified by nursing administration. | |
| 4. Or [DATE]. mixing administration provided subaction to musing suff regarding use of oxygen and maintenance of filter is 0. So (DATE). F 025 Level of human - Linuxidan A. Data and S. Markan (Linux) (EADACTED) is 1. Hint on the subaction of the subaction | Residents Affected - Some | | | g administration and care plans were | |
| 5. Or. [DATE], the MAR indicated [REDACTED]. MAR indicated [REDACTED] 11. Hiere output with the special and exceeding and active setup of a data setup data setup of a data setup of a data setup of a data setup of | | 4. On [DATE], nursing administra | | use of oxygen and maintenance of filter | |
| Level of Lamm - Limitedia Testionics, "d 3: propert and insestigate any acts or Payment of Lamose, neglect or Residents Affeted - Som Resident Resident and record review, the facility failed to report to the State Survey Aperty with incident of reglect or one Resident and reglect. Resident Resident and Resident in which RF4 walked to the shore writhout weating her oxygen, which was one due by The failing data to report an incident in which RF4 walked to the shore writhout weating her oxygen, which was one due by The failing the payment and resident. Residents Affeted - Som Resident Resident and Resident in which RF4 walked to the shore writhout weating her oxygen, while not receiving or page resident for RF4. Resident Resident and RF4. Resident RF | | 5. On [DATE], the MAR indicate | | | |
| jeopardy **NOTE. TEMSN IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTALITY** Reidens Affected - Some Rei | F 0225 | | | | |
| Based on interview and record review, the factily field to report to be State Survey Agency an incident of neglect of one Review (Bit14) of 15 states and region: we without seeming her royate, which was concluded by the physician to be worn containanosity, became short of herath and fall, 'Incurring her royate, which was concluded by the physician to be worn containanosity, became short of herath and fall. 'Incurring her royate, the physician to be worn containanosity, became short of herath and fall. 'Incurring her royate, the royate continued in provide percention of their physician to be worn containanosity, became short of herath and fall. 'Incurring her royate, the royate continued in provide percention of their physician to prove the percention of their physician to report to be short Survey (Servey Control of Control of Percention). The failure to incurring the respective of provide the was characted by the physician to provide percention of their physician on page 164 (2021)? revealed Ref 14 was contained by monitor to resource ontinued in provide percention of their physician on page 164 (2021)? To everall Ref 14 was contained by mainting on their row of the Ref 14 sector (Servey (| | | IS HAVE BEEN EDITED TO PROTECT CONFI | DENTIALITY** | |
| The facility data or toport an incident in which RP14 walks of hesh shower without wearing her oxygen, which was ordered by the physician to be was constitutionably because a store of the test and 10. Incidents for the physical order of the physical store of the p | | Based on interview and record rev | view, the facility failed to report to the State Survey | | |
| extremities. Interventions included evaluating for proper consistency of diet, homoring for dargets evaluation and physication and systemication loss or gain, monitoring for changes in mutritional status, and monitoring inducé at all meals. Initiated 02/07/17. No interventions were noted regarding elevating BLE when [MEDICAL CONDITION] information included administering oxygen as ordered linkinget, evaluating hereath sounds a traft a large (DID) | | 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 (JJ) 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 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 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 | | | |
| Review of Re14'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] 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: Duo Neb 5. mg (milligram)/3 mg one vial with Nebulizer every six hours as needed 11/28/16: Duo Neb 5. mg (milligram)/3 mg one vial with Nebulizer every six hours as needed 12/26/16: [MEDICATION NAME] Solution .5-2.5 (3) mg/3ML (milliliters) 1 vial inhale orally every 6 hours related to [MEDICAI CONDITION] 12/27/16: Diffures Tablet 30 mcg (micrograms) Give 1 lablet by mouth one time a day related to [MEDICAL CONDITION] 12/27/16: Diffures Tablet 30 mcg (micrograms) Give 1 lablet 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 0.2 at 2 <i>UM</i> per NC (two liters of oxygen per nasal canula). Review of Re14'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: 95 02/01/17: 95 02/01/17: 95 02/01/17: 94 Review of Re14'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 RP14/s facility record revealed the following: 01/14/17: RF14 with increased occurrence of shortness of breath/coupy. Administered nebulizer treatment with little results observed. Oxygen insprecated on working properly. Oxygen sats = 84% and tose cyanot | | extremities. Interventions include weighing weekly and alerting die status, and monitoring intake at a [MEDICAL CONDITION] was] R#14 has [MEDICAL CONDITION] respiratory function for rate, rhyt physician of changes from baseli fatigue, and observe for worsenir | d evaluating for proper consistency of diet, honori tition and physician to any significant loss or gain 11 meals. Initiated 02/07/17. No interventions were present. ONJ. Interventions included administering oxygen hm, depth, rhonchi, wheezes q (every) shift and wi ne; observe patient at rest and exertion, notify phy | ing food preferences within meal plan, , monitoring for changes in nutritional e noted regarding elevating BLE when as ordered/indicated, evaluating breath sounds and ith a change of condition, notify sician of increased weakness and | |
| f0/28/16: [MEDIČATION NAME] 2 puffs inhale two times a day related to [MEDICAL CONDITION] f0/31/16: Oxygen at 2L(iters)min (minucly) via nasal cannula continuously, every shir fleated to [MEDICAL CONDITION] f1/22/16: [MEDICATION NAME] ER Extended Release 30 mg two times daily for pain f1/28/16: Duo Neb 5 mg (miligram)/3 mg one vial with Nebulizer every six hours as needed f1/28/16: Duo Neb 5. mg (miligram)/3 mg one vial with Nebulizer every six hours as needed f1/28/16: [MEDICATION NAME] Solution .5-25 (3) mg/3ML (millitiers) 1 vial inhale orally every 6 hours related to [MEDICAI CONDITION] f1/27/16: [MEDICATION NAME] Solution .5-25 (3) mg/3ML (millitiers) 1 vial inhale orally every 6 hours related to [MEDICAI CONDITION] f1/27/16: [MEDICATION NAME] Tablet 20 mg once daily for [MEDICAL CONDITION] f2/27/16: Diatiresp Tablet 500 mcg (micrograms) Give 1 lablet 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 02 at 2 <i>DM</i> 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.: 02/04/17: 95 02/04/17: 95 02/04/17: 94 Review of Progress Notes from R#14's facility record revealed the following: 01/14/17: R#14 waif hintor and noor in front of her recliner. Cause of fall was slippery socks. Socks changed out. 01/14/17: R#14 waif hintor and noor in front of her recliner. Cause of fall was slippery socks. Socks changed out. 01/14/17: R#14 waif increased occurrence of shortness of breath/cough. Administered nebulizer treatment with little results observed. Oxygen inscreased occurrence of shortne | | Review of R#14's Order Summar | y Report printed on 03/30/17 for the date range 01/ | /01/16 to 02/28/17 revealed the following | |
| 1227/16: (MEDICATION NAME] Tablet 20 mg once daily for [MEDICAL CONDITION] 1227/16: Dairesp Tablet 500 mg (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 revealed After speaking with nurse verified that resident is on continuous O2 at 2 L/M per NC (two liters of oxygen per revealed after speaking with nurse verified that resident is on 202017: 93 02/00/17: 93 02/00/17: 95 02/00/17: 94 02/00/17: 94 02/00/17: 94 02/00/17: 94 02/00/17: 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 weith increased occurrence of shortness of breath/cough. Administered nebulizer treatment with little results observed. Oxygen inspected and working properly. Oxygen sats = 84% and tose cyanotic. Oxygen increased to 3.5 via nasal canula. Oxygen sats were 90% after oxygen adjustment. 01/27/17: R#14 silpped while ambulating to the restroom in her room. No injury sustained. Root cause was R#14 was wearing inappropriate foottwear. 02/02/17: Family member of R#14 expressed concern that R#14 had swelling in bilateral extremeties (BLE). Nurse noted 2+ [MEDICAL CONDITION]. 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 and referent 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 r | | 10/28/16: [MEDIČATION NAM 10/31/16: Oxygen at 2L(liters)/mi 11/22/16: [MEDICATION NAM 11/28/16: Duo Neb .5 mg (milligr 11/28/16: [MEDICATION NAM 12/23/16: Check O2 (oxygen) dai 12/26/16: [MEDICATION NAM | in (minute) via nasal cannula continuously, every s EJ ER Extended Release 30 mg two times daily for am)/3 mg one vial with Nebulizer every six hours EJ Liquid 100 mg/5ML Give 10 ml by mouth ever ly and prn (as needed) every day shift for dyspnea. | shift related to [MEDICAL CONDITION] r pain as needed y 6 hours as needed for cough | |
| 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 Telephone Physician order [REDACTED]. 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. | | 12/27/16: [MEDICATION NAMI 12/27/16: Daliresp Tablet 500 mc Review of Interdisciplinary Team continuous O2 at 2 L/M per NC (Review of R#14's Treatment Adm were checked during the day shif 02/01/17: 93 02/02/17: 95 02/03/17: 95 02/05/17: 93 02/05/17: 93 02/06/17: 96 | g (micrograms) Give 1 tablet by mouth one time a Notes dated 11/10/16 revealed After speaking wit (two liters of oxygen per nasal canula), ninistration Record (TAR) for February, 2017 reve | day related to [MEDICAL CONDITION] th nurse verified that resident is on | |
| 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]. Referal 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 Telephone Physician order [REDACTED]. 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. | | Review of R#14's TAR for Februa | ary, 2017 revealed nebulizer treatments were admi | nistered at noon only on 02/01/17, 02/06/17 | |
| 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. | | Review of Progress Notes from R 01/14/17: R#14 was found on flor 01/19/17: R#14 with increased oc observed. Oxygen inspected and canula. Oxygen sats were 90% af 01/27/17: R#14 slipped while aml inappropriate footwear. 02/02/17: Family member of R#1. [MEDICAL CONDITION]. Nurr 02/03/17: physician progress note and refer R#14 to a different phy echocardiogram, and labs. For [N NAME] 60 mg BID (twice daily) and monitor fluid st | or in front of her recliner. Cause of fall was slipper currence of shortness of breath/cough. Administer working properly. Oxygen sats = 84% and toes cy fter oxygen adjustment. bulating to the restroom in her room. No injury sus 4 expressed concern that R#14 had swelling in bila se notified physician and physician gave no new or is [REDACTED]. Referral to Pulmonologist was p sician. BLE Venous Doppler (blood flow test) ord/ MEDICAL CONDITION], change [MEDICATION tatus. | ed nebulizer treatment with little results anotic. Oxygen increased to 3.5L via nasal stained. Root cause was R#14 was wearing ateral extremeties (BLE). Nurse noted 2+ rders but will see R#14 on 02/03/17. ending since 12/27/16. Cancel that referral ered, as well as chest xray, an | |
| | | Review of chest xray report dated Review of Progress Notes from R 02/04/17: Results from Ultrasoun | 1 02/03/17 revealed R#14 had mild [MEDICAL CO #14's facility record revealed the following: d and Venous Doppler were negative at this time. | ONDITIONS] | |

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | PRINTED:8/17/2017 FORM APPROVED OMB NO. 0938-0391 | | |
|---|---|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/18/2017 | | |
| NAME OF PROVIDER OF SU | 455974 JPPLIER | | DDRESS, CITY, STATE, ZIP | | |
| OAK CREST NURSING CE | | | RT, TX 78382 | | |
| For information on the nursing (X4) ID PREFIX TAG | | cy, please contact the nursing home or the state DEFICIENCIES (EACH DEFICIENCY MUST | e survey agency. Γ BE PRECEDED BY FULL REGULATORY | | |
| | OR LSC IDENTIFYING INFORM | | | | |
| F 0225 Level of harm - Immediate jeopardy | time. 3+ [MEDICAL CONDITIC NAME] | tly in bed with head of bed raised for comfort. N] to BLE noted. No cough observed or repor | Oxygen via nasal canula in place at this ted. Seems to tolerate increased [MEDICATION | | |
| Residents Affected - Some | dropping to 85%. Staff report she [MEDICAL CONDITION] to BL | was walking to the bathroom without her oxyg | episode of [MEDICAL CONDITION] with sats gen and became very short of breath. 2-3+ DITION]. [MEDICATION NAME] increased to 80 | | |
| | 02/07/17: Facility staff meeting, rd Administrator present. R#14 has j compliant with elevating her low 02/07/17 10:37: Referral to pulmo made as soon as possible. 02/07/17 12:25: physician progres days around 2/9. 02/08/17 12:16: R#14 had an unpl 02/08/17 17:55: Change in Condit | or extremities. Started on weekly weights X 4 v nologist. Expected to be one to two weeks before a notes [REDACTED]. Yesterday with episodo anned transfer. ion. Per CNA F, R#14 was standing awaiting s | vices, Dietary Manager, ADON, and EDICAL CONDITION] to BLE, is sedentary and weeks to monitor fluid balance. ore appointment can be made but it would be e of [MEDICAL CONDITION]. Follow up in a few shower and fell against door, hitting head, arm | | |
| | upon return to room. Observation lower, left upper, left lower pittin side weakness. | | g crackles/rales present, right upper, right left LE [MEDICAL CONDITION], lower body right | | |
| | | nysical revealed R#14 was admitted to the hosp MEDICAL CONDITION] from diastolic dysfu | inction [DA1E] at 18:21. Review of R#14's unction [MEDICAL CONDITION], hypertensive | | |
| | CONDITION], type 2 diabetes, c CONDITION] | | defibrillator, dementia, history of [MEDICAL | | |
| | (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 | | | | |
| | CNA E said R#14 fell right inside CNA E said R#14 used her regula walking. CNA E said she had sho CNA E said R#14 usually had her in the shower. CNA E said R#14 | r portable oxygen on the other side of the wall told her she did not need her oxygen and some | #14 said she was dizzy and could not breathe. | | |
| | Review of ADL Report of ADLs 1 In February, 2017, R#14 was sho person. The Walk in Corridor tash were made three times daily, for (| wered on 02/03/17 and 02/06/17 and required e k in February, 2017 was not applicable or resid | of the bathing task in the month of January, 2017. extensive assistance with the help of one lent refused for almost all entries, which | | |
| | therapy when R#14 fell on [DAT] told him she got out of her wheele head and broke the knob off of he was eating ice cream. FM BB said talking to her on 02/17/17. | E]. FM BB went to check on R#14 and found h chair and walked into the bathroom and fell. R br hip. FM BB said R#14 always wore her oxyg d R#14 returned to the facility after her hip was | her sitting in a chair in bad pain. FM BB said R#14 ##14 had a big knot on the right side of her gen and only took it off once in a while if she s repaired, and passed away as he was | | |
| | her, and when R#14 left the facili | ty, she was always using her portable oxygen. | d R#14 always had her oxygen on when he visited put her oxygen on before they walked down the | | |
| | hall toward the shower room on 0 pressure her to wear her oxygen. ' In an interview at 10:20 a.m. on 0 oxygen, said R#14 went without 1 would go around the building wit need for oxygen the week before In an interview with the Administ with R#14's fall on 02/08/17 beca | 12/08/17, CNA E said she did not ask R#14 to j CNA E said sometimes R#14 wore her oxygen 3/3/1/7, the Assistant Director of Nurses (ADC her oxygen sometimes and probably wore her or | put on her oxygen because she did not want to and sometimes she did not wear it. ON), when asked how often R#14 wore her oxygen about 50% of the time. The ADON said R#14 if there was any change in R#14's breathing and ot know of any change. ator said she did not report the incident | | |
| | bruise, fracture and skin tear. Em Circumstances of the event and ir dizzy and fell . CNA reported imi right arm, skin tear noted. Neuro extremities. Resident assisted bac min. (minute). Skin Tear cleansec felt dizzy once arriving to shower to bilateral feet, with [MEDICAT antihypertensives, diuretics, and r | mediately to LVN who assessed. O2 Sat at 85% check complete and WNL (within normal limit k to room and requests to sit in recliner. O2 ap and covered. The fall was related to ambulativ area. R#14 had a change of condition in the la ION NAME] increased to 80 mg. Current med narcotics. R#14 was administered [MEDICAT] | nsferred to the hospital at 12:15 p.m. (ambulated) 30 ft (feet) to shower room, became 6. Resident c/o (complained of) pain to head and ts). Full ROM (range of motion) to all oplied, SAT return to 95% (in less than) 1 | | |
| | decreased and caused resident bet in room and while showering. CN included further education on use complications related to oxygen of prevent desaturation. Resident c/c right [MEDICAL CONDITION]. Review of Witness Statements dat | t of incident with R#14 dated 02/08/17 revealed come dizzy. O2 at 2L ordered continuous, but r JA was unable to effectively catch resident in t of oxygen continuous, standby assistance and lependent residents. Resident needs to use her p pain to right hip over one hour after being in the 02/10/17, attached to the facility Risk Mana | resident refuses to wear O2 while in bathroom ime to prevent fall. Corrective actions s/s (signs/symptoms) of possible portable oxygen during bathing process to chair and was sent out to hospital with a agement System report, revealed the following: | | |
| | shower. She said okay. I have my door. Right when she was enterin tried to catch her but she fell too o I, (CNA G), did observe on (blank shower room. On occasion. | 17 at 10:20 a.m. I went to (R#14's) room and to clothes and stuff together lets go. I was walkin g the bathroom, (R#14) stood very still then sh quickly. She ended up falling on her shoulder a c) at (blank). Have witnessed (R#14) to refuse t | ng her to the shower room. We opened the le lost balance and fell over on the floor. I and hit her head. to use her oxygen to the restroom or the | | |
| | The facility's Oxygen: Transport of full (oxygen level at time of depa oxygen) for patients requiring con therapist, or rehabilitation therapi where capability to continue to de The facility's Oxygen Concentrato Attach prescribed oxygen deliver, On 04/13/17 at 9:50 a.m., the Adn | of Patient on Continuous Oxygen Policy dated (rture), portable oxygen equipment (concentratt inuous oxygen. Portable oxygen will be set u st as appropriate. The duration begins . or alloo | or, compressed oxygen, liquid portable p by a licensed nurse, respiratory ws for travel time to the destination rify order .11. Set liter flow per order. 12. dent. entified due to the above failures. | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YL1011

Facility ID: 455974

If continuation sheet Page 6 of 21

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE & | | | PRINTED:8/17/2017 FORM APPROVED OMB NO. 0938-0391 | | | |
|---|--|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/18/2017 | | | |
| NAME OF PROVIDER OF SU | 455974 | STREET AD | DRESS, CITY, STATE, ZIP | | | |
| OAK CREST NURSING CEN | | 1902 FM 303 | | | | |
| | | ROCKPORT | Г, ТХ 78382 | | | |
| - | · · · · · · · · · · · · · · · · · · · | cy, please contact the nursing home or the state | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | | | |
| F 0225 | (continued from page 6) | | | | | |
| Level of harm - Immediate jeopardy | 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: | | | | | |
| Residents Affected - Some | Submission of this Letter of Cred | his Plan of Removal (POR) pursuant to Federal ible Allegation does not constitute an admission and written notice of Immediate Jeopardy and/ | or agreement of the facts alleged or the | | | |
| | Submission of this Letter of Cred conclusions set forth in the verbal Deficiencies. Corrective Action and Identification Review of orders identified 22 of 7 this facility has put in place imme 1. On March 30, 2017, nursing administration reeducated 2. On April 13, 2017, rursing administration reeducated reviewed and revised accordingly 4. On April 13, 2017, the MAR in 6. On March 31, 2017, the MAR in 6. On March 31, 2017, the MAR in 6. On March 31, 2017, the Kardes information regarding resident cat items on a Kardex are mobility, tr 7. On April 13, 2017, Nursing staff oxygen tubing/filter maintenance Charge nurse to remove and replat Humidification bottles are to be re replaced. 9. CNAs on April 13, 2017 received Oxygen therapy' or 'PRN oxygen 10. CNAs on April 13, 2017 received and changes of condition for appr will alert the charge nurse so that using the oxygen as ordered and of for cyanosis and encourage the re resident's status and concerns and nurse and CNA will ensure that re condition related to respiratory di CNA to alert charge nurse, charge saturation levels, vital signs, lung 11. Care Plans were reviewed and updated April 13, 2017. 12. Nursing staff to receive the abo The Administrator and other consy oxygen per physician's orders [Rf On 04/14/17 at 2:54 p.m., the Adn facility mained out of complian pattern. The facility Abuse Prof POLICY (Facility) will prohibit abuse, negl includes, but is not limited to, free erestigation of postilat hires; -Training of employees (both new -Prevention of occurrences; -Identification of postilat during inve -Reporting of incidents, investigat Federal Definitions; Neglect is defined as the failure of patient. The facility Abuse Prof POLICY (Facility) will prohibit abuse, negle includes, but is not limited to, free -Straining of employees (both new -Prevention of occurrences; -Identification of postilat hore, investigat federal Definitions; Neglect is defined as the failure of patient. The Center staff are doi neglect, exploitation, involuntary for all patients. PR | ible Allegation does not constitute an admission and written notice of Immediate Jeopardy and/ on: 72, residents as having orders for Oxygen. ediate corrective action as evidenced by: ministration provided education on abuse and ne staff members on abuse and neglect. oxygen therapy assessed and compliance with o audit of residents using oxygen was conducted , inistration provided education to nursing staff r dicated [REDACTED]. MAR indicated [REDA vere updated to reflect those residents receiving - sused by the CNAs and nursing to communicate is located in the CNA electronic tablet that is u re and needs specific to the CNA level. It is the ransfer, eating and oxygen status. ere updated to reflect those residents that are on therapy'. f educated regarding the MAR updates that refle process. The tubing will be changed on Sunday (cc old tubing and date new tubing. Remove old emoved and replaced as needed. Humidification ed education provided regarding the updated Ka therapy'. ved education to alert charge nurses or nurse ma opriate intervention and documentation. Examp the charge nurse can come assess and speak to theck the residents oxygen saturation levels, lev sident to comply with the oxygen as ordered. Th communicate this to nurse management, the att esident is safe from falls or other injury related t stress such as shortness of breath, dusky nail be e nurse to perform respiratory assessment of resi- sounds and intervene and notify as appropriate, revised to ensure they reflect the current oxyger ove education before returning to the floor. ultants re-assessed residents who were identified cocess, on 04/13/17, the facility provided an upda tified as having physician orders [REDACTED] observation, interview and record review that th ving oxygen therapy. The resident property, and e edom from corporal punishment, involuntary sec- resident's medical symptoms. The Center will in "employees and ongoing training for all employe ts or allegations; stigations; stigations; and ions, and Center response to the result | or agreement of the facts alleged or the or any subsequent Statement of eglect to staff members. On April 13, 2017, orders verified by nursing administration and care plans were egarding use of oxygen and maintenance of CTED]. oxygen with the verbiage 'respiratory e what type of care the resident needs from used to document resident care and provides equivalent of a care plan. Examples of oxygen with the verbiage 'Continuous et the tubing and filter changing and the by the charge nurse on the 10-6 shift. filter and replace with new filter. to bottles will be dated each time they are urdex that reflects the verbiage, 'Continuous users on all resident oxygen use refusals the resident regues oxygen the CNA the resident refuses oxygen the CNA the resident of axygen. Changes of el of consciousness, nail beds and fingers the nurse will be sure to document the trending MD and family if needed. Charge or of the facility as having a need for the facility as having a need for the facility as having a need for the facility re-assessed all the residents in ygen therapy were found to be receiving e informed the J was removed. However, the tual harm with a scope identified as nitions for oxygen therapy were accurate ollowing: exploitation for all residents. This clusion, and any physical or chemical aplement an abuse prohibition program ees); investigations. to provide goods and services to a nual distress. ervices that are necessary to avoid arrences of abuse, mistreatment, tion, and misappropriation of property. alizing policies and procedures that itation, and misappropriation of patient patient-to-patient abuse. clusion, injuries of unknown origin, or | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF | (X1) PROVIDER / SUPPLIER | | OMB NO. 0938-0391 |
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| CORRECTION | / CLIA IDENNTIFICATION NUMBER 455074 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/18/2017 |
| NAME OF PROVIDER OF SU | 455974 PPLIER | STREET ADDRES | SS, CITY, STATE, ZIP |
| OAK CREST NURSING CEN | | 1902 FM 3036 ROCKPORT, TX | |
| For information on the nursing (X4) ID PREFIX TAG | · · | cy, please contact the nursing home or the state surve DEFICIENCIES (EACH DEFICIENCY MUST BE PL | |
| F 0225 | OR LSC IDENTIFYING INFORM | | |
| F 0225 Level of harm - Immediate jeopardy Residents Affected - Some | and other officials in accordance 5.1.1.1 If the patient/resident sust suspicion. Refer to Reporting Sus 6. Upon receiving information cor seclusion, injuries of unknown or 6.1 Enter allegation into the Risk 6.2 Immediately, not to exceed 24 6.2.1 Online at report incident on 6.2.2 By phone at [PHONE NUM 6.7 Initiate an investigation withii 6.7.1 whether abuse or neglect oc 6.7.2 clinical examination for sig 6.7.3 clusative factors; and 6.7.4 Interventions to prevent furf 7.3 The CED or designee will rep 7.3.1 DADS Form 3613-A, Provi 7.3.2 Submit the investigation as 7.3.2.2.1 Texas Department of Ag Consumer Rights and Services-C | ains serious bodily injury, report no later than two (2) pected Crimes Under the Elder Justice Act (EJA) pol icerning a report of suspected or alleged abuse, mistry igin, or misappropriation of property, the CED or des Management System (RMS). I hours, notify the Texas Department of Aging and D ine, or IBER], regardless of the day or time; select option 5 f n 24 hours of an allegation of abuse that focuses on: curred and to what extent; as of injuries, if indicated; her injury. ort findings of all completed investigations within fiv der Investigation Report follows: ging and Disability Services omplaint Intake Unit gen dated 04/12/17 and received on 04/13/17 identifi is requiring continuous oxygen at night, and 17 reside |) hours after forming the licy. eatment, neglect, involuntary signee will perform the following: visability Services either: from the main menu ve (5) working days utilizing: ied four residents as requiring |
| F 0272 Level of harm - Potential for minimal harm Residents Affected - Many | Conduct initial and periodic ass ***NOTE- TERMS IN BRACKET Based on interview and record rev strengths, goals, life history and p included an accurate determinatic Set (MDS) assessments. The facility did not accurately con for R #3. The failure placed all 74 residents The findings included: R #3's Face Sheet dated 03/21/17 R #3's Admission MDS, section M ulcers at Stage 1 or higher. The fc not completed. R #3's Admission assessment date X width-4.3 centimeters. Interview with Regional MDS Co Coordinator therefore, she was as RMDSC reviewed R #3's Admiss section of the assessment was not included R #3's pressure ulcer sta ulcer and then said she would imm | essments of each resident's functional capacity. S HAVE BEEN EDITED TO PROTECT CONFIDE iew, the facility failed to ensure comprehensive asses references, using the resident assessment instrument n of pressure ulcer risk for one Resident (R #3) of 13 nplete the determination of pressure ulcer risk assess at risk for not having their skin care needs identified documented R #3 was admitted to the facility on [DA 10210-Unhealed Pressure Ulcers dated 03/16/17 doct ollowing section entitled Current Number of Unhealed d [DATE] documented R #3 had a Stage 2 pressure u ordinator (RMDSC) on 03/29/17 at 11:03 a.m. reveal sisting with completing the MDS's. The RMDSC wai ion assessment dated [DATE] and stated she could n accurately completed. The RMDSC said this error co | ssments of a resident's needs, (RAI) specified by CMS that 8 residents reviewed for Minimum Data ment portion of the MDS assessments and met. MTE] with the [DIAGNOSES REDACTED]. Imented R #3 had zero unhealed pressure d Pressure Ulcers at Each Stage was alcer to her coccyx that measured length-4.5 led the facility did not have an MDS s presented R #3's MDS dated [DATE]; the ot answer or explain why the pressure ulcer essment was incorrect and should have uld reflect R #3's care for his pressure |
| F 0279 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some | actions that can be measured. ***NOTE- TERMS IN BRACKET Based on observation, interview a for two Residents, (R#5 and R#10 The facility did not have a plan of the facility did not have a plan of items. This failure could affect 21 residen The findings were: R#5 Review of R#5's Admission Recor REDACTED]. R#5 was [AGE] y Review of R#5's Annual Minimur usually understand others and cou- behavior concerns. R#5 needed su used a wheelchair to move around and extensive assistance with per- was unsteady in his balance but c no bowel incontinence. Review of R#5's Care Plan dated 0 personal hygiene, dressing, eating included providing R#5 with exte hygiene. There was no care plan 1 according to the care plan but the Review of R#5's Care Plan dated 0 personal hygiene, dressing, eating included providing R#5 with exte hygiene. There was no care plan 1 according to the care plan but the Review of R#5's Care Plan dated 0 personal hygiene, dressing, eating included providing R#5 with exte hygiene. There was no care plan 1 according to the care plan but the Review of R#5's Care Plan dated 0 pan intervention related to R#5's On initial tour on 03/28/17 at 9:200 he could remember when he last 1 some facial hair stubble on his ch In an interview on 03/28/17 at 9:200 he could remember when he last 1 some facial hair stubble on his ch In an interview on 03/28/17 at 9:200 hout when she asked a CNA to bat did not like to shower and got cor AA said sometimes R#5's hair sm Review of the 300 Hall Shower S6 | n Data Set ((MDS) dated [DATE] revealed he had me ild usually make himself understood. R#5 had severe ipervision with the help of one person to transfer fror 1 the facility. R#5 required limited assistance with drr sonal hygiene. R#5 required physical help with one p bould stabilize without staff assistance. R#5 had occas REDACTED]. 2/02/17 revealed R#5 was at risk for alterations in cc of pain characteristics: quality, severity, location, p 10/13/16 revealed he required assistance at times for . , bed mobility, transfer, toileting related to Dx (diagr nsive assistance of one for bathing and with set-up. In elated to R#5 resisting or refusing ADL care. R#5 w re was no mention of urinary incontinence. 01/06/15 revealed he had difficulty recalling recent ev t the day and to validate his thoughts/feelings when c refusal of ADL care due to his dementia or pain. a.m., when asked how he was doing, R#5 said I have ad a bath, R#5 did not reply. R#5 was lying in bed w in and jaw area. 20, Family Member (FM) AA said there was a shorta A said she visited R#5 in the evening and sometimes he R#5, they would sometimes reply, No showers tor fused about time and needed to be approached at diffielled dirty. .hedule (undated) revealed R#5 was scheduled for a h | ENTIALITY** prehensive person-centered care plan olans. ing. und storing away food and personal cility on [DATE]. R#5's [DIAGNOSES oderate difficulty hearing others but could cognitive impairment but had no m bed to chair but did not walk. R#5 essing, supervision with toileting, person's assistance with bathing and sional urinary incontinence but had omfort related to chronic pain, with recipitating/relieving factors. ADL care in bathing, grooming, nosis) of Dementia. Interventions imited assist of one for personal as occasionally incontinent of bowel vents. Interventions included asking confused or anxious. There was no care en't had a bath in days. When asked if with his covers up to his chin. R#5 had age of staff at the facility especially on s noticed R#5 needed a shower and shave, night. We're short handed. FM AA said R#5 ferent times to get him to shower. FM |
| EORM CMS 2567(02.00) | during the 6:00 a.m. to 2:00 p.m. | Eacility ID: 455974 | If continuation sheet |

| TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AME OF PROVIDER OF SU | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION | (X2) MULTIPLE CONSTRUCTI A. BUILDING | ION | OMB NO. 0938-0391 (X3) DATE SURVEY | |
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| AME OF PROVIDER OF SU | NUMBER 455974 | | COMPLETED 04/18/2017 | | |
| | | | STREET ADDRESS, CITY, ST | ATE, ZIP | |
| AK CREST NURSING CEN | VTER | | 1902 FM 3036 ROCKPORT, TX 78382 | | |
| | home's plan to correct this deficient | | | VELLI DECLI ATODY | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM | | NC I MUSI BE PRECEDED E | I FULL REGULATOR I | |
| 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 97: Not applicable. 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 | | | | |
| | | 142 applicable) applicable) available) t applicable) 59 50 50 50 50 51 59 59 | of the days that R#5 was sched | uled for a bath. NPE B said | |
| | Review of Progress Notes for Febr 02/26/17: (R#5) refused shower or success. In an interview on 03/29/17 at 2:00 on 03/281/7. CNA F said R#5 sai In an interview on 03/29/17 at 2:31 about taking a bath, and he agreed his shower, he refused to shower. refused a shower. | n 02/25/17. Was asked again this sl 0 p.m., CNA F said she offered R# d, No, I think I'll stay right here. | hift and again refused. Multiple 5 a shower around 8 a.m. on 03 a.m. to 2 p.m. shift, said she tal ether for bathing R#5 and wher | attempts made with no /28/17, and again at 9 a.m. ked to R#5 on 03/28/17 she went to get him for | |
| | 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 Core) Core the process of the several ways to do this: A verbal report to the nurse; STOP WATCH paper form or on the Ipad through POC (Plan of | | | | |
| | feeling down, depressed or hopele concerns regarding behaviors wer | years old. | and others and could make hers he was cognitively intact. R#10 and frequently had trouble conc uld transfer, dress, eat, use the t | elf understood. She scored 13 had some symptoms of entrating on things. No oilet, and bathe with | |
| | Review of Social Services Assessi | iors. The SSA said that R#10 was | visited by an LPC (Licensed Pr | ofessional Counselor) as | |
| | did not remember much about cor her with very little clothing and fe regarding her missing things beca taken but she knew it was clothing replaced. Observation of R#10's room durin against her small chest of drawers | ning to the facility except that a nu w belongings. R#10 said she had l use she was afraid of retaliation. R g. R#10 said she had to go to buy r | rrse came into her room and too been afraid to speak with anyon #10 said she could not give mu nore clothing because her missi 5 p.m. revealed two large bags f oks and other personal items; a | k her things away and left e at the facility ch detail on what was ng items were not ull of items on the floor large tub next to her | |
| | answered that they were things the not live in the area and she had no. when the facility took residents to In an interview on 03/30/17 at 2:50 silverware, food, books and other through her belongings to clean o plastic tub or under her bed. The <i>i</i> everything that R#10 brought fror found on the floor of her home. SI home was unlivable and she could Review of R#10's Care plan reveal | at she bought at the store since com one to help her buy things, so she the store. D.p.m., the Assistant Director of Ne things in her room. The ADON sa ut food that was saved, including s ADON said R#10 had never broug n home was in very poor conditior he was taken to the hospital and ha I not return there. | ning to the facility. R#10 said h purchased items that she neede urses (ADON) said R#10 was a id on shower days, the CNAs tr poiled food from her tray that s ht up a concern related to missi h. The ADON said R#10 was liv d a Urinary Tract Infection. Th cognitive function or impaired t | er family members did d, such as snacks, hoarder and she gathered ied to go in and check he put in a covered ng belongings, but ring alone at home and was e condition of R#10's hought process related to | |

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| NAME OF PROVIDER OF SU DAK CREST NURSING CEM | PPLIER | I | STREET ADDRESS, CITY, ST 1902 FM 3036 | ATE, ZIP | |
| For information on the nursing | home's plan to correct this deficient | cy, please contact the nursing ho | ROCKPORT, TX 78382 me or the state survey agency. | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM | DEFICIENCIES (EACH DEFICI | | Y FULL REGULATORY | |
| F 0279 | (continued from page 9) | | | | |
| Level of harm - Minimal harm or potential for actual harm Residents Affected - Some | 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 t care. Person-Centered care means to fo choices and having control over h A comprehensive, individualized v for each patient that includes mea mental and psychosocial needs th The interdisciplinary team, in con the expected goals and outcomes to the effectiveness of the plan of Documentation will show evidenc -Patient's goals and preferences; -Patient's status in triggered Care -Development of care planning in -Rationale for not care planning fo A comprehensive person-centered 2.1 Services that are to be furnish 2.4.1 n consultation with the patien 2.4.2 Preference and potential for 2.4.2.1 Document whether the pa agencies and/or other appropriate 4. The PointClickCare (PCC) care 4.1 The care plan must be custom 4.2 If there is not a care plan avai PCC. | cus on the patient as the locus of his/her daily life. care plan will be developed within sureable objectives and timetable at are identified in the comprehe junction with the patient and/or r of care, the type, amount, freque care. the of: Area Assessments (CAAs): terventions for all CAAs triggere or a specific triggered CAA. I care plan must be developed for ed. at and the resident representative(future discharge. tient's desire to return to the com entities. plan library is used to develop the ized to each individual patient's lable to meet a patient's needs, st ty to assist patients to participate | control and support the patient in n 7 days after completion of the ces to meet a patient's medical, nur nsive assessments. esident representative, as appropri- ncy, and duration of care, and any d by the MDS; and each patient and must describe the s): munity was assessed and any references and needs. aff may develop one using the cus by: | making his/her own comprehensive assessment sing, nutrition, and iate, will establish other factors related the following: rrals to local contact | |
| | 7.4 Incorporating the patient's per Review of CMS Form 672 dated (| | | | |
| F 0312 Level of harm - Minimal harm or potential for actual market actual Residents Affected - Some | Assist those residents who need and oral hygiene. **NOTE- TERNS IN BRACKET Based on interview and record rev Activities of Daily Living (ADL) The facility did not assist R#5 wit grooming at other times when R# This failure could affect 48 reside The findings were: Review of R#5's Admission Recoo REDACTED]. R#5 was [AGE] y Review of R#5's Annual Minimur usually understand others and cou behavior concerns. R#5 needed si used a wheelchair to move aroun and extensive assistance with per was unsteady in his balance but c no bowel incontinence. Review of R#5's Physician order [Review of R#5's Care Plan dated 0 interventions including Evaluatio Review of R#5's Care Plan dated 0 interventions related to R#5's on initial tour on 03/28/17 at 9:20 he could remember when he last some facial hair stubble on his ch In an interview on 03/28/17 at 12: the evening and night shift. FM A but when she asked a CNA to bat did not like to shower and got co AA said sometimes R#5's hair sr Review of the 200 Hall Shower St during the 6:00 a.n. to 2:00 p.m. Review of the ADL Activity Log February, 2017: 02/02/17 (Thursday): Shower at 1 02/07/17 (Saturday): Blank 02/07/17 (Saturday): Blank 02/07/17 (Saturday): Shower at 1 02/14/17 (Saturday): Shower at 1 02/14/17 (Saturday): Shower at 1 02/21/17 (Thursday): Shower at 1 02/21/ | TS HAVE BEEN EDITED TO Pliew, the facility failed to ensure care, received the necessary serv h bathing and grooming accordir 5 refused bathing and grooming nts who needed the assistance of rd dated 03/29/17 revealed he wa ears old. n Data Set ((MDS) dated [DATE ild usually make himself underst upervision with the help of one p d the facility. R#5 required phy: ould stabilize without staff assist (REDACTED]. 02/02/17 revealed R#5 was at ris n of pain characteristics: quality, 10/13/16 revealed he required ass , bed mobility, transfer, toileting ensive assistance of one for bathin related to R#5 resisting or refusir 01/06/15 revealed he had difficul the day and to validate his thou refusal of ADL care due to his do had a bath, R#5 did not replly. R: in and jaw area. 20, Family Member (FM) AA sa A said she visited R#5 in the evu he R#5, they would sometimes r nfused about time and needed to elled dirty. chedule (undated) revealed R#5 visit 142 tapplicable) available) t applicable) available) t applicable) at applicable) t applicable) t applicable) t applicable) t applicable) t applicable) | ROTECT CONFIDENTIALITY* ROTECT CONFIDENTIALITY* cone Resident, (R#5), of 15 Reside vices to maintain good grooming a g to his regular schedule, and did at his regularly scheduled times. one or two staff with bathing. as admitted to the facility on [DA7] (] revealed he had moderate diffic ood. R#5 had severe cognitive im erson to transfer from bed to chain d assistance with dressing, super- sical help with one person's assist ance. R#5 had occasional urinary k for alterations in comfort related severity, location, precipitating/ry isstance at times for ADL care in 1 related to Dx (diagnosis) of Dem g and with set-up, limited assist t g ADL care. R#5 was occasional ty recalling recent events. Interve ghts/feelings when confused or ar ementia or pain. oing, R#5 said I haven't had a bat #5 was lying in bed with his cover id there was a shortage of staff at ening and sometimes noticed R#5 eply. No showers tonight. We're s be approached at different times to was scheduled for a bath on Tuesc evealed the following codes for th | nts reviewed for ind personal hygiene, not offer bathing and FE]. R#5's [DIAGNOSES ulty hearing others but could pairment but had no r but did not walk. R#5 vision with toileting, ance with bathing and incontinence but had I to chronic pain, with elieving factors. bathing, grooming, tentia. Interventions of one for personal ly incontinent of bowel. ntions included asking toious. There was no care h in days. When asked if rs up to his chin. R#5 had the facility especially on needed a shower and shave, hort handed. FM AA said R#5 o get him to shower. FM lays, Thursdays and Saturdays he ADL Activity Log: | |
| FORM CMS-2567(02-99) Previous Versions Obsolete | 02/25/17 (Saturday): Code 98 (ref Event ID: YL1011 | Facility ID: 45 | 5974 If com Page 1 | tinuation sheet | |

| CENTERS FOR MEDICARE | AND HUMAN SERVICES & MEDICAID SERVICES | | PRINTED:8/17/2017 FORM APPROVED | | |
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| X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | | |
| F 0312 Level of harm - Minimal harm or potential for actual harm | (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) | | | | |
| Residents Affected - Some | Assistants (CNAs) would mark no NPE B said CNAs should tell the the Progress Notes regarding R#5 Review of Progress Notes for Feb 02/26/17: (R#5) refused shower or success. In an interview on 03/29/17 at 2:0 on 03/281/7. CNA F said R#5 sai In an interview on 03/29/17 at 2:3 about taking a bath, and he agreet his shower, he refused to shower. refused a shower. In an interview on 03/29/17 at 2:4 had difficulty showering R#5 who said R#5 did not keep track of tim In an interview on 03/29/17 at 3:2 03/22/17: Reporting changes in Co Anytime a resident refuses any po bathing, turning & repositioning, document refusal. Do not use the such. There are several ways to do this: Care); Give the nurse a note. | 59 141 06 27 used) used) 14 19 14 19 14 19 14 19 19 19 19 19 19 19 19 19 19 | the days that R#5 was scheduled for a bath. rge nurse should enter a nurses note into ote related to R#5 refusing showers: refused. Multiple attempts made with no nund 8 a.m. on 03/28/17, and again at 9 a.m. shift, said she talked to R#5 on 03/28/17 ng R#5 and when she went to get him for te on 03/28/17 after CNA C tried, but R#5 R#5 was refusing showers. FM AA said she not sweat so did not need a shower. FM AA e for a shower. arding residents who refused care: med. This includes, but is not limited to i, transfers. For refusal of care only ailable for your shift document it as er form or on the Ipad through POC (Plan of | | |
| | bathing. | | | | |
| F 0314 | sores. | to prevent new bed (pressure) sores or heal ex | 0 | | |
| Level of harm - Immediate jeopardy Residents Affected - Some | Based on observation, interview, a pressure ulcers did not develop pr consistent with professional stand pressure ulcers for one resident (I R #1's Stage 2 coccyx pressure ulc | S HAVE BEEN EDITED TO PROTECT CONF and record review the facility failed to ensure resis essure ulcers and a resident having pressure ulcer ards of practice to promote healing and prevent fi R #1) of four residents reviewed for pressure ulcer er discovered on 03/27/17, acquired in the facility acility did not provide R #1 with pressure relief (of lays. | dents who entered the facility without rs received care and treatment urther development of skin breakdown or rs. y, steadily worsened to an unstageable | | |
| | The facility did not ensure R #1 w | ore her Prevelon Boots (pressure relieving device ssue Injuries (DTI) on her left heel that the facilit | | | |
| | | Nurses (ADON) inaccurately identified R #1's D | TI's as calluses and incorrectly measured | | |
| | facility remained out of complian monitor to ensure continued impl These failures could affect four re- | Immediate Jeopardy (IJ) situation on 04/14/17. W ce at actual harm with a scope identified as patter ementation of their plan of removal. sidents with pressure ulcers and 53 residents receives ressure ulcers or a decline in existing pressure ulcers and the state of | n. The facility was continuing to iving preventative skin care and place | | |
| | 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 and bladder. The care plan did not include a tur R #1's most current Care Plan was -(R #1) is at risk for decreased abi dressing, bed mobility, transfer, lo | documented Resident is at risk for skin breakdow | ed: bathing, grooming, personal hygiene, quires extensive assist of two . | | |
| | R #1's Admission assessment date R #1's Skin assessment dated [DA R #1's Five Day Assessment Mini -Sometimes made self understood -Had a Brief Interview of Mental | d [DATE] revealed R #1 did not have any pressu TE] revealed no evidence of R #1 having any pre mum (MDS) data set [DATE] documented R #1: and sometimes understood others. Status score of 1 (severely impaired). h one person physical assistance for bed mobility | ssure injury/ulcer to her coccyx/buttocks. | | |
| ORM CMS-2567(02-99) revious Versions Obsolete | Event ID: YL1011 | Facility ID: 455974 | If continuation sheet Page 11 of 21 | | |

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | PRINTED:8/17/2017 FORM APPROVED OMB NO. 0938-0391 |
|---|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 455974 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/18/2017 |
| NAME OF PROVIDER OF SU | PPLIER | | SS, CITY, STATE, ZIP |
| | | ROCKPORT, TX | |
| | | | |
| | OR LSC IDENTIFYING INFORM | | |
| OAK CREST NURSING CEN | PPLIER VTER home's plan to correct this deficient SUMMARY STATEMENT OF E OR LSC IDENTIFYING INFORM (continued from page 11) -Was fequently incontinent of uri -Was 62 inches tall and weighed 1 -Was at risk for pressure ulcer dev -Skin and Ulcer Treatments: Press R #1's Care Plan revised 03/27/17 Ulcer (Partial-thickness loss of sk present as an intact or ruptured se infection X 90 days. Intervention: Weekly wound assessment to incl specific for R #1. R #1's physician's orders [REDAC environment) every shift. R #1's bhysician's orders [REDAC environment) every shift. R #1's Skin-Pressure Ulcer Report Initial Stage: Stage 2 Date first observed: 03/27/17, acq Body Location: Coccyx, light drai Slough or piece of dead tissue tha Slough (moist yellow/grey) (sloug NAME] (Stage 2): 100%; Surroun exposure to moisture), purple/mail Interventions: turning program and netrevention of R #1 on 03/28/17 at the television of the common area Observation of R #1 on 03/28/17 at common area of the 300 Hall. Observation of R #1 on 03/28/17 at Observation of R #1 on 03/28/17 at the speech therapist. Observation of R #1 on 03/28/17 at common area of the 300 Hall. Interview with Licensed Vocation Treatment Nurse. LVN L explain assistance to turn every two hours had a Stage 2 pressure ulcer that vis broken blister to her coccyx with #1's room. R #1's coccyx/sacrum bed was covered with yellow and non-blanchable on the rest of the eschar with some granulation aroo 75% eschar and slough and there wound is now Unstageable. I am going to Interview with CNA M on 03/28/17 were to be repositioned and/or ch reposition R #1 every hour due to her wheelchair. CNA M said she- included in her Kardex. It just say Plan/instructions we follow to car of bed at approximately 7:30 a.m. had been busy with therapy all my get her out of the wheelchair. CN 2:15 p.m. R #1's Skin-Pressure Ulcer | 1902 FM 3036 ROCKPORT, TX cy, please contact the nursing home or the state survey DEFICIENCIES (EACH DEFICIENCY MUST BE PI MATION) ne and always incontinent of bowel. 01 pounds. elopment but did not have any unhealed pressure ulca arre reducing device for bed and wheelchair. documented (R #1) has actual alteration in skin integ in with exposed dermis. The wound bed is viable, pir rum-filled blister) to coccyx. Goal: Wound will rema s. Apply skin barrier cream, Pressure redistribution su lude measurement and description of wound . The car TEED]. Softens and loosens necrotic tissue while main a dated 03/27/17 at 12:30 p.m. documented: uired in-house nage amount- serous lo; Intact/Deep purple: No; Granulation (red): 0%; Es ti s cast off from the surface of the skin) 0% th-ycollow [MEDICATION AME] tissue associated nding tissue: mascerated (softening and breaking dow roon; Wound edges: distinct, even with base; Measurd thair cushion. Pressure Ulcer Risk dated 03/28/17 at 6:21 p.m. reve ATE RISK: Total Score 13-14. at 8:52 a.m. revealed R #1 sat in her wheelchair in the at 10:38 a.m. revealed R #1 sat in her wheelchair in at 11:20 p.m. revealed R #1 sat in her wheelchair in at 11:20 p.m. revealed R #1 sat in her wheelchair in al Nurse (LVN) L on 03/28/17 at 2:38 p.m. revealed I al the facility on 03/27/17. LVN L descr the peri-wound red and it measured 3.3 X 3.5 X 0.1. wound presented as a wound to the coccyx/sacrum es black tissue and the peri-wound was red, blanchable surrounding area. LVN L said, The wound has signifi und the wound. The peri-wound was red, blanchable surrounding area. LVN L said, The wound has signifi uired in-house if or the residents. Each resident has their own Karde CNA M said R #1 was out of bed from approximate is to proposition every two hours. CNA M said that incl- her wound worsening. CNA M saidt shat inch wase dub is be | 78382 y agency. RECEDED BY FULL REGULATORY ers. prity as evidenced by Stage 2 Pressure is k or red, moist, and may also in free from signs and symptoms of urfaces to chair as per protocol, re plan did not include a turning schedule intaining a moist wound healing char (grey/black/brown) (eschar: a with bacterial activity): 0%; [MEDICATION /m of skin resulting from prolonged ement: 3.3 X 3.5 X 0.1 centimeters ealed a score of 13. The assessments essure relieving cushion) in front of e therapy room engaged in therapy with in front of the television of the was being escorted to the dining room. Int of the television of the common LVN L stated she was the facility's positioning of a any resident needing ment Cart for R #1, LVN L explained R #1 ribed R #1's wound as An open area, a these urey accompanied LVN L into R tending to both upper buttocks. the wound at 12 o'clock - 3 o'clock, icantly deteriorated.1 see slough and e on top area. There is approximately easures 9.5 X 8.5 X 0.4 centimeters. The CTED]. readed assistance in turning or changing uded R #1 until LVN L told her to usally reposition R #1 while she was in the wheelchair because That isn't rdex is the CNA Care ex. CNA M said she assisted R #1 out IJy 7:30 a.m. to 2:15 p.m. CNA M said R #1 n therefore, she could not change or are twice her shift at 7:15 a.m. and at le (slough and/or eschar prevents e extent of tissue damage within char (grey/black/brown): 75-99%; Slough g issue: purple/maroon; Wound edges: distinct, %/17: Provide wound treatment as tolerated, ution surfaces to chair as per 1. |
| | every hour when in bed. CNA M been instructed to reposition/offle | 1 03/29/17 at 4:52 p.m. revealed she was caring for R said she did not reposition R #1 when R #1 sat in her oad R #1 when sat sat up in the wheelchair or couch. | wheelchair. CNA M stated she had not CNA M said she changed R #1's brief |
| | at approximately 9:00 a.m. and ag back to check if R #1 needed char | gain at approximately 2:00 p.m., when she put R #1 ir nging. dated 03/29/17 at 5:01 p.m. documented: | |
| | Body Location: Coccyx, moderate evaluation) | e drainage amount- serous. Deepest Stage: Unstageabl | |
| Wound appearance: Intact/pink: No; Intact/Deep purple: No; Granulation (red): 0%; Eschar (grey/black/brown): 75-99%; (moist yellow/grey): 25-49%; [MEDICATION NAME] (Stage 2): 25-49%; Surrounding tissue: mascerated, purple/marou edges: distinct, diffuse, not clearly visible; Measurement: 8.5 X 9.5 X 0.4 centimeters | | | |

| CENTERS FOR MEDICARE | I AND HUMAN SERVICES & MEDICAID SERVICES | | PRINTED:8/17/2017 FORM APPROVED OMP NO. 0038 0201 |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 04/18/2017 |
| AME OF PROVIDER OF SU AK CREST NURSING CE | | 1902 FM 3036 | RESS, CITY, STATE, ZIP |
| or information on the nursing | home's plan to correct this deficien | cy, please contact the nursing home or the state sur | |
| (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 | OR LSC IDENTIFYING INFOR (continued from page 12) Interventions: mattress- low air lo Observation of R #1 on 03/30/17 assisting her with exercises. Observation of R #1 on 03/30/17 area of the 300 Hall. Observation of R #1 on 03/30/17 was escorted back to the 300 Hall television. R #1 was relieved 11:03 a.m. R #1 was transferred 1 relieved from her buttocks for ap the dining room. Interview with CNA's E and O on a.m. on 03/30/17. Observation of R #1 on 03/30/17 redirecting R #1 to stay in bed si want to stay in bed. Observation of R #1 on 03/30/17 LVN L removed R #1's dressing compared to 03/29/17. The peri- vic to the dressing. Approximately 8 from yesterday to today, a slight and granulation tissue is evident : outward. There is now Deep Tiss red, maroon, purple discoloration and temperature change often pre shear forces at the bone-muscle i may resolve without tissue loss) i X 7.0 centimeters, now measurin repositioned every two hours but physically follow-up to ensure R times because she frequently atte her from falling. The surveyor in It sounds like she is up too long w with a better plan so we can offic time to relieve pressure to her bu deteriorating. R #1's Skin-Pressure Ulcer Repor Initial Stage: Stage 2 Date first observed: 03/27/17, acq Body Location: Coccyx, moderate evaluation) Wound appearance: Intact/pink: N (moist yellow/grey): 25-49%; [M edges: distinct, diffuse, not clear] Interventions: mattress- low air lo physician progress notes [REDAQ progressed rapidly since then. Pri wound to sacrum. Wound is mos and covered with a foam dressing (Kennedy terminal ulcers are irree blister or an abrasion, but quickly or black. Kennedy ulcers also ten ifte), and she has a poor prognosi closely. *Record review of all of R #1's PI (DIAGNOSES REDACTED]. Ti services from Speech therapy, OC Interview with LVN A on 03/31/1 said R #1 was not in the stages of hospice and ther was present, the explained that the turning prograd diagnosed to be in the dying proc Interview with Physician T on 03, diagnosed R #1 wi | MATION) ss, turning program, and chair cushion. at 8:48 a.m. revealed R #1 sat in her wheelchair in at 10:08 a.m. revealed R #1 sat in her wheelchair in at 10:28 a.m. revealed R #1 was taken to therapy w l common area at 10:51 a.m. and remained seated i as assisted with transfer from her wheelchair to the from pressure of her buttocks for 10 seconds befor rom the couch to her wheelchair and was escorted proximately 10 seconds. At 12:00 p.m. R #1 was o 03/30/17 at 12:14 p.m. revealed they both assisted at 1:50 p.m. revealed R #1 was transferred from he tace R #1 was attempting to get out of bed. LVN A at 1:50 p.m. revealed LVN L was preparing to prov dated 03/20/17; R #1's coccyx/sacrum presented w vound also had dark maroon/purple discoloration. 5 5% of the wound bed contained yellow and black t unprovement is that the Santy1 is working to remoin a small part of the wound. The peri-wound is de ue Injury (Intact or non-intact skin with localized a or [MEDICATION NAME] separation reveal I noticeable in the per-wound that was not there yest g all the peri-wound included is 15 X 8.9 X 0.4 cer had instructed staff to reposition her every houry ye #1 was frequently repositioned. LVN L said she k there to g to ut of bed and since she was a high fa formed LVN L of R #1's observations sitting up in vithout reliving pressure. We have to coordinate v ad her bottom. LVN L confirmed 10 seconds of of tocks. LVN L said prolonged pressure on the wound t dated 03/30/17 at 2:42 p.m. documented: uired in-house c crainage amount- serous. Deepest Stage: Unstage do; Intact/Deep purple: No; Granulation (red): 0%; ty slough with some eschar, and is thus unstageabl Based on my exam noted above and her overall c gularly shaped and often resemble a pear, butterfly yest deeper and turn different colors. I can start as d to start out larger than a regular bedsore, occurs s. Continue with the Santyl, offloading pressure, a orgress Notes and physician's orders [REDACTED oreposition, then the care plan | the therapy room with the male therapist a front of the television of the common while still seated in her wheelchair. R #1 in her wheelchair in front of the couch in the same area in front of e she was again seated on the couch. At to the therapy room. Again, pressure was bserved to be sitting in her wheelchair in IR #1 out of bed at approximately 7:15 r wheelchair to her bed. LVNs A and L were said We layed her down but she does't //de R #1 treatment to her pressure ulcer. ith her per-wound extending further out Some of the black tissue was seen to attach issue. LVN L said, There is a difference we the slough and some [MEDICATION NAMI teriorating, the redness extending trea of persistent non-blanchable deep a dark wound bed or blood filled blister. Pain thense and/or prolonged pressure and the actual extent of tissue injury, or erday. Just the wound bed measures 9.0 trimeters. LVN L said R #1 should be sterday. CVN L should R #1 should be stable (slough and/or eschar prevents Eschar (grey/black/brown): 75-99%; Slough ding tissue: mascerated, purple/maroon; Woung rs contimeters stage 2 on 03/28/17. It has 5 X 8.5 centimeter butterfly shaped le. She is receiving Santyl on the slough linical picture, there is a Kennedy ulcer or horseshoe. They usually start as a reddish color, then turn yellow when someone i |

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | PRINTED:8/17/2017 FORM APPROVED |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 04/18/2017 |
| NAME OF PROVIDER OF SU OAK CREST NURSING CEI | | 1902 FM 3036 | RESS, CITY, STATE, ZIP |
| For information on the nursing | home's plan to correct this deficien | cy, please contact the nursing home or the state su | |
| (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 | Interview with the Occupational 7 therapy five days a week. The OT during activity of daily living car minutes, on a good day, which w sitting position. Interview with the Physical Thera times a week. The PTA said the 1 | ⁴ I was not offloaded off her buttocks at any time d herapy Assistant (OTA) on 03/31/17 at 11:31 a.m. 'A stated R #1's therapy included grooming and hy e, and transfers. The OTA said the longest she had as rare. The OTA said the majority, if not all, of th py Assistant (PTA) on 03/31/17 at 11:33 a.m. reve ongest he had gotten R #1 to stand was 20 minutes i did not stand daily and it depended on her cognit | a. revealed R #1 received occupational ygiene, upper body dressing, dynamic sitting 1 gotten R #1 to stand was three the therapy was done with R #1 in a ealed R #1 received physical therapy five s but those 20 minutes included several |
| | of R #1's therapy was done sitting According to the National Pressur (http://www.npuap.org/resources. 04/05/17 revealed: Pressure Injury Prevention Points: 1 Consider bedfast and chairfast in 2 Use a structured risk assessment as soon as possible (but within 8 f 3 Refine the assessment by includ A. Fragile skin | g in her wheelchair. e Ulcer Advisory Panel website /educational-and-clinical-resources/pressure-injury Risk Assessment: ndividuals to be at risk for development of pressur t, such as the Braden Scale, to identify individuals lours after admission). | y-staging-illustrations/) searched on e injury. at risk for pressure injury |
| | C. Impairments in blood flow to th D. Pain in areas of the body expose 5 Develop a plan of care based on risk stems from immobility, addr turning, repositioning, and the sur Skin Care: Avoid positioning an Repositioning and Mobilization: 1 Turn and reposition all individu | he extremities from vascular disease, diabetes or to sed to pressure . the areas of risk, rather than on the total risk asses | obacco use ssment score. For example, if the ess those problems. ED] or pressure injury |
| | individual's preferences. 3 Consider lengthening t/e turning 4 Turn the individual into a 30-de 5 Avoid positioning the individua 6 Ensure that the heels are free fre 7 Consider the level of immobility choosing a support surface. 8 Continue to reposition an indivi | based on the support surface in use, the tolerance of schedule during the night to allow for uninterrupt gree side lying position, and use your hand to dete l on body areas with pressure injury. m the bed. A exposure to shear, skin moisture, perfusion, body dual when placed on any support surface. ad when using microclimate management surfaces | ted sleep/ rmine if the sacrum is off the bed y size and weight of the individual when |
| | 10 Use a pressure redistributing ci 11 Reposition weak or immobile i Observation of R #1 on 04/13/17 compression stockings on each le her feet nor any pillows under he Interview with LVN A on 04/13/11 that normally lives in the intestim contaminating the wound. LVN A stated it was a possibility that R # cans of enteral feeding R #1 had the ADON of R #1's weight Oss. Record review of R #1's April 201 eats less than 50% of meal .Start Record review of R #1's April 201 (REDACTED]. There were no er of 04/03/17, for lunch or supper c Observation of R #1 was suppose weak but did not know what hap closet. Upon the surveyor's requed dark brown and light marroon dis Interview with LVN A said R #1 con ensuring R #1 had the Prevalon b on her feet. LVN A said she did r Interview with Physician T on 04/ not being offloaded off her sacruf #1's order when to wear her Prevy- receiving her bolus feedings as on of R #1 having any new pressure pressure areas can contribute to 1. stated he was aware R #1 did not did not provide an answer when a | hair cushion for individuals sitting in chairs or who ndividuals in chairs hourly at 10:10 a.m. revealed R #1 was asleep in bed on a cg. R #1's heel rested on her bed. R #1 did not have r feet. Prevalon boots were not visible anywhere ir 7 at 10:42 a.m. revealed R #1's sacral wound deve es) in the wound. LVN A said R #1 likely got E.C. A said R #1 had lost approximately five pounds in 1 was not given her bolus feedings as ordered thrc in her room, only three cans were missing within t 17 Medication Review Report documented Vital 1. | eelchairs. an inflated air mattress. R #1 had white e on any pressure relieving devices on h er room. Eloped E. Coli (Escherichia Coli: a bacteria oli in her wound from her urine or feces one week from 04/01/17-04/07/17. LVN A ough her [DEVICE] because out of 26 hat one week. LVN A said she informed .5 bolus feeding/ one can after meals PRN if 7/17 = 105.0 pounds; 04/06/17 = 101.5 pounds; ED].Start date: 03/27/17. The MAR indicated olus feeding given or not, for the entire day supper on 04/06/17. .0 on an air mattress. R #1's feet rested on ws under her feet. Prevalon boots were m R #1 to eat. R #1 refused. CNA F said he R #1 using Prevalon boots sometime last som and found the Prevalon boots in her ckings and presented R #1's feet; R #1 had e wearing her Prevalon boots whenever she said the nursing staff were responsible for s not aware of R #1 having any pressure areas ed to Physicain T her observations of R #1 offload her heels, the CNA not aware of R ad within 15 days due to possibly not eft heel. Physician T said he was not aware nutrition and not providing offloading to ordered the bolus feedings. Physician T oided but said This did not help. |
| F 0328 Level of harm - Immediate jeopardy Residents Affected - Some | said she was available to assess R surveyor accompanied the ADON in bed on her right side with her d wearing the boots. Upon the surv Properly care for residents need ureostomy, ileostomy, tracheosi care, and prostheses **NOTE- TERMS IN BRACKET Based on observation, interview, a the facility, as outlined in the con | [3/17 at 1:20 p.m. revealed she stated that the Treat #1. The ADON stated she was not aware of R #1 into R #1's bedroom. There were two blue Preval eyes closed. The ADON said R #1 probably took the eyer's request, the ADON assessed R ling special services, including: injections, colos tomy care, tracheal suctioning, respiratory care TS HAVE BEEN EDITED TO PROTECT CONFI and record review the facility failed to ensure that aprehensive care plan (Physician Orders), met prof three residents reviewed with orders for continu | having any pressure areas to her feet.The lon boots on R #1's wheelchair. R #1 was lying he boots off when asked if R #1 should be stomy, c, foot IDENTIALITY** respiratory care services provided by fessional standards of practice, for |
| FORM CMS-2567(02-99) Previous Versions Obsolete | Event ID: YL1011 | Facility ID: 455974 | If continuation sheet Page 14 of 21 |

| STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY DEFICIENCIES / CLIA A. BUILDING COMPLETED AND PLAN OF IDENNTIFICATION B. WING 04/18/2017 | DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | PRINTED:8/17/2017 FORM APPROVED OMB NO. 0938-0391 |
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| ANA CEEST NURSING CENT IN THE PLANE AND ADDRESS CONTROL ON THE ADDRESS CONTROL OF ADDRESS CONTROL ON THE ADDRESS C | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | / CLIA IDENNTIFICATION NUMBER | A. BUILDING | (X3) DATE SURVEY COMPLETED |
| Out of the intervent production of the state streng spaces. Out of the intervent production of the streng spaces. IF (03) DPENTA Tool IOMAGENESS STRENGT OF CONFIGURATION CONTACTION STRENGT OF CONFIGURATION STRENGT OF CONFIGURATI | | | 1902 FM 30 | 036 |
| F038 continuedfree page 14) 47, and R PM of even creations the Complexation and RELEACED, RFL to type concentration Rel by particulation. Resided 17, and R PM of even creations the Complexation and RELEACED, RFL to type concentration Rel by particulation of the Complexation and RELEACED, RFL to type concentration Rel by particulation of the Complexation of the Complexatio | | home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | |
| and 2.5 LPM on these occasions on IDATE[-DATE], and during transfers to the hisker room when R 44 wise provide with no R 2.3 The facility of not ensure that R 44 ways provide during multical during transfers to the hisker room when R 44 wise provide during the real. The facility did not ensure that a respect theory was consistently multicad. b) The facility high and hinting ther heal. The facility did not ensure that a veget high and the expect theory was consistently multicad. c) The facility high and multication on corrent aveget heap was consistently multicad. c) The facility of not ensure to aveget high and the expect theory was consistently multicad. c) The facility of not ensure to aveget high and the expect theory was consistently multicad. c) The facility of not ensure to aveget and the expect theory was consistently multicad. The facility relation of or congrigure at potential for notice has axin line may was low expect on the TTE. In the facility relation of or congrigure at a potential for notice has axin line was the expect of high and expect on the transfer to the facility of potential of a congrigure has a potential for notice has axin line was the expect of high and the expect of high | | (continued from page 14) #17, and R #19) of seven resident | s reviewed for oxygen concentrator filter and | |
| cupied on [DATE]. In the facility. A) The facility due are summer R44 must current oxygen therapy order of continuous Oxygen at 3 lites readed cumulated and R44. R47 multiple readed cumulated current R44 multiple readed cu | jeopardy | and 2.5 LPM on three occasions on [DATE]-[DATE], and during transfer to the shower room when R #4 was proxygen. Some 2.) The facility did not ensure that R #14 wore her oxygen during ambulation, she became short of breath and she | | e shower room when R #4 was provided with no he became short of breath and she fell, |
| R #15 Bace Sheet duted [DATE] documented a [AGE] year-old female admitted to the facility on [DATE] with the [DIAGNOSES BACE]. R #15 DATE] Treatment Administration Record (TAR) documented O2 (Oxygen) via NC (nasal cannula) @ (a) 2LPM as needed for some set of a partial momentance of partia momentance partial momentance partial parti | | expired on [DATE], in the facility 3.) The facility did not ensure R # was accurate on her Treatment AA 4.) The facility did not ensure the filters remained clean for R #4, R The above failures resulted in an I facility remained out of complian facility was continuing to monitor This failure could place 22 resider Findings included: | 4's most current oxygen therapy order of conti dministartion Record and the oxygen therapy o oxygen tubings were changed weekly, as per t #17, and R #19. mmediate Jeopardy (IJ) situation on [DATE]. ce at a potential for more than actual harm wit to ensure continued implementation of their J | inuous Oxygen at 3 liters per nasal cannula was consistently monitored. the facility's policy and oxygen concentrator While the IJ was removed on [DATE], the th a scope identified as pattern. The plan of removal. |
| R 445 physician's orders [REDACTED] (# 3 LPM via NC continuously. R 455 Care Plan dated [DATE] documented R 441 R 445 Significant Champe MDS dated [DATE] documented R 441 R 445 Significant Champe MDS dated [DATE] documented R 441 R 445 Significant Champe MDS dated [DATE] documented R 441 R 445 Significant Champe MDS dated [DATE] documented R 441 R 445 Significant Champe MDS dated [DATE] documented R 441 R 445 Significant Champe MDS dated [DATE] and Significant and while a resident at the facility. Observation of R 44 on [DATE] at 850 am, revealed R 44 was selepting and was receiving O2 @ 2.12 MP vin NC. Observation of R 44 on [DATE] at 850 am, revealed R 44 was receiving C 2 @ 2.12 MP vin NC. Observation of R 44 on [DATE] at 850 am, revealed R 44 was receiving C 2 @ 2.12 MP vin NC. Observation of R 44 on [DATE] at 850 am, revealed R 44 was receiving C 2 @ 2.12 MP vin NC. Observation of R 44 on [DATE] at 10.13 m, R 44 was scottared R 44 was in bel. LVN1 replaced R 444 was receiving C 2 @ 2.2 MP vin NC. LVN1 replaced R 444 was receiving C 2 @ 2.2 MP vin NC. LVN1 replaced R 444 was receiving C 2 @ 2.2 MP vin NC. LVN1 replaced R 444 was receiving C 2 @ 2.2 MP vin NC. LVN1 replaced R 444 was receiving C 2 @ 2.2 MP vin NC. LVN1 replaced R 444 was received the room and aid R 44 had noticous O 2 @ 3.2 MP vin NC. LVN1 replaced R 444 was received R 44 was recei | | R #4's Face Sheet dated [DATE] of REDACTED]. R #4's [DATE] Treatment Admini | | |
| room and said R #4 had continuous O2 @ 31.PM ordered when asked how much oxygen R #4 should be receiving. Upon the surveyor's request, LNN K adjusted R #4's oxygen concentrator to 3 LPM and then checked R #4's oxygen saturation which was 92%. LNN K stated LNN was currently R #4's oxygen concentrator to 3 LPM and then checked R #4's oxygen saturation which was 92%. LNN K state LNN N in IDATE in all 135 nm 35. LPM to IDATE in all DATE in the inter LNNK known O2 @ 31.DM via an NCL IV in the state was used in the state of the state was not transcribed to 31.PM LNN verified she had not well LNN in the event of the state was set at 2.3 LPM but was adjusted to 31.PM LNN interfied she had not well LNN in the event of the state of t | | R #4's physician's orders [REDAC R #4's Care Plan dated [DATE] dt reoccurence of aspiration pneumo R #4's Significant Change MDS d -Rarely made self understood and -Had short and long-term memory -Had an active [DIAGNOSES RE -Received oxygen therapy while n Observation of R #4 on [DATE] a Observation of R #4 on [DATE] a Vocational Nurse (LVN) I and Cc During this time, CNA H remove #4 to the shower room, without at chair and transferred to bed with 1 nasal cannula in R #4's nares at 1 -R #4 was not provided with oxyg | becumented (R #4) exhibits a risk for complicat onia .Approaches: .O2 as ordered. ated [DATE] documented R #4: rarely understood others. problems and had severely impaired cognitiv DACTED]. tot a resident and while a resident at the facility t 8:50 a.m. revealed R #4 was sleeping and wa t 10:51 a.m. revealed R #4 was receiving O2 (ertified Nurse Aides H and J assisted to transfie d R #4's nasal cannula, leaving R #4 without a ny oxygen therapy. At 11:33 a.m., R #4 was est the assistance of LVN I and CNAs H and J. O 1:45 a.m The oxygen concentrator was set at 2 en therapy from 10:51 a.m 11:45 a.m. | e skills for daily decision making. y. as receiving O2 @ 2 LPM via NC. @ 2.5 LPM per NC. At 10:54 a.m., Licensed er R #4 from the bed to the Geriatric chair. ny oxygen administration. Both CNAs escorted R scorted back to her bedroom in the Geriatric nce R #4 was in bed, LVN I replaced R #4's 2.5 LPM. |
| Review of the Admission Record (closed record) dated [DATE] revealed R#14 was initially admitted on [DATE] and readmitted on [DATE], and 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 not steady in her balance during transitions and walking but was able to stabilize herself without staff assistance. R#14 was not steady in her balance during transitions and walking but was able to stabilize herself without staff assistance. R#14 was not steady in her balance during transitions and walking but was able to stabilize herself without staff assistance. R#14 was not steady in the stanted with exertion. 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, ransfer, locomotion, toileting related to: SDB (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 included evaluating for proper consistency of diet, honoring for changes in nutritional status, and monitoring intake at all meals. Initiated [DATE]. No interventions were noted regarding elevating BLE when [MEDICAL CONDITION]. Interventions included admininstering oxygen as ordered/indicated, evaluating breath soun | | room and said R #4 had continuous surveyor's request, LVN K inspec liters, LVN K adjusted R #4's oxy stated LVN I was currently R #4's Interview with LVN I on [DATE] I was informed of R #4 only recei surveyor that R #4's concentrator #4's oxygen concentrator was set changed to 3 LPM. LVN I review not right. After LVN I reviewed I will do it immediately. LVN I was being prepared and escorted to th then said R #4 should have had th been provided with a portable oxy said each nurse caring for R #4 w that any nurse that received a new nurse caring for R #4 should have administered but that was not don | us O2 @ 3LPM ordered when asked how muc ted R #4's oxygen concentrator and stated It is gen concentrator to 3 LPM and then checked s nurse. at 11:35 a.m. revealed she stated R #4 was or iving O2 @ 2.5 LPM on [DATE] and [DATE] was set at 2.5 LPM but was adjusted to 3LPM at 3 liters. LVN I explained R #4 used to received R #4's Treatment Administration Record a #4's hysician's orders [REDACTED]. The r s informed of the surveyor's observation of R e shower room; LVN I verified she witnessed to eoxygen since her order was to receive oxygg ygen tank. LVN I said she took responsibility as responsible to ensure R #4 received continu or order, transcribed that order to the Medicatio referred to the Treatment Administration Rec | h oxygen R #4 should be receiving. Upon the s set at 2.5 liters, it should be at 3 R #4's oxygen saturation which was 92%. LVN K dered to receive continuous O2 @3LPM via NC. LVN). At this time LVN K approached LVN I and the 1. LVN I verified she had not verified that R ive O2 at 2.5 LPM but her order was recently nd said It still say's 2 liters as needed, that's new order was not transcribed to the record, I #4 not receiving any oxygen on [DATE] while R #4 without any oxygen in the shower room en continuously. LVN I stated R #4 should have for not ensuring R #4 had oxygen on and then ious oxygen. LVN I stated the procedure was on Administration Record. LVN I said each |
| 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 ar respiratory function for rate, rhythm, depth, thonchi, 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]: ON NAME] 2 puffs inhale two times a day related to [MEDICAL CONDITION] [DATE]: [MEDICATION NAME] 2 puffs inhale two times a day related to [MEDICAL CONDITION] [DATE]: [MEDICATION NAME] 2 puffs inhale two times a day related to [MEDICAL CONDITION] [DATE]: [MEDICATION NAME] ER Extended Release 30 mg two times daily for pain [DATE]: [MEDICATION NAME] Liquid 100 mg/5ML Give 10 ml by mouth every 6 hours as needed [DATE]: [MEDICATION NAME] Liquid 100 mg/5ML Give 10 ml by mouth every 6 hours as needed for cough [DATE]: Conck 0 2 (oxygen) daily and prn (as needed) every day shift for dyspnea. [DATE]: CONDITION] [DATE]: Conck O 2 (oxygen) daily and prn (as needed) every day shift for dyspnea. [DATE]: CONDITION] | | Review of the Admission Record [DATE]. R#14's [DIAGNOSES I Review of R#14's Quarterly Minin good ability to express her ideas a Interview for Mental Status (BIM walker in her room or corridor wi the bathing activity with the help able to stabilize herself without st on scheduled pain medication. R# when lying flat. R#14 received on Review of R#14's Care Plan inclu R#14' requires assistance/is depend dressing, eating, bed mobility, tra secondary to [MEDICAL COND were no other interventions listed R#14 is at nutritional risk and may | REDACTED]. R#14 was [AGE] years old. R # num Data Set ((MDS) dated [DATE] revealed and wants. R#14 had no cognitive deficits and (S). R#14 had no mood or behavior problems. th supervision, could dress herself, toilet herse of one person. R#14 was not steady in her bal aff assistance. R#14 was continent of bowel a \$14 had shortness of breath or trouble breathin cygen therapy. ded the following: dent for ADL (Activities of Daily Living) care nsfer, locomotion, toileting related to: SOB (s ITION]. Interventions included R#14 was inde . Initiated [DATE] and revised [DATE]. y gain or lose weight due to fluid retention as of | #14 expired on [DATE], in the facility. I she was clearly able to understand others and had scored 15 out of 15 points on the Brief R#14 was able to walk independently using a elf, but required physical help in part of ance during transitions and walking but was ind bladder. R#14 had frequent pain and was g with exertion, when sitting at rest and e in bathing, grooming, personal hygiene, hortness of breath) with exertion ependent with bed mobility and with transfers. There evidenced by [MEDICAL CONDITION] to lower |
| [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] | | weighing weekly and alerting die status, and monitoring intake at al [MEDICAL CONDITION] was p R#14 has [MEDICAL CONDITIO respiratory function for rate, rhytl physician of changes from baselin fatigue, and observe for worsenin updates. Review of R#14's Order Summary orders [REDACTED]. [DATE]: [MEDICATION NAME [DATE]: Oxygen at 2L(liters)/mir | titian and physician to any significant loss or g Il meals. Initiated [DATE]. No interventions w resent. NI. Interventions included administering oxy hm, depth, rhonchi, wheezes q (every) shift an he; observe patient at rest and exertion, notify g SOB, notify physician if unrelieved or new y report printed on [DATE] for the date range [] 2 puffs inhale two times a day related to [MI h (minute) via nasal cannula continuously, eve | gain, monitoring for changes in nutritional vere noted regarding elevating BLE when gen as ordered/indicated, evaluating breath sounds and d with a change of condition, notify physician of increased weakness and SOB at rest. Initiated [DATE] with no : [DATE] to [DATE] revealed the following physician EDICAL CONDITION] ry shift related to [MEDICAL CONDITION] |
| | | [DATE]: Duo Neb .5 mg (milligra [DATE]: [MEDICATION NAME [DATE]: Check O2 (oxygen) daily [DATE]: [MEDICATION NAME [MEDICAL CONDITION] | m)/3 mg one vial with Nebulizer every six ho] Liquid 100 mg/SML Give 10 ml by mouth e y and prn (as needed) every day shift for dyspr] Solution XXX,[DATE].5 (3) mg/3ML (milli | urs as needed very 6 hours as needed for cough nea. liters) 1 vial inhale orally every 6 hours related to |

| DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | PRINTED:8/17/2017 FORM APPROVED OMB NO. 0938-0391 |
|---|---|---|--------------------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCT A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 04/18/2017 |
| | 455974 | | | |
| NAME OF PROVIDER OF SUI | PPLIER | | STREET ADDRESS, CITY, STA | ATE, ZIP |
| OAK CREST NURSING CENTER 1902 FM 3036 ROCKPORT, TX 78382 | | | | |
| For information on the nursing l | nome's plan to correct this deficien | cy, please contact the nursing horr | ne 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) | | | Y FULL REGULATORY | |
| | | | | |

| Terret and the second s | F 0328 | (continued from page 15) | | | |
|---|---------------------------|---|---|--|--|
| Jeppendy Reithers Allered - See Seithers Allered - See See Allered - See Seithers Allered - See See Allered - See See Allered - See Allered - S | | [DATE]: [MEDICATION NAME] Ta | | | |
| Residents Affected - Some rer thereball along the day shift \$600 a.m. to 4:00 p.m.: INTER 1991 INTE | | continuous O2 at 2 L/M per NC (two | iters of oxygen per nasal canula). | | |
| Lin KLE 199 Lin KLE | Residents Affected - Some | were checked during the day shift 8:0 | | vealed the following oxygen levels when they | |
| Lin ATE 9 30 DATE 9 40 DATE 9 40 DATE 9 41 DATE 9 41 DATE 9 41 DATE 9 41 with increased number of Paralhesing. Administeril inclusion of the stable stabl | | [DATE]: 95 | | | |
| [DATE] 96 [DATE] 97.14 vas found on floor in four of neuroimatic Cases of Mayes informy rocks, Socksteininged ent. (Linking and the second on floor in four to predict on colling of the second on floor in four to predict on colling.) [DATE] 197.14 vas found on floor in four to predict on colling in the second on colling on the second on colling on the second on the se | | [DATE]: 93 | | | |
| IDATE: 94 DATE: Rel 4 with increased non-intrast of protections: Case of all was physery socks. Socks charged out. DATE: Rel 4 with increased non-intrast of protections: Physe and expanded. System Rel 4 as warring the physical protection of the international system and the physical protection of the physi | | | | | |
| IDATE: Bit I was from on floor in first of her rectiner. Cause of all was singpersy posses, Sorks changed out, morth the order of the provide and the sorter of the second of the second | | [DATE]: 94 | facility record revealed the following: | | |
| cherved. Oxygen intergeted and working prepring. Oxygen state: ASk and the scynatic. Oxygen interased to 25, bit in audio appropriate forevert. DATE: Physical preprints of the style of the state in the root. Not interget in a bit and intercenting in bitsers (PHL). Note that the state interpreprint forevert. DATE: Physical preprints of the style of the st | | [DATE]: R#14 was found on floor in f | ront of her recliner. Cause of fall was slippe | | |
| [DATE]: Bil 4 signed while ambellating to the restroom in her room. No tigny sustained. Root care was R44 an warding in DATE]: A sequence of cores in the R44 fail overlaps in philorent strength (DLE). Name need 2+ MEDICAL CONDITION). Insues needing they rook and gase CDLE). Cancer DATE]: Cancel that ecform and the observation of the DATE]: Cancel that ecform and the observation provement of the DATE]. Cancel that ecform and the observation of the DATE]: Cancel that ecform and the observation of the DATE]: Cancel that ecform and the Observation of the DATE]: Cancel that ecform and the Observation of the DATE] evolution of t | | observed. Oxygen inspected and work | ing properly. Oxygen sats $= 84\%$ and toes of | | |
| [DATE] Faulty member of R414 expressed sourcem that R41 had avoiding in balancia extension (BATE). Constructions (BATE) and (BATE) is a source of the source (BATE) and (BATE) is a source of the source (BATE) is a source (BATE) in the source of the source (BATE) is a source (BATE) in the source of the source (BATE) is a source (BATE) in the source of the source (BATE) is a source (BATE) in the source of the source of the source (BATE) is a source (BATE) in the source of the s | | [DATE]: R#14 slipped while ambulati | kygen adjustment. ng to the restroom in her room. No injury su | ustained. Root cause was R#14 was wearing | |
| [DATE]: physical magnetises used: RED ACTED1; Referral of Pulmoniologist was pending size [DATE]: caller that referral and more Refer. A word in a different physical material caller of the physical material referral and more Referral and the state of t | | | ressed concern that R#14 had swelling in bi | lateral extremities (BLE). Nurse noted 2+ | |
| infer R4¹¹ is a different physical. BEV viscol: Doppler (hole flow usi) ordered, as well as clust xxy, an exchange of hPED/CAL CONDITION, change (HDECAL CONDITIONS). Review of Caphone Physical code (HEDA/CHED): Review of Caphone Physical code (HEDA/CHED): Review of Progress Notes from R414 h pathing record revealed the following:: DATE: Incursion of the two set of the two set of the two set of the two sets of two sets of two sets of the two sets of tw | | | | | |
| NAME! (o) Ting: IDD Theve of chest stars proper dated [DATE] evented RP14 handling (MEDICAL CONDITIONS). Review of chest stars proper dated [DATE] evented RP14 handling (MEDICAL CONDITIONS). Review of chest stars proper dated [DATE] evented RP14 handling or regards: a this time. The BELICAL CONDITIONS [In BELICARC) has compared by a star of the stars increased [MEDICATION NAME]. IDTE: [In Spatian (Internet Theorem and the properties over angelistic at this time. The MEDICAL CONDITIONS [In BELICARC). IDTE: [In Spatian (Internet Theorem and the properties over angelistic at this time. IDTE: [In Spatian (Internet Theorem and the properties over angelistic at the properties of MEDICAL CONDITION] with and dopping. IDTE: [In Spatian (Internet Theorem and the properties over angelistic at the properties of MEDICAL CONDITION]. IDTE: [In Spatian (Internet Theorem and the properties over angelistic at the properties of the properties over angelistic at the properties of MEDICAL CONDITION]. [IDATE] Facility and meeting-reviewed mult (MEDICAL CONDITION]. [IDATE] Facility and meeting-reviewed mult (MEDICAL CONDITION]. [IDATE] Facility and meeting-reviewed RP14's condition. Namering: Social Services. Delaring Memory: ADVID ref. [IDATE] Facility and meeting-reviewed RP14's condition. Namering: Social Services. Delaring Memory: ADVID ref. [IDATE] Tacility and meeting-reviewed RP14's condition. Namering: Social Services. Delaring Memory: ADVID ref. [IDATE] Tacility and meeting-reviewed RP14's condition. Namering: Social Services. Delaring Memory: ADVID ref. [IDATE] Tacility and meeting-reviewed RP14's condition. Namering: Social Services. Delaring Memory: ADVID ref. [IDATE] Tacility and meeting-reviewed RP14's condition. Namering: Social Services. Delaring Memory: ADVID ref. [IDATE] Tacility and meeting-reviewed RP14's condition. Namering: Social Serv | | refer R#14 to a different physician. Bl | E Venous Doppler (blood flow test) ordered | ed, as well as chest xray, an | |
| Review of Telephone Physician order (REDACTED). Review of Telephone Physician order (REDACTED). DATE; Review for from Ultrasonal and Venous Deprive vere negative at the sime. DATE; Review for multifusional and Venous Deprive vere negative at the sime. DATE; Review for multifusional and Venous Deprive vere negative at the sime. DATE; Review for multifusional and Venous Deprive vere negative at the sime. DATE; Review for more threas weaking to the handor for daraged for comfort. Scenes to tokane increased (MEDICATION NAME) Well. Design print. DATE[15:09: Numes Practitioner (NP) Progress Note. NP seeing RP14 due to episode of (MEDICAL CONDITION) with as a sime grading of the sime of the | | NAME] 60 mg BID | enter condition, change [MEDICATIC | (daily) to [weblerrior | |
| Review of Progress Notes from RP145 facility record revealed the following: DATE: Review for Dopper Network 1000 per verse register at this time. The Review of Progress Notes from RP145 facility record responsed seems to tolerate increased [MEDICATION NAME] well. Device pair well. Device pair to SNs. Staff report she was walking to the bathroom without her oxygen and became very short of breach. DATE]: (MEDICAL CONDITION] to BLE. Cost any showed multi MEDICAL CONDITION]. MEDICAL CONDITION] DATE: The SNs. Staff report she was walking to the bathroom without her oxygen and became very short of breach. DATE]: (MEDICAL CONDITION to BLE. Developed: a condition. Names, Social Sovieces. Developed Date MEDICAL CONDITION]. DATE: Facility staff meeting, reviewed RP14 is condition. Names, Social Sovieces. Develop Meetinger, ADON, and Administrator present. Re14 has gained 11 pounds in 30 days. Re14 has 2.1 MEDICAL CONDITION]. DATE: Laboration of the Development of the | | Review of Telephone Physician order | | | |
| [DATE] 02:25: RPI4 resting quistly in bed with held of the raised for conflort. Oxygen via nassi canual in place at this time. 5: IntelEDEAT.COMDITION to BLE Leads. No congli observed or reported. Sense to tokerate increased (BEEDCATL CONDITION) with sats dropping the provide the rest scaling to the hadroom without her raygen and hexine very door of forced. [DATE] in EDECAL CONDITION to BLE.CONSTRUME to the hadroom without her raygen and hexine very door of network. [DATE] is the provide the ray of the rest scale of the rest were today. Today with epicode of [MEEDCAL CONDITION] to BLE.CONSTRUME to the rest scale of the rest were today. Today with epicode of MEEDCAL CONDITION to BLE.CONSTRUME to the rest scale of the rest were today. Today with epicode of [MEEDCAL CONDITION] to BLE.CONSTRUME to the rest scale of the rest were today. Today with epicode of [MEEDCAL CONDITION]. Fourth and the rest scale of the rest were today. Today with a very scale to nee tow to weeks hefore appointment can be made but it would be made and compare with elevation be rever scale mines. But the rest scale is the rest weight is a very scale to rest weight of the rest to rest weight a very scale and rest weights. The rest scale can be rest weight a very scale and rest weights a very scale and rest weights. The rest scale can be rest to rest weights a very scale and rest weights are scale and rest weights. The rest scale can be rest to rest weights are scale and scale weight and weight and rest are scale and rest weight and rest are scale and rest are rest. The rest weight are scale and rest are scale and rest are rest. The rest rest rest rest are scale and rest are rest and rest rest are rest. The rest rest rest rest rest rest rest res | | Review of Progress Notes from R#14's | facility record revealed the following: | - | |
| Immed 3: INEDICAL CONDITIONI ID LED noted. No cough observed or reported. Seems to tolerate increased IMEDICATION NAME To provide the test of the second seco | | | | | |
| well. Denies pain. IDATE! 15:09: Nurse Practitioner (NP) Progress Note. NP seeing R#14 due to opisode of [MEDICAL CONDITION] with sats to RSm. MERCINE CONDITION to BLE. Chest varys showed mild (MEDICAL CONDITION). INCOMING (MEDICAL CONDITION). MERCINE CONDITION to DELECE (Lest vary showed mild (MEDICAL CONDITION). MERCINE THE AND AND AND AND AND AND AND AND AND AND | | time. 3+ [MEDICAL CONDITION] t | | | |
| dopping. to SS. Shift report she was walking to the balaroom without her oxygen and became very short of breash. [DATE]+ (MEDICAL CONDITION] [MEDICAL CONDITION]. to SLE. Chest aray showed mild (MEDICAL CONDITION) [MEDICAL CONDITION]. the State of Ong BID. Progenits: Guarded was nee today. Today with episode of [MEDICAL CONDITION]. [DATE]: Facility suff meeting, reviewed RF14's condition. Nursing, Social Services, Deterny Manager, ADON, and and Chemistrator present. Rel 14 has agained 11 provals in 30 days, Rel 14 has 2. [MEDICAL CONDITION] to BLE is sedentary and constraints of presents. Rel 14 has agained 10 provides on the set of the set of the set of two weeks before appointment can be made but it would be made as soon as possible. [DATE] 12:75: The constraint progress notes (REDACTED). Yestenday with episode of [MEDICAL CONDITION]. Follow up in a few days. [DATE] 12:17:55: Change in condition. PC CTA F, RF14 was standing awaiting shower and fell against door, hitting head, arm and hip on floor upon landing. RF14 oxygen statistical control to the song threading awaiting shower and fell against door, hitting head, arm and hip on floor upon landing. RF14 oxygen statistical conduction (MEDICAL CONDITION), hower holy right side weakness. Review of hospital Hittiany pating in LE (MEDICAL CONDITION), hyming the LE (MEDICAL CONDITION), hower holy right side weakness. Review of hospital Hittiany and major LE (MEDICAL CONDITION) in a material ophysical and the song pating in the MEDICAL CONDITION) program data the two physical metrics of RF14's present ifflue travelation and the control in the song pating in the MEDICAL CONDITION) in program data the material strave of RF14's present ifflue travelation and the song travelation (MEDICAL CONDITION). Income data the song travelation (MEDICAL CONDITION), hower hospital filling presension. History of MEDICAL CONDITION]. The sotable application (MEDICAL COND | | well. Denies pain. | Prograss Note ND social D#14 due to an | isode of IMEDICAL CONDITIONI with anto | |
| CONDITION] to BLE. Chest arey showed mild (MEDICAL CONDITION], IMEDICAL CONDITION], and Maintardo present. Rel 4h as sparked The proteins of MEDICAL CONDITION], and Administrator present. Rel 4h as sparked The proteins in 30 days, Rel 4h as 2 - MEDICAL CONDITION]. To BLE, is sedemary and compliant with elevating her lower extremities. Started on weekly weights X 4 weeks to monitor flat balance. [DATE] 12:51 relation progress notes [REDACTED]. Yesteriday with episode of [MEDICAL CONDITION]. Follow up in a few days are and 10.71 relation of the started flat and the started relation of the started rela | | dropping | с с : | | |
| resime 60 mg BID. Prognosis: Guarded, worse today. Today with episode of MEDICAL CONDITION. IDATEJ Facility staff meeting, reviewed Rel14's condition. Nursing. Social Services, Detaty Manager, ADON, and Administrator present. R814 has gained 11 pounds in 30 dys. R14 has 21 (MEDICAL CONDITION) to BLL, sedentary and Administrator present. R814 has gained 11 pounds in 30 dys. R14 has 21 (MEDICAL CONDITION). IDATEI [12:57: Reference on the sedent of the one to two weeks before appointment can be made but it would be made as soon as possible. IDATEI [12:55: Thysician progress notes (REDACTED). Yesterday with episode of MEDICAL CONDITION. IDATEI [12:65: Reference on the set of the one to not an at time of mcident and 95% on 31 NC (nasal candua) upon return to noon. Observations included labored hreathing, shallow hreathing cracklex/alse present, right apper, right age weathers. Review of hooginal History and Physical revealed R914 was admitted to the hooginal on IDADTCAL. INONTRON, Inover Physical Reveales Adv and admitted to the hooginal on IDADTCAL. INONTRON, Informations included labored hreathing, shallow hreathing challes whereas in the program of Rel14 was admitted to the hooginal on IDADTCAL. CONDITION, Information context artery), depression, history of Rel2/CAL. CONDITION, Information context artery), depression, history of MEDICAL. CONDITION, Information context artery), depression, history of MEDICAL. CONDITION, Information, right farmonia, right farmonia, right farmonia, right result, MEDICAL CONDITION, Information and the result of the room on so to the shower room. Context artery, depression, history of MEDICAL. CONDITION, Information and the result of the room one context artery). depression, history of MEDICAL CONDITION, Information and the result of the room one context artery). depression, history of back surgery on neck artery), depression, history of back surgery on theoret and the add and the result of the room onext ar | | CONDITION] to BLE. Chest xray she | | | |
| Administrator present. RP14 has gained 11 pounds in 30 days. RP41 has 2-1 (MEDICAL CONDTION) to BLE, is sedentary and compliant with elevation for lower creatives. Started on weeks before appointment can be made but it would be made IDATE [1257; Rhytain progress notes [REDACTED]. Yesterday with episode of [MEDICAL CONDTION]. Follow up in a few days around [DATE] [255; Rhytain progress notes [REDACTED]. Yesterday with episode of [MEDICAL CONDTION]. Follow up in a few days around [DATE] [255; Rhytain progress notes [REDACTED]. Yesterday with episode of [MEDICAL CONDTION]. Follow up in a few days around [DATE] [255; Rhytain RP145] and an unplanned transfer. IDATE] [255; Change in Condition. Per CNA F, RP14 was standing availing shower and F10 against door, htting head, arm and hip on floor upon landing. RP14 oxygen starting N2 on omia at it mori diricted and 95% on 31. NC reasal cannula upon return to room. Observations included labored breathing, shallow breathing crackles/rales present, right upper, right lower, Ich upper, Ich lower pluin right L1 [MEDICAL CONDITION] from disatolic dysfunction [MEDICAL CONDITION]. Jower body right executions and History and Physical revealed RP14 was admitted to the hospital on [DACLCONDITION]. Inpertensive [MEDICAL CONDITION], https://datactec.doi.org/10.1016/j.startec.doi.org/1 | | | ed, worse today. Today with episode of [MI | EDICAL CONDITION]. | |
| compliant with Elevating her lower extremities. Started on weekly weights X 4 weeks no monitor fluid balance. [DATE] [DATE] Constant and the starter of the starter | | [DATE]: Facility staff meeting, review Administrator present R#14 has gained | ed R#14's condition. Nursing, Social Servic d 11 pounds in 30 days, R#14 has 2+ [ME] | ces, Dietary Manager, ADON, and DICAL CONDITION to BLE is sedentary and | |
| as soon as possible. [DATE] 12:25: physician progress notes [REDACTED]. Yesterday with episode of [MEDICAL CONDITION]. Follow up in a few days [DATE] 12:16: R14 had an umplanned transfer. [DATE] 12:16: R14 had an umplanned transfer. [DATE] 17:55: Change in Condition. Per CNA F, R414 was standing awaiting shower and foll against door, hitting bead, arm and hip on floor upon lamiding. R414 oxyses naturation 82 on room air at time of incident and 95% on 18 (CitasaL canada) upon return to room. Observations included labored breathing, shallow breathing crackles/nations presses. It can be also an another the standard stand | | compliant with elevating her lower ex | tremities. Started on weekly weights X 4 we | eeks to monitor fluid balance. | |
| days around (DATE) [DATE] [2]: 6 R814 and an implamed framfic. [DATE] [2]: 6 R814 and an implamed framfic. [DATE] [2]: 6 R814 and an implamed framfic. [DATE] [2]: 6 R814 and an implamed framfic. [Dh or top inplaming. R914 oxyses stamation R3 on room air at time of incident and 95% on 31 NC (tastic medial, around here turn to room. Observations included labored breathing, shallow breathing cracklevinghes present, right upper, right lower, [4] tupper, [1] to lower pitting right LE [IMEDICAL CONDITION] from diastotic dysfunction (IMEDICAL CONDITION], lower body right side weakness. Review of hospital History and Physical revealed R914 was admitted to the hospital on [DATE] at 18:21. Review of R#14's present of the state of the tower pitting right LE [IMEDICAL CONDITION] from diastotic dysfunction (IMEDICAL CONDITION], (CONDITION], type 2 diabetes, chronic [IMEDICAL CONDITION] from diastotic dysfunction (IMEDICAL CONDITION], (Pripid heart ratio, [MEDICAL CONDITION], left carotid endatterectomy (suggery on neck artery), depression, history of back suggery, hysterectomy, and rotator cuff injury. (CONDITION], where exacerbation and Chronic (MEDICAL CONDITION] in an interview on [DATE] at 11-45 a.m., CNA E said on [DATE] is be assisted R914 or the room to go to the shower room. (CNA E said R914 resolution and Chronic (MEDICAL CONDITION] in an interview on [DATE] at 11-45 a.m., CNA E said on the shower room door and K914 full to the skill, CNA E said R914 sued for englined of being a little dizzy when sho opened the shower room door and R914 full to the skill, CNA E said R914 sued here regular walker with a portable oxyger and sometimes did not wark her oxygen. CNA E said R94 to the pi just walker with a norther or one diver oxygen and sometimes did not wark her oxygen. CNA E said R94 to said R914 sued to reveat the oxygen and sometimes did not wark her oxygen. CNA E said R94 to the pi just walker with a norther oxygen and sometimes did not wark her oxygen. CNA E said R94 to said R914 setto there disc R94 to said R914 w | | as soon as possible. | | | |
| [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 \$2 on room air at time of micident and 95% on 31 NC (casa) canabul upon return to room. Observations included labored heating, shallow breating crackleviates, meeting, high upon right as the two provides of | | | es [REDACTED]. Yesterday with episode of | of [MEDICAL CONDITION]. Follow up in a few | |
| hip on floor upon landing. R#14 oxygen saturation \$2 on room air at time of fincident and 95% on 31 NC (nasal cinula) upon return to room. Observations included labored beating, shallow breating cracks/rates present, right upper, Review of hospital History and Physical revealed R#14 was admitted to the hospital on [DATE] at 18:21. Review of R#14's preEDCAL. CONDITION], type 2 diabetes, chronic [MEDICAL CONDITION] pacemaker defibrillator, dementia, history of [MEDICAL CONDITION], type 2 diabetes, chronic [MEDICAL CONDITION] pacemaker defibrillator, dementia, history of IMEDICAL CONDITION], type 2 diabetes, chronic [MEDICAL CONDITION] pacemaker defibrillator, dementia, history of back surgery, hystercetory, and rotator courd injury. Review of hospital Assessment and Plan dated [DATE] revealed R#14 had Penumoni, right femoral neck fracture, [MEDICAL CONDITION]. In an interview on [DATE] at 11:45 a.m., CNA E said on [DATE] she assisted R#14 val of the room to go to the shower room. CNA E said R#14 couplained of bread in the darky when he opende the shower room door and R#14 fell to the saide. CNA E said at he had showerd R#14 heffer and R#14 sail was the shower room door and R#14 fell to the saide. CNA E said R#14 tool ther regular walker with a pertable oxygen talk on it hut she was not using oxygen when she was valking; CNA E said R#14 tool for regular walker with a pertable oxygen and sometimes with on your on the shower room when was valking; CNA E said R#14 tool for need hot one dee nor oxygen and form the shower room when the was valking; CNA E said her Jotable oxygen on the other side of the walf from the shower and her dark and drying of CNA E said R#14 tool for regular walker with a pertable oxygen and sometimes who was the was negleven instructions about whether R#14 needed to was her oxygen and found her sitting in a chair in bad pain. FM BB said X#14 tool hars is gor out of her whether har and walked in the healthy and a file (hot to healthy oxygen) an an interview wal 11:55 a.m. on (DATE]. FM BB wanto | | | l transfer. | | |
| reium to room. Observations included labored breathing, shallow breathing crakles/rales present, right upper, right how relating right LE [MEDICAL CONDITION], printing 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 phenotype 2 diabetes, chronic [MEDICAL CONDITION] from diastolic dysfunction [MEDICAL CONDITION], presensave difficultation (MEDICAL CONDITION], presensave difficultation (MEDICAL CONDITION], presensave difficultation (MEDICAL CONDITION], (rapid heart rate), [MEDICAL CONDITION], left carotid endatterectomy (surgery on neck attery), 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 CONDITION], which assessment and Plan dated [DATE] revealed R#14 had Pneumonia, right femoral neck fracture, [MEDICAL CONDITION], which assessment and Plan dated [DATE] revealed R#14 was not and R#14 for the comparisod of being a tilt dictigar when she greated the shower room to go to the shower room. If CAA E said R#14 fell right inside the shower room by the door. CNA E said R#14 substitue for regular walker with a portable oxygen on the other side of the walk from the shower and she was a values. CNA E said R#14 fell right inside the shower room by the door. CNA E said R#14 subla and the regular walker, with a portable oxygen and the number show are and she was not given the mass and using off. CNA E said R#14 told there she did not need her oxygen all of the time but she kawe RH at could not be left alone. CNA E and R#14 fell right shale here do to PATE]. Finally, Mrooma room and R#14 Fell could not be sheld alone on the rest side of the walk from the shower and she was not given instructors about whether R#14 here do the roxygen and on the shower and sheld sheld was not given instructores about whether R#14 here ale the roxygen and room and R#14 | | | | | |
| 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], CONDITION], type 2 diabetes, chronic [MEDICAL CONDITION] pacemaker defibrillator, dementia, history of [MEDICAL CONDITION], Griphely bysterectomy, and ottota culfi injur, Review of hospital Assessment and Plan dated [DATE] revealed R#14 had Pheumonia, right femoral neck fracture, [MEDICAL CONDITION], bysterectomy, and ottota culfi injur, Review of hospital Assessment and Plan dated [DATE] revealed R#14 had Pheumonia, right femoral neck fracture, [MEDICAL CONDITION], with exacerbation, and Chronic (MEDICAL CONDITION]. In an interview on [DATE] at 11:35 a.m. CNA E sido (DATE] he assisted R#14 out of her room to go to the shower room. CNA E sid R#14 complained of being a little dizzy when she opened the shower room on the obser and R#14 sually only meded help with washing her back and drying off. CNA E sid R#14 sid she was follower R#14 hereaded to wear her oxygen and sometimes did not wear her oxygen. CNA E sid R#14 sual she was stall did here side and R#14 sually only meded help with washing her back and drying off. CNA E side R#14 usually had her portable coxygen on the other side of the wall from the shower and she wore the hask care with end Review 11:55 am. on (DDTE], FMI BB went to exceed and R#14 and from the factility side here was and she was receiving therapy when R#14 fell to [DATE]. FWI BB went to exceed n#14 and found here with end a away as he was taking to here no [DATE]. FWI BB went to exceed n#14 and found her bright side of here here in an interview at 11:55 am. on (DDATE]. FWI BB went to exceed n#14 and found here side in the had pain. FM BB side R#14 to ld him she go to of for her hip. FM BB side R#14 actured free hip. Weak fell 4 but here in the side fell 4 down the hall words the shower corron on [DATE]. CA family member of R#14 and found he | | return to room. Observations included | labored breathing, shallow breathing crack | les/rales present, right upper, right | |
| present illness revealed she had [MEDICAL CONDITION] from diastolic dysfunction [MEDICAL CONDITION], type 2 diabetes, chronic [MEDICAL CONDITION] pacemaker defibrillator, dementia, history of [MEDICAL CONDITION], type 2 diabetes, chronic [MEDICAL CONDITION] pacemaker defibrillator, dementia, history of [MEDICAL CONDITION], type 2 diabetes, chronic [MEDICAL CONDITION], the art rate), [MEDICAL CONDITION], the factor of the art rate), [MEDICAL CONDITION], the factor of the side (TION) and the side (TION), the art rate), [MEDICAL CONDITION], the art rate), [MEDICAL CONDITION], the an interview on IDATE [at 1145 a.m., CNA te sid on [DATE] the assisted R44 fat on the side. CNA E said R44 fat [16] the side for gard rate is a side rate is | | side weakness. | | | |
| ¹ CONDITION], type 2 diabetes, chronic [MEDICAL CONDITION] pacemaker defibrillator, dementia, history of [MEDICAL CONDITION], (and the durater ectomy, surgery, on neck artery), depression, history of back surgery, hysterectomy, and rotator culf injury. Review of hospital Assessment and Plan dated [DATE] revealed R#14 Mad Pneumonia, right femoral neck fracture, [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 complianed of being a little dizzy when she opened the shower room dor and R#14 fell to the side. CNA E said R#14 said she was dizzy and could not breathe. CNA E said R#14 said she was direzy when she was vas valking. CNA E said R#14 tell right inside the shower room by the door. CNA E said R#14 said she was direzy and could not be after caginar walker with a portable oxygen tawn in thus showas not using oxygen when she was valking. CNA E said R#14 tell right inside the shower room by the door. CNA E said R#14 said she was chand anying off. CNA E said R#14 tell tept portable oxygen on the other side of the wall from the shower and she wore the nasil canula in the shower. The protable oxygen on the other side of the wall from 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. The PLTE]. Family Member (FM) BB, who also resided in the facility, and her oxygen on when he visited hera and when R#14 fell the facility, she was always using her portable oxygen and resked tift hard returned to the facility after her hip was repaired, and passed away as he was talking to her on [DATE]. If MB said R#14 returned to the facility after her hip was repaired, and passed away as he was talking to her on [DATE]. If AB said k#14 tretured to the facility after her hip was repaired, and passed away as he was talking to her on [DATE]. If AB said X#14 tretured to the facility ather her oxygen on be | | present illness revealed she had [MED | | | |
| (rapid heart rate), [MEDICAL CONDITION], left caroid endarterectomy (surgery on neck artery), depression, history of back surgery, hysterectomy, and rotator culf injury. Review of hospital Assessment and Plan dated [DATE] prevaled R#I 4 had Pneumonia, right femoral neck fracture, [MEDICAL CONDITION]. In an interview on [DATE] at 11:45 a.m., CNA E said on [DATE] she assisted R#I4 out of her room to go to the shower room. CNA E said R#I4 complianed of being a little dizzy when she opened the shower room down dR#I4 fell to the side. CNA E said R#I4 said she was dizzy and could not breathe. CNA E said R#I4 said she was dizzy and could not breathe. CNA E said R#I4 said she had showered R#I4 hefore and R#I4 usually not need her hysit was malker with a portable oxygen tank on it but she was not using oxygen when she was was walking. CNA E said R#I4 usually had her portable oxygen and kind from the shower and associated and the shower. CNA E said R#I4 hefore and R#I4 is needed to wear her oxygen all of the time but she know R#I4 fell. In an interview at 11:55 a.m. on [DATE]. Family Member (FM) BB, who also resided in the facility, said he was neceiving therapy when R#I4 fell on [DATE]. FM BB went to check on R#I4 and found her sitting in a chair in bad pain. FM BB said R#I4 to this was utilizing to here (TM) BB sid R#I4 staid full thad ab gains. TM BB said R#I4 to lid him she go to ot for wheelchair and wavas using her portable oxygen and sometimes dH i4 to put her oxygen on when he visited her, and when R#I4 fell on [DATE]. FM BB sidt R#I4 returned to the facility atter her hip was repaired, and passed away as he was talking to here IDATE]. In an interview on [DATE] at 1:00 p.m., FM CC, a family member of R#I4, said R#I4 always had her oxygen on before they walked down the hall toward the shower room on [DATE]. FM BB said she did not aks R#I4 to put her oxygen on before they walked down the hall toward the Abover room on [DATE]. Is a said she did not aks | | CONDITION], type 2 diabetes, chron | c [MEDICAL CONDITION] pacemaker d | efibrillator, dementia, history of [MEDICAL | |
| Review of hospital Assessment and Plan dated [DATE] revealed R#14 had Pneumonia, right femoral neck fracture, [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 dorand R#14 fell to the side. 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 at 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 neasal canula in the shower. CNA E said R#14 told her she did not need 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 abig 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]. The Assistant Director of R#14, said R#14 always had her oxygen on when he visited her, and when R#14 left he chick he assistant Director of Ntres (ADON), when asked fid not want to pressure her to ware no roygen. CNA E said she did not ask R#14 to put her oxygen on when the voxygen, said R#14 went without her oxygen sometimes and probably wore her oxygen and sometimes she did not ware it. In an interview at 10 | | (rapid heart rate), [MEDICAL COND | [TION], left carotid endarterectomy (surger | y on neck artery), depression, history of back | |
| CONDITIONS] with exacerbation, and Chronic [MEDICAL CONDITION]. In an interview on [DATE] at 1145 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 fell right inside the shower room by the door. CNA E said R#14 sids he was dizzy and could not breathe. CNA E said R#14 led liright 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 and 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 R#14 usually had her portable oxygen on the other row on 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 said R#14 round not her sitting in a chair in bad pani. 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 brois the knob of of her hip. FM BB said R#14 returned to the facility asid her oxygen on when he visited her, and when R#14 fell to facility, she was always using her portable oxygen. In an interview on [DATE] the BB side R#14 returned to the facility and her oxygen on before they walked down the hall toward the shower room on [DATE]. CNA E said she di not sak R#14 to put on her oxygen on before they walked down the hall toward the shower room on [DATE]. CNA E said she di not tas R#14 to put on her oxygen on before they walked down the hall toward the shower room on [DATE]. CNA E said she di not tas R#14 wore har oxygen on before they walked down the hall toward the shower room on [DATE]. CNA E said she di not the opt her oxygen on before they walked down the hall toward the shower room on [DATE]. | | surgery, hysterectomy, and rotator cuf Review of hospital Assessment and Pla | f injury. in dated [DATE] revealed R#14 had Pneum | nonia, right femoral neck fracture, [MEDICAL | |
| CNA E said R#14 fcl right inside the shower room by the door. CNA E said R#14 said she was follow to 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 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 R#14 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 had her portable oxygen on the other side of the time but she knew R#14 could not be left alone. CNA E said the yia walked two doors doown from R#14 rent to the time but she knew R#14 fcll. In an interview at 11:55 a.m. on [DATE]. FAMIIY Member (FM) BB, who also resided in the facility, said he was receiving therapy when R#14 fcll. BB went to check on R#14 around her sitting in a chair in bothe the show for form her fAH IB B went to check on R#14 and found her sitting in a chair in bas and R#14 to the basid R#14 to the facility after her hip was repaired, and passed away as he was talking to her on [DATE]. FMB BS and R#14 returned to the facility after her oxygen on when her visited her, and when R#14 left the facility, she was avays using her portable oxygen. In an interview at 10:10 a.m. on [DATE]. CNA E said R#14 atfl4 to the roxygen because she did not want to pressure her to wear her oxygen. CNA E said she was not an osometimes she did not wark to express the did not ware it. The source her oxygen and sometimes the did not wark to express the foll. The therapy here of R#14 said after was the did not wark to express the did not wark to express the foll. The there have the she war to the facility the shower room on [DATE]. CNA E said the did not wark the show often R#14 wore her oxygen the way the advert here | | CONDITIONS] with exacerbation, an | d Chronic [MEDICAL CONDITION]. | - | |
| said R#14 used fier regular walker with a portable oxygen tank on it but she was not using oxygen when she was walking. 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 dher 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 and sometimes did not wear her oxygen. CNA E said she was not given is still they just walked two doors down from R#14's room to the shower room when R#14 eould 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 switt R#14 returned to the facility after her hip was repaired, and passed away as he was talking to her on her pht side of her head and broke the knob off of her hip. FM BB said R#14 fell on the data big knot on the right side of her head and broke the shower room [DATE]. CNA E said sheek did not as kR#14 always had her oxygen on when he visited her, and when R#14 the facility, he was always using her portable oxygen. In an interview at 10:10 a.m. on [DATE]. When Skew sing her portable oxygen and sometimes she did not wear it. In an interview at 10:10 a.m. on [DATE], the Assistant Director of Nurses (ADON), when asked how often R#14 wore her oxygen. CNA E said sheet din to at ak R#14 to put her oxygen to wase her did not want to pressure her to wear her oxygen. CNA E said sheet din to as kR#14 wore her oxygen chasses she did not wari it. In an interview at 10:10 a.m. on [DATE], the Assistant Director of Nurses (ADON), when asked how often R#14 wore her oxygen. CNA E said sheet din to they alter oxygen. CNA E said sheet din to the oxygen passes alter did not wari it. In an interview with the Administrator on [DATE], at 10:10 a.m., t | | CNA E said R#14 complained of bein | g a little dizzy when she opened the shower | room door and R#14 fell to the side. CNA E | |
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| 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 i | | | |
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| Resident assisted back to room and request 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. | | fell . CNA reported immediately to LV | N who assessed. O2 Sat at 85%. Resident | c/o (complained of) pain to head and right | |
| 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. | | Resident assisted back to room and requests to sit in recliner. O2 applied, SAT return to 95% (in less than) 1 min. | | | |
| antihypertensives, diuretics, and narcotics. R#14 was administered [MEDICATION NAME] ER Tablet Extended Release 30 mg within eight hours prior to the fall. | | dizzy once arriving to shower area. Ra | 14 had a change of condition in the last sev | ven days with 3+ [MEDICAL CONDITION] to | |
| | | antihypertensives, diuretics, and narco | | | |
| FORM CMS-2567(02-99) Event ID: YI 1011 Eacility ID: 455974 If continuation cheet | | within eight hours prior to the fall. | | | |
| r Gran Chig 2007/02/777 Event 12, 1 El Q11 Faulity 12, 4007/14 II CONDUMINOU MICCI | FORM CMS-2567(02-99) | Event ID: YL1011 | Facility ID: 455974 | If continuation sheet | |

FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet Page 16 of 21

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | PRINTED:8/17/2017 FORM APPROVED OMB NO. 0938-0391 |
|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 455974 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/18/2017 |
| NAME OF PROVIDER OF SU | | STREET A | DDRESS, CITY, STATE, ZIP |
| OAK CREST NURSING CEN | NTER | 1902 FM 30 ROCKPOF | 036 RT, TX 78382 |
| For information on the nursing | home's plan to correct this deficien | cy, please contact the nursing home or the stat | |
| (X4) ID PREFIX TAG | | | T BE PRECEDED BY FULL REGULATORY |
| F 0328 | OR LSC IDENTIFYING INFORM (continued from page 16) | MATION) | |
| Level of harm - Immediate | Review of Event Summary Report decreased and caused resident be | | ed root cause to be Resident oxygen saturation resident refuses to wear O2 while in bathroom time to prevent fall. Corrective actions |
| Residents Affected - Some | complications related to oxygen of prevent desaturation. Resident c/o | of oxygen continuous, standby assistance and lependent residents. Resident needs to use her p pain to right hip over one hour after being in | portable oxygen during bathing process to |
| | I, (CNA E) did observe on [DATT shower. She said okay. I have my door. Right when she was enterin tried to catch her but she fell too o I, (CNA G), did observe on (blank shower room. On occasion. I, (CNA H), did observe on (blank The facility's Oxygen: Transport o (oxygen level at time of departure for patients requiring continuous rehabilitation therapist as appropricapability to continue to deliver of capability to continue to deliver of capability to continue to deliver of the start of th | ted [DATE], attached to the facility Risk Mana E] at 10:20 a.m. 1 went to (R#14's) room and to clothes and stuff together lets go. I was walki g the bathroom, (R#14) stood very still then si quickly. She ended up falling on her shoulder c) at (blank). Have witnessed (R#14) to refuse c) at (blank). In the past I have known (R#14) of Patient on Continuous Oxygen Policy dated c), portable oxygen equipment (concentrator, c oxygen. Portable oxygen will be set up by a li riate. The duration begins . or allows for travel oxygen exists. | ing her to the shower room. We opened the he lost balance and fell over on the floor. I and hit her head. to use her oxygen to the restroom or the not to wear her o2 to bathroom or shower room. I [DATE] documented The center will provide full compressed oxygen, liquid portable oxygen) icensed nurse, respiratory therapist, or I time to the destination where |
| | Attach prescribed oxygen deliver R #17: | or Procedure dated [DATE] documented 1. Ve y device and apply oxygen delivery to the resi | ident . |
| | R #17's [DATE] TAR indicated the changed. | | licate when her oxygen tubing should have been |
| | tubing was dated [DATE]. | at 9:48 a.m. revealed she received oxygen at 3 | |
| | Observation of R #16 on [DATE] concentrator filter had white dust | hinistrator was informed an IJ situation was ide at 9:51 a.m. revealed she received oxygen at 3 covering the filter. R #16's oxygen tubing was | 3 liters per nasal cannula. R #16's oxygen |
| | R #19: R #19's Face Sheet dated [DATE] REDACTED]. R #19's admission orders [REDAC | | ed to the facility on [DATE] with the [DIAGNOSES |
| | | at 9:54 a.m. revealed she received oxygen at 3 | 3 liters per nasal cannula. R #19's oxygen |
| | Interview with LVN U on [DATE | | w many liters of oxygen R #19 should be receiving. TED]. I have to check her orders. LVN U consulted |
| | On [DATE] at 11:08 a.m., LVN K #19's physician's orders [REDAC | #19's physician's orders [REDACTED]. C informed the surveyor that she received orde (TED].@ 2LPNC PRN (as needed) for saturati Id have retrieved anorder from her physician f | |
| | signature on [DATE], indicating -However, observation on [DATE] Observation of R #18 on [DATE] concentrator filter was covered w Interview with LVN U on [DATE approximately one week ago. LV and procedure was or who was re | indicated her oxygen concentrator filter was on that the oxygen tubing was changed on that da] revealed R #18's tubing was dated [DATE], at 9:57 a.m. revealed she received oxygen at 4 ith white dust. R #18's oxygen tubing was dat] at 10:09 a.m. revealed she stated she had rec N U said oxygen tubing should be changed w | 4 liters per nasal cannula. R #18's oxygen ted [DATE]. |
| | same time the concentrator filters | were cleaned. LVN I said this was scheduled one. LVN I said each resident's Treatment Adr | |
| | Removal documented: This Plan of Removal is in respon [DATE] during a return visit pror | ity was notified of the acceptance of the final is se to the alleged identification of Immediate J npted by the annual survey with exit date of [] e identified in the following areas: | leopardy communicated by the survey team on |
| | -Quality of Care -Neglect The facility respectfully submits the Submission of this Letter of Cred | his Plan of Removal (POR) pursuant to Federa ible Allegation does not constitute an admissi l and written notice of Immediate Jeopardy an | on or agreement of the facts alleged or the |
| | Corrective Action and Identification Review of orders identified 22 of This facility has put in place immediate | 72, residents as having orders for Oxygen. ediate corrective action as evidenced by: ation provided education on abuse and neglect | t to staff members. On [DATE], nursing |
| | On [DATE] residents on oxyge On [DATE], a complete audit o reviewed and revised accordingly On [DATE], nursing administra | n therapy assessed and compliance with order f residents using oxygen was conducted by nu | ursing administration and care plans were |
| | and tubing. 5. On [DATE], the MAR indicate 6. On [DATE] Kardexes were upc Kardex is a tool that is used by th perspective. The Kardex is locate information regarding resident ca items on a Kardex are mobility, th 7. On [DATE], Kardexes were up therapy' or PRN oxygen therapy' | d [REDACTED]. MAR indicated [REDACTED] lated to reflect those residents receiving oxyge e CNAs and nursing to communicate what typ d in the CNA electronic tablet that is used to c re and needs specific to the CNA level. It is the ransfer, eating and oxygen status. dated to reflect those residents that are on oxy | ED]. en with the verbiage 'respiratory therapy'. A pe of care the resident needs from the CNA document resident care and provides he equivalent of a care plan. Examples of 'gen with the verbiage 'Continuous Oxygen |
| | On [DATE], nursing staff education tubing/filter maintenance process nurse to remove and replace old t bottles are to be removed and rep | ated regarding the MAR updates that reflect the . The tubing will be changed on Sunday by the ubing and date new tubing. Remove old filter laced as needed. Humidification bottles will be cation provided regarding the updated Kardex | e charge nurse on the ,[DATE] shift. Charge and replace with new filter. Humidification |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/18/2017 |
| CORRECTION | 455974 | | |
| NAME OF PROVIDER OF SU | | STREET A | ADDRESS, CITY, STATE, ZIP |
| OAK CREST NURSING CEI | NTER | 1902 FM 3 ROCKPO | 3036 DRT, TX 78382 |
| For information on the nursing | home's plan to correct this deficient | ncy, please contact the nursing home or the sta | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR | | ST BE PRECEDED BY FULL REGULATORY |
| F 0328 | (continued from page 17) | | |
| Level of harm - Immediate jeopardy | changes of condition for appropriate appropriate the charge nurse so that the | lucation to alert charge nurses or nurse manag iate intervention and documentation. Example charge nurse can come assess and speak to th check the residents oxygen saturation levels, | e resident to explain the importance of |
| Residents Affected - Some | resident's status and concerns and nurse and CNA will ensure that r condition related to respiratory d CNA to alert charge nurse, charg saturation levels, vital signs, lung 11. Care Plans were reviewed and updated [DATE]. 12. Nursing staff to receive the ab The Administrator and other cons oxygen thereapy Through this pr therapy. Four residents were ider The surveyors confirmed the Plan -eight CNA's were interviewed ar identify them. -five nurses were interviewed and therapy, and could identify them. physician's orders [REDACTED -The updated resident Kardex's ar reviewed and it was found they c oxygen filter was to be cleaned. | I said they had been trained as to which reside . The nurses said they received instruction and In Treatment Administration Record for all re- contained the order for oxygen and when the o | attending MD and family if needed. Charge d to refusal of oxygen. Changes of beds, increase in confusion, drowsiness resident including but not limited to oxygen ate, and document findings and outcomes. /gen therapy orders. Care plans will be field by the facility as having a need for dated list of those residents on oxygen ED]. thy to remove the Immediate Jeopardy by: th residents required oxygen therapy, and could ents were identified with use of oxygen d were able to state and retrieve the current esidents with ordered oxygen therapy were oxygen tubing were to be changed and when the ere informed the IJ was removed. However, the |
| | pattern. The facility was continui for all residents. Review of List of Patients on Oxy | ing to monitor to ensure assessments and inter ygen dated [DATE] and received on [DATE] g continuous oxygen at night, and 17 residents | rventions for oxygen therapy were accurate identified four residents as requiring continuous |
| F 0353 | | every resident in a way that maximizes the | e resident's well |
| Level of harm - Minimal | being. **NOTE- TERMS IN BRACKET | IS HAVE BEEN EDITED TO PROTECT CO | ONFIDENTIALITY** |
| harm or potential for actual harm | Based on observation, interview a | and record review, the facility failed to have s | ufficient staff to care for residents on the |
| Residents Affected - Some | The facility did not have a suffici 10:00 p.m. to 6:00 a.m. shifts to 1 This failure could affect the quali respond to their needs, and by ha The findings were: 100/200 Hall Staffing Observation at 11:00 p.m. on 04/1 LVN 0, and CNA P. Observation Hall, which was a locked unit for with positioning, incontinent car of residents provided by the facil passing medications most of this | n of CNA P from 11:00 p.m. to 12:00 p.m. rer female residents with [MEDICAL CONDIT e, and hydration. There were 49 residents on t ity on 03/28/17. Observation of LVN O from time on the 200 Hall. | CNAs) on the 2:00 p.m. to 10:00 p.m. and e 100, 200 and 300 halls. y having too few licensed staff to double shifts to provide care when needed. on the 100 and 200 Halls. These included LVN N, vealed she was going back and forth between the 100 IONJ/Dementia, and the 200 Hall, assisting residents he 100 and 200 halls according to the list 11:00 p.m. to 1:30 p.m. revealed she was |
| | they did not have coverage (staff Alzheimer's/Dementia females w incontinent. LVN N said two resi said R#23 was up all night on 04 completing monthly summaries of medications. LVN N said she ass In an interview at 11:45 p.m. on 0 she passed medications on the 20 closer to the three hour mark. LV grab someone from another hall 1 p.m. to 6:00 a.m. shift but one of In an interview on the 100 hall se at 9:00 p.m. and she was waiting there were three residents in the s In an interview and observation a point all residents on the 100 hall the unit, into the activities area an Review of a list of residents on th incontinent. In an interview with the ADON a | sisted CNA P with residents who needed two j 4/13/17, LVN O said she always worked the 0 hall. LVN O said all residents were on a roi N O said two residents required two people t to help the CNA with positioning them. LVN 'them called in at the last minute and said that cure unit at 12:20 a.m. on 04/14/17, LVN N s on CNA P to assist her with a resident who n secure unit who required two person assist wi t 12:30 a.m. on 04/14/17, CNA P said during l secure unit were incontinent. CNA P was ob nd give her a glass of water. Ie 100 hall prepared by the ADON on 04/14/17 t 12:30 a.m. on 04/14/17 surveyor showed her | who resided in the unit for 14 of the residents in that unit were h repositioning and incontinent care. LVN N parson positioning and incontinent care. LVN N said her duties included sting the 24 hour report, and passing 6:00 a.m. person positioning and incontinent care. late shift (10:00 p.m. to 6:00 a.m.). LVN O said tation for incontinent care and repositioning o assist with positioning and she needed to O said two CNAs were scheduled to work the 10:00 t they could not come in. aid residents in the secure unit were changed eeeded two persons to provide care. LVN N said th positioning and incontinent care. the night all residents were checked and at one served to walk R#23, who was walking around 7 revealed there were four residents who were r the list of four incontinent residents on the |
| | 100 hall, and advised her that LV the 100 hall were assisted to the 1 CNAs would not show up for the In an interview at 12:40 a.m. on 0 enough staff members to care for accuity of the residents. The AD0 residents with the current staff. T accepted at the facility, new resic In an interview on 04/14/17 at 12. secure unit, rendering care to tha nurse would come out and get he assistance had been given to the i Observation of residents and staff was walking around the unit and care and positioning. Observation at 12:30 a.m. on 04/1 monitoring R#23 was LVN O, ar left unsupervised. | /N N identified 14 residents as being incontin- toilet. The ADON said it was rare that the fac- ier shift. 04/14/17, the ADON said there were no safety the residents. The ADON said there was no s ON said the facility looked at new residents to he ADON said some behaviors require one to lents had to be free of one to one supervision :50 a.m., the ADON said if two staff member: tresident, and other residents in the secure un lp to watch the resident who was walkinig. Th nurse and CNA on the secure unit on the 100 fing on the 100 hall secure unit on 04/14/17 fr LVN N and CNA P went into R#25's room an 14/17 revealed only one other staff member, L nd if LVN O came into the secure unit to assis | ent. The ADON said most of the residents on ility would be short-handed and rare that rissues regarding staffing and there were system to staff the facility according to the o see if they could meet the needs of those o one supervision at the hospital. To be for 24 hours at the hospital. s were in a room with a resident in the 100 hall it were up walking around, the CNA or he ADON said the directive to come out and get hall. |
| | | | |

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | PRINTED:8/17/2017 FORM APPROVED OMB NO. 0938-0391 |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 455074 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 04/18/2017 |
| NAME OF PROVIDER OF SU | 455974 PPLIER | STREET AD | DRESS, CITY, STATE, ZIP |
| OAK CREST NURSING CEN | NTER | 1902 FM 303 | |
| For information on the nursing | home's plan to correct this deficient | cy, please contact the nursing home or the state | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF D | DEFICIENCIES (EACH DEFICIENCY MUST | |
| F 0353 | OR LSC IDENTIFYING INFORM (continued from page 18) | MATION) | |
| Level of harm - Minimal harm or potential for actual harm Residents Affected - Some | [DIAGNOSES REDACTED]. R Review of R#23's Quarterly MDS without staff assistance. R#23 ha Review of R#23's Care Plan reviss confusion and an actual fall withor rolling walker. In an interview on 04/14/17 at 12: | | ssisting R#23 with ambulation providing a ing. LVN Q said she was assisting other |
| | REDACTED]. R#25 was [AGE] years old. Review of R#25's Quarterly MDS | d 04/14/17 revealed she was admitted to the fac | ve impairment, and required extensive assistance |
| | required extensive assistance with Review of R#25's Care Plan dated unhurried manner and reassure he when possible. Staff were require R#25 was at risk for injury relates safety awareness. Interventions ir R#26 (200 Hall) | h toileting and hygiene with the help of two plus 1 03/22/17 revealed she was resistant to care and re when needed. She required a consistent, trust ed to anticipate all of her needs due to her inabili d to falls and skin tears secondary to frail skin d included monitoring for and assisting with toileti | s persons. I required staff to approach her in a calm, ed caregiver and structured daily routine ity to verbalize them. ue to impaired mobility and lack of ng needs. |
| | Review of R#26's Face Sheet date REDACTED]. R#26 was [AGE] years old. Review of R#26's Annual MDS di R#26 was independent with super In an interview on 04/14/17 at 11: hall. R#26 said he could do most limited use of one arm. R#26 said would assist him. R#26 said he co said he ate dinner in the dining ro 4:30 p.m., dump them and leave t high school. R#26 said this nursii | d 04/14/17 revealed he was admitted to the faci ated [DATE] revealed he scored 15 points on th rvision with most of his activities of daily living 45 a.m., R#26 said there was a constant shortag activities of daily living without much assistanc 1 he needed help to straighten his bed during the bould hear call lights going off and not being ans soom and staff would bring in residents early into them unsupervised. R#26 said some of the CNA ng home was his home and he expected maturity | e BIMS, indicating he was cognitively intact. to used a wheelchair and could not walk. e of staff and never enough CNAs on his see but needed help to make his bed due to two to ten shift and occasionally someone wered during the two to ten shift. R#26 the dining room, between 4:00 p.m. and s were immature and talked like they were in |
| | REDACTED]. R#5 was [AGE] y Review of R#5's Annual Minimur usually understand others and con behavior concerns. R#5 needed si used a wheelchair to move aroum and extensive assistance with per | rd dated 03/29/17 revealed he was admitted to the ears old. In Data Set ((MDS) dated [DATE] revealed he huld usually make himself understood. R#5 had supervision with the help of one person to transfed d the facility. R#5 required limited assistance wissonal hygiene. R#5 required physical help with ould stabilize without staff assistance. R#5 had | ad moderate difficulty hearing others but could evere cognitive impairment but had no er from bed to chair but did not walk. R#5 ith dressing, supervision with toileting, one person's assistance with bathing and |
| | no bowel incontinence. Review of R#5's Care Plan dated personal hygiene, dressing, eating included providing R#5 with exter hygiene. There was no care plan i Review of R#5's Care Plan dated R#5 about preferences throughou | 10/13/16 revealed he required assistance at time g, bed mobility, transfer, toileting related to Dx (ensive assistance of one for bathing and with set related to R#5 resisting or refusing ADL care. R 01/06/15 revealed he had difficulty recalling rec t the day and to validate his thoughts/feelings w refusal of ADL care due to his dementia or pair | s for ADL care in bathing, grooming, (diagnosis) of Dementia. Interventions -up, limited assist of one for personal #5 was occasionally incontinent of bowel. sent events. Interventions included asking then confused or anxious. There was no care |
| | Ôn initial tour on 03/28/17 at 9:20 |) a.m., when asked how he was doing, R#5 said had a bath, R#5 did not replly. R#5 was lying in | I haven't had a bath in days. When asked if |
| | the evening and night shift. FM A but when she asked a CNA to bat | 20, Family Member (FM) AA said there was a sAA said she visited R#5 in the evening and some he R#5, they would sometimes reply, No shower flused about time and needed to be approached | etimes noticed R#5 needed a shower and shave, ers tonight. We're short handed. FM AA said R#5 |
| | Review of the 300 Hall Shower So during the 6:00 a.m. to 2:00 p.m. Review of the POC (Plan of Care) Code 99: Resident not available. Code 98: Resident refused. | chedule (undated) revealed R#5 was scheduled t | for a bath on Tuesdays, Thursdays and Saturdays lowing codes for the ADL Activity Log: |
| | Code 97: Not applicable. Review of the ADL Activity Log February, 2017: 02/02/17 (Thursday) : Shower at 14 02/04/17 (Saturday): Blank 02/09/17 (Thursday): Shower at 14 02/09/17 (Thursday): Shower at 1 02/11/17 (Saturday): Code 97 (no | 135 142 | he following schedule of bathing for R#5: |
| | 02/12/17 (Sunday): Code 97 (not 1 02/14/17 (Tuesday): Code 99 (not 02/16/17 (Thursday): Code 97 (no 02/18/17 (Saturday): Shower at 12 02/20/17 (Monday): Shower at 13 02/21/17 (Tuesday): Shower at 13 | applicable) : available) t applicable) 359 50 11 | |
| | 02/23/17 (Thursday): Shower at 1 02/25/17 (Saturday): Code 98 (ref 02/26/17 (Sunday): Code 97 (not a 02/28/17 (Tuesday): Shower at 13 March 2017 03/02/17 (Thursday): Code 98 (ref | used) applicable) 559 fused) | |
| | 03/04/17 (Saturday): Shower at 13 03/07/17 (Tuesday): Shower at 13 03/09/17 (Thursday): Shower at 13 03/11/17 (Saturday): Shower at 13 03/11/17 (Thursday): Shower at 11 03/16/17 (Thursday): Code 98 (ref 03/18/17 (Saturday): Code 98 (ref 03/21/17 (Tuesday): Code 98 (ref | 59 141 306 27 fused) iused) | |
| | 03/23/17 (Thursday): Code 98 (refn 03/23/17 (Thursday): Code 97 (no 03/25/17 (Saturday): Shower at 12 03/28/17 (Tuesday): Code 98 (refn | ot applicable) 311 | |

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | PRINTED:8/17/2017 FORM APPROVED |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 04/18/2017 |
| 455974 NAME OF PROVIDER OF SUPPLIER OAK CREST NURSING CENTER | | STREET ADDR 1902 FM 3036 ROCKPORT, T | EESS, CITY, STATE, ZIP |
| For information on the nursing | home's plan to correct this deficien | cy, please contact the nursing home or the state sur | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR | DEFICIENCIES (EACH DEFICIENCY MUST BE MATION) | PRECEDED BY FULL REGULATORY |
| 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): - C1 said there was a problem with the facility not having nearly enough staff. C1 1 said sometimes employees had to work | | |
| | 16 hours straight and some staff I to assist with personal care if they Cl 2 said call lights were not ans Two Cls said there were residents disturbed them to hear the resident them. Review of Daily Position Sheets f | and been quitting because of the long hours. CI 1 say y did not know you; CI 1 said there was no continui wered especially from 6:00 p.m. to 8:00 p.m. at nig in the facility who screamed a lot, or called for hel hts call out all the time, and they wondered if any or or March, 2017, which showed the schedule of CN who worked the 10 p.m. to 6 a.m. shift. | aid it was difficult to allow someone ity of care for residents. ht. lp frequently. These CIs said it f the CNAs or nurses responded to |
| | In an interview with the Administ Administrator further stated at tin On $04/14/17$ at 11:10 a.m., observ feet away from her tied to the bec said the staff told her she probabl On $04/14/17$ at 11:15 a.m., intervi light. Surveyor asked R #19 how 11:15 a.m.? R #19 said she had tt unable to find her call light. R #1 right back. R #19 said the staff for On $04/14/17$ at 12:19 p.m., intervi care. R #17 said sometimes it too times she had to yell out for help, will come into the room and cut of R #17 said she gets that answer a Review of CMS Form 672 dated (bathing; 50 residents required the assistance of one or two staff with dependent on staff for transferrin | rator on $03/31/17$ at $11:10$ a.m. she stated staffing C nes nurses will work as CNAs on the over night shi ation revealed R#18 was sitting up in a chair and h 1 rail. Surveyor asked R #18 if she could reach her of 9 would not receive her shower today because she ' ew with R #19 said sometimes it took up to 4 hours she was able to account for the time. R #19 said, Sc o activate her call light for her room-mate (R #18) b 9 said the staff would answer the call light, cut the ' reget to come back. we with R #17 said the facility did not have enough k between 15 minutes to 1 hour and 45 minutes to a R #17 said it made her feel like a piece of furniture off the call light and tell her that they will be right b | ift. er call light was approximately four call light and R #18 said no. R #18 was told it was a State Holiday. s for anyone to respond to the call ee that clock on the wall? Does it say secause many times her room-mate was light off then say they will be h staff to help all the residents with answer her call light. R #17 said at e. R #17 said many times the aides back, but that was never the case. d the assistance of one or two staff with d 55 residents required the or bathing; 9 residents were et use. 32 residents were |
| F 0441 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some | **NOTĒ- TĒRMS IN BRACKĒT Based on observation, interview, i Program with a system for prevei diseases for all residents to preve involved in direct resident contac Certified Nurse Aides (CNAs) H and procedure, while assisting R This failure could place 55 residen (ADL) at risk for exposure to infe The findings included: The facility's Hand Hygiene polic and water: Wet hands with warm seconds covering all surfaces of t towel. R #4's Face Sheet dated 12/06/16 REDACTED]. R #4's Significant Change MDS d -Rarely made self understood and -Had short and long-term memory -Was totally dependent with two s -Had an active [DIAGNOSES RE -Received oxygen therapy while r Observation of R #4 on 03/29/17. Observation of R #4 on 03/29/17. H and J entered R #4's room and hands and scrubbed her hands wi her hands with soap for a total of fw4, they each doffed their gloves of five seconds, before rinsing. C Simultaneous interview with CNA- hands for a total of 30 seconds. C hands with soap. Each CNA said Observation of R #4 on 03/29/17. Geriatric chair and a shower. CNA with soap for 11 seconds, before Interview with the Assistant Direc observations of CNAs H and J. T seconds before rinsing. | this identified as needing one to two person assistant cctions. y and procedure dated 11/28/16 documented .Hand water, apply soap to hands, and rub hands vigorous he hands and fingers. Rinse hands with warm water documented a [AGE] year-old female admitted to t ated [DATE] documented R #4: rarely understood others. problems and had severely impaired cognitive skil taff physical assistance for bed mobility, transfers, DACTED]. tot a resident and while a resident at the facility. at 8:50 a.m. revealed R #4 was sleeping and was re- at 8:53 a.m. revealed R #4 hays die for provide i th soap for a total of 11 seconds, before rinsing. Th 10 seconds, before rinsing. After both CNAs comp and again separately washed their hands. CNA J sc NA H scrubbed her hands with soap for a total of 1 s H and J on 03/29/17 at 11:38 a.m. revealed they 'NA H said they were told to sing the Happy Birthd they did not count or sing while washing their hand at 10:54 a.m. revealed CNAS H and J were preparin A J scrubbed her hands with soap for 11 seconds, b | d maintain an Infection Control trolling infections and communicable procedures to be followed by staff ed receiving resident personal care. econds, according to the facility's policy ce for activities of daily living I Hygiene techniques: To wash hands with soap sly outside the stream of water for 20 r and dry thoroughly with a disposable the facility on [DATE] with the [DIAGNOSES Ils for daily decision making. dressing, and personal hygiene. ceiving O2 @ 2 LPM via NC. e up position with her eyes closed. CNAs incontinent care. CNA H began washing her ten, CNA J washed her hands and scrubbed oleted performing incontinent care on R rrubbed her hands with soap for a total 1 seconds, before rinsing. stated they were trained to wash their tay song twice while scrubbing their ds during both observations. ng R #4 for a transfer from her bed to the before rinsing. CNA H scrubbed her hands vealed she was informed of the other hands with soap for a total of 20 |
| F 0498 Level of harm - Minimal harm or potential for actual harm | for residents' needs. **NOTE- TERMS IN BRACKET Based on observation, interview, a and techniques necessary to care personal care, in that: | w they have the skills and techniques to be able to TS HAVE BEEN EDITED TO PROTECT CONFIL and record review the facility failed to ensure nurse for residents' needs, for one Resident (R #4) of three | DENTIALITY** e aides were able to demonstrate skills ee residents observed receiving |
| Residents Affected - Some | Certified Nurse Aides (CNAs) H a | Eacility ID: 455974 | If continuation sheet |

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | PRINTED:8/17/2017 FORM APPROVED |
|---|--|---|--|
| STATEMENT OF DEFICIENCIES | (X1) PROVIDER / SUPPLIER / CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING | OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED |
| AND PLAN OF CORRECTION | IDENNTIFICATION NUMBER | B. WING | 04/18/2017 |
| NAME OF PROVIDER OF SU | 455974 IPPLIER | STREET AD | DRESS, CITY, STATE, ZIP |
| OAK CREST NURSING CEN | NTER | 1902 FM 303 ROCKPORT | |
| For information on the nursing | home's plan to correct this deficien | cy, please contact the nursing home or the state | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR | DEFICIENCIES (EACH DEFICIENCY MUST | BE PRECEDED BY FULL REGULATORY |
| F 0498 | (continued from page 20) | · · · · · | |
| Level of harm - Minimal harm or potential for actual harm | (ADL) at risk for exposure to info The findings included: | nts identified as needing one to two person assis ections. | , , |
| Residents Affected - Some | REDACTED]. R #4's Significant Change MDS d -Rarely made self understood and -Had short and long-term memory -Was totally dependent with two 3- -Had an active [DIAGNOSES RE -Received oxygen therapy while r Observation of R #4 on 03/29/17 H and J entered R #4's room and hands but only scrubbed her hand only scrubbed her hands with soa incontinent care on R #4, they ea with soap for a total of five secon rinsing. Simultaneous interview with CN/ hands for a total of 30 seconds. Chands with soap. Each CNA said Observation of R #4 on 03/29/17 Geriatric chair and a shower. CN/ with soap for 1 seconds, before Interview with the Assistant Direc observations of CNAs H and J. T seconds before rinsing. The facility's Hand Hygiene polic and water: Wet hands with warm seconds covering all surfaces of t towel . | lated [DATE] documented R #4: rarely understood others. y problems and had severely impaired cognitive staff physical assistance for bed mobility, transfe iDACTED]. tot a resident and while a resident at the facility. at 8:50 a.m. revealed R #4 was sleeping and was at 8:53 a.m. revealed R #4 layed in her bed in a explained to R #4 that they were going to provid swith soap for a total of 11 seconds, before riming. After ch doffed their gloves and again separately was dis, before rinsing. CNA H scrubbed her hands v As H and J on 03/29/17 at 11:38 a.m. revealed th 'NA H said they were told to sing the Happy Bir they did not count or sing while washing their h at 10:54 a.m. revealed CNAs H and J were prep. A J scrubbed her hands with soap for 11 second rinsing. tor of Nurses (ADON) on 03/31/17 at 9:31 a.m. | ers, dressing, and personal hygiene. s receiving O2 @ 2 LPM via NC. face up position with her eyes closed. CNAs de incontinent care. CNA H began washing her sing. Then, CNA J washed her hands but r both CNAs completed performing hed their hands. CNA J scrubbed her hands with soap for a total of 11 seconds, before ney stated they were trained to wash their rthday song twice while scrubbing their nands during both observations. aring R #4 for a transfer from her bed to the ls, before rinsing. CNA H scrubbed her hands . revealed she was informed of the rub their hands with soap for a total of 20 and Hygiene techniques: To wash hands with soap rously outside the stream of water for 20 vater and dry thoroughly with a disposable |
| F 0514 Level of harm - Minimal harm or potential for actual harm | professional standards **NOTE- TERMS IN BRACKET Based on observation, interview, a accepted professional standards or residents whose records were rev | ganized clinical records on each resident that ITS HAVE BEEN EDITED TO PROTECT CON and record review the facility failed to maintain of practice, that were complete and accurately do iewed. | IFIDENTIALITY** clinical records in accordance with ocumented, for one Resident (R#4), of 15 |
| Residents Affected - Some | accurately documented on her Tr This failure could place all three r treatments at risk for shortness of The findings included: | residents on continuous oxygen therapy and seve f breath and respiratory distress. | |
| | R #4's March 2017 Treatment Ad SOB. Start date: 01/22/16. R #4's physician's orders [REDAO R #4's Care Plan dated 03/08/17 d | CTED].@ 3 LPM via NC continuously. locumented (R #4) exhibits a risk for complicati- imonia .Approaches: .O2 as ordered. | via NC (nasal cannula) @ (at) 2LPM as needed for |
| | -Rarely made self understood and -Had short and long-term memory -Had an active [DIAGNOSES RE -Received oxygen therapy while r Observation of R #4 on 03/29/17 Vocational Nurse (LVN) I and C During this time, CNA H remove #4 to the shower room, without a bed with the assistance of LVN I nares. The oxygen concentrator w Observation of R #4 on 03/30/17 the room and said R #4 had conti surveyor's request, LVN K inspee liters. LVN K adjusted R #4's ox stated LVN I was currently R #4' Interview with LVN I on 03/30/17 LVN I was informed of R #4 on 03/30/17 LVN I was informed of R #4 on 03/30/17 VN I was informed of R #4 on 03/30/17 LVN I was informed of R #4 on 03/30/17 VN in eceded, that's not right. After LV the record, I will do it immediate 03/29/17 while being prepared ar that time and she should have sin provided with a portable oxygen each nurse caring for R #4 was re any nurse that received a new orr caring for R #4 referred to the Tr | rarely understood others. y problems and had severely impaired cognitive IDACTED]. not a resident and while a resident at the facility. at 8:50 a.m. revealed R #4 was sleeping and was at 10:51 a.m. revealed R #4 was steeping O2 @ ertified Nurse Aides H and J assisted to transfer ed R #4's nasal cannula, leaving R #4 without an ny oxygen therapy. At 11:33 a.m., R #4 was esc and CNAs H and J. Once R #4 was in bed, LVN vas set at 2.5 LPM. at 11:30 a.m. revealed R #4 was lying in bed rec nuous O2 @ 3LPM ordered when asked how m cted R #4's oxygen concentrator and stated It is s ygen concentrator to 3 LPM and then checked R s nurse. 7 at 11:35 a.m. revealed she stated R #4 was ord y receiving O2 @ 2.5 LPM on 03/29/17 and 03/ ator was set at 2.5 LPM N I reviewed R #4's Treatment Administration R N I reviewed R #4's took responsibility for not escorted to the shower room; LVN I verified ice her order was to receive oxygen continuousyo ice took resolve took resonsibility for not sponsible to ensure R #4 received continuous oz ler, transcribed that order to the Medication Adf eatment Administration Record to document the 03/28/17 revealed 7 residents were receiving res | s receiving O2 @ 2 LPM via NC. @ 2.5 LPM per NC. At 10:54 a.m., Licensed R #4 from the bed to the Geriatric chair. yo xygen administration. Both CNAs escorted R sorted back to her bedroom and transferred to N I replaced R #4's nasal cannula in R #4's seiving O2 @ 2.5 LMP via NC. LVN K entered uch oxygen R #4 should be receiving. Upon the set at 2.5 liters, it should be at 3 R #4's oxygen saturation which was 92%. LVN K lered to receive continuous O2 @3LPM via NC. 30/17. At this time LVN K approached LVN I and PM. LVN I verified she had not verified that eive O2 at 2.5 LPM but her order was CTED]. The new order was not transcribed to vation of R #4 not receiving any oxygen on R #4 did not have any oxygen provided during y. LVN I stated R #4 should have been ensuring R #4 had oxygen on and then said xygen. LVN I saite ach nurse prescribed treatment administered. |
| FORM CMS-2567(02-99) Previous Versions Obsolete | Event ID: YL1011 | Facility ID: 455974 | If continuation sheet Page 21 of 21 |