STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41392 Based on observation, interview, and record review the facility failed to ensure residents were free from abuse for 5 of 9 residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5) reviewed for abuse. - Resident #1 hit Resident #2 on 07/08/21 and pushed Resident #2 on 07/09/21 causing a fall with a head injury. Resident #2 was sent to the hospital to receive treatment. - Residents #3, #4, and# 5 did not feel safe in the facility while Resident #1 resided in the facility. An Immediate Jeopardy (IJ) was identified on 09/17/2021. While the IJ was lowered on 09/20/2021, the facility remained out of compliance at a severity level of actual harm and a scope of isolated due to the facility still monitoring the effectiveness of the Plan of Removal An Immediate Jeopardy (IJ) was identified on 09/17/2021. While the IJ was lowered on 09/20/2021, the facility remained out of compliance at a severity level of actual harm and a scope of isolated due to the facility still monitoring the effectiveness of the Plan of Removal. These failures placed residents at risk of abuse, neglect, pain, decline in health, and being displaced or hospitalized . Findings Included: Resident #1 Record review of Resident #1's face sheet revealed a [AGE] year-old male admitted to the facility on admitted on [DATE]. His diagnoses included dementia, adjustment disorder, delusional disorders, alcohol induced mood disorder, substance abuse, autistic disorder, epilepsy, blindness in one eye, hearing loss, hypertension, and restlessness/agitation. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 7 indicating he had severe cognitive impairment. His speech was unclear. He sometimes made himself understood and sometimes understood others. He required supervision only for walking in the corridor and supervision with set up only when resident moved to and returned from off-unit locations. He had no impairments to upper or lower extremities. He had no physical or verbal behaviors symptoms towards others. Record review of Resident #1's admission MDS dated [DATE] revealed he had physical and verbal behavior symptoms directed towards others that occurred 1 to 3 days and other behavior symptoms not directed to others that occurred 1 to 3 days. Record review of Resident #1's undated care plan printed on 07/29/2021 revealed in part . he had potential to be physically aggressive. The goal: resident will demonstrate effective coping skills and the interventions included, to keep resident away from any resident that tends to cause distress. Monitor behaviors every shift. Document observed behavior and attempted interventions in behavior log. When the resident becomes agitated: intervene before agitation escalates . Resident #1 had potential to be verbally aggressive. The goal: the resident will verbalize understanding of need to control verbally abusive behavior through the review date. Interventions included, give the resident as many choices as possible about care and activities and monitor behaviors every shift . Record review of Resident #1's Physicians Order's from 11/04/20 (admission) to 09/17/21 revealed no changes to the frequency of behavioral management orders since admission: - Order initiated on 11/04/20 and discontinued on 08/02/21 read Behavior Management attempts document aggression, verbal outbursts, and or physical aggression, number of behavior episodes, interventions and outcomes every shift document details in progress note 0= none present, 1= not present. - Order initiated on 08/02/21 and ongoing as of 09/17/21 read: Behavior Management attempts document aggression, verbal outbursts, and or physical aggression, number of behavior episodes, interventions and outcomes every shift document details in progress note 0= none present, 1= not present. Record review of Resident #1's Physicians Orders 11/04/20 (admission) to 09/13/21 revealed: no active, completed or discontinued orders for one-on-one supervision. Record review of Resident #1's facility progress notes dated 07/09/2021 at 6:45 AM, written by LVN A noted, this nurse observed resident exit his room this morning as usual for the coffee cart, this morning another female resident was helping herself to coffee before he could, one on one side the cart and one on the other side of the cart, he called her outside her name, to be exact bitch give it here, let it go, when he did not get his way, he pushed the resident, the other resident lost balance and fell to the floor. Record review of Resident #1's hospital records with the admitted [DATE] and discharge date of [DATE], revealed in part . the patient was having paranoid delusions with the belief that people wanted to harm him, he physically assaulted another resident by knocking her down causing her to hit her head, verbally and physically threatening staff and other residents . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Behavioral Hospital Discharge Summary dated 08/24/21 revealed: Reason for Termination, Other- Patient refused to participate in psychotherapy. Symptoms are being treated with medication .If patient shows the ability to benefit from treatment, he may be referred again for therapy if he remains in or returns to the facility. Record review of Resident #1's July MAR revealed in part . Depakote 500 mg by mouth two times a day for dementia (start date 07/06/2021 and discontinue date 07/28/2021); Zyprexa 5 mg by mouth two times a day for antipsychotic (start date 07/28/2021). Record review of Resident #1's Clinical Progress Notes revealed resident had at least 19 documented incidents of verbal and physical aggression from 07/30/21 to 09/17/21: 1. Progress Note dated 07/30/21 at 11:48 AM read: Continues to curse both staff and resident out. Continues on contact isolation but comes out often. Unable to reorient resident due to continuous confusion. 2. Progress Note dated 07/31/21 at 06:51 AM read: . resident cursed this nurse shut up b***h, you stupid, go on now, resident cannot be redirected easily. 3. Progress Note dated 07/31/21 at 09:26 AM read: . resident has been verbally inappropriate, saying things like you N*****s need to leave me alone, you stupid b***h, resident came to nursing station . took his pants down and bent over opening his buttocks cheeks exposing himself to staff. 4. Progress Note dated 07/31/21 at 11:33 AM revealed: Resident was adamant about leaving his room, cursing the sitter and this writer out with vulgar language, the resident then said you think I'm playing with you MF, and grabbed the broom from his closet, and [NAME] it back like a bat . 5. Progress Note dated 07/31/21 at 10:21 PM revealed: Patient is coming out of his room instead of staying in isolation as directed. When directed, he screamed at staff and called them name by using B and F words. He even tried to hit one of the nurses, he refused his medication because he said we tried to poison him which is not true. 6. Progress Note dated 08/01/21 at 10:42 PM revealed: Patient kept going to the kitchen disturbing the kitchen crew . while trying to redirect patient he got aggressive and screaming and cursing using B and F words. He even tried to hit writer, he finally calmed down and went to his room. 7. Progress Note dated 08/02/21 at 07:17 AM revealed: Resident out of his room started cursing staff and as staff wanted to redirect resident, resident started throwing punches on all staff randomly. Resident punched this nurse on her left shoulder, threw coffee on nurse's station, punched another staff and another staff lost 2 of her nails trying to redirect resident. 8. Progress Note dated 08/03/21 at 05:31 AM revealed: Resident came out from his room severally just walking up and down aimlessly. Writer was busy writing her notes and resident walked up to her and was cursing at her using all kinds of profanities. 9. Progress Note dated 08/03/21 at 06:49 AM revealed: This nurse tried to help resident with coffee, and he pushed, punched, tried to choke nurse from the back. Two other nurses came to the nurse's rescue. NP made aware. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. Progress Note dated 08/08/21 at 06:00 AM revealed: Was a behavior observed? Yes. Observed patient walk out of his room behind the nursing station to the mobile coffee stand. Patient (pt) attempted to get some coffee but could not get the pump to work. CNA came to assist pt with coffee. Patient became aggressive with staff member and began to yell at her Patient redirected in his behavior and instructed to stop and informed he could not take all the sugar. Patient became aggressive and began to argue, curse and yell at staff member. Patient yelling and calling all staff members mother***er and B*****s. Patient instructed to go back to his room. Patient yelled at staff and eventually went to his room. 11. Progress Note dated 08/08/21 at 09:25 AM revealed: Was a behavior observed? Yes. Resident continues to curse staffing using M F words and does not follow orientation. 12. Progress Note dated 08/23/21 at 09:17 AM revealed: This nurse had to redirect resident after going up to another resident saying, I'm going to f**k him up, let him keep on, this nurse did not hear the conversation, I just redirected him back to his room and he complied. 13. Progress Note dated 08/28/21 at 04:13 PM revealed: Situation- resident was verbally abusive to another patient. 14. Progress Note dated 08/30/21 at 08:23 PM read: Late entry 6-2. Resident continues to be monitored for aggressive behaviors with none noted. Resident though intermittently will curse staff but then back to his room. Will continue to monitor. 15. Progress Note dated 09/04/21 at 06:57 PM read: Was behavior observed? Yes. 16. Progress Note dated 09/14/21 at 01:33 PM read: Resident continues to curse staff, stupid, I don't want to f . with you. Resident quietly puts himself on the floor and says pillow, pillow, pillow. Resident gets himself up and started counting his money still cursing staff. Unable to reorient resident and NP made aware by the DON. 17. Progress Note dated 09/14/21 at 07:40 PM read: Resident ran after another resident who had a jacket on and said mine, mine, mine. This nurse and a CNA ran after and stopped him from getting closer to the resident. Resident continued to curse nurse, funky M F unable to reorient resident as he was pacing up and down the hallway. 18. Progress Note dated 09/15/21 at 01:06 PM read: Resident continues to curse staff intermittently, stupid M F, you crazy, crazy, crazy. 19. Progress Note dated 09/17/21 at 01:33 PM read: Resident earlier this morning passed room [ROOM NUMBER] (Resident #5's room), looked into the room and said to the resident in the room n*****, n*****, n*****, M F. This nurse reminded resident not to curse residents especially one minding his business not saying a word to him. Resident said to this nurse, shut up ugly M F. In an observation on 07/29/2021 at 10:30 AM, Resident #1 walked rapidly out of his isolation room three times. His eyes were shifting in all directions. There were two nurses at the station and each time they redirected him back to his room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 07/29/2021 at 10:35 AM, LVN C said Resident #1 has behaviors, he had OCD and he repeat things. He thinks he owns everything and does not want anyone else to have them, like the coffee cart. When asked how to do you monitor him if you are not at the nurse station to redirect him, LVN C threw her arms and shoulders up towards the air, indicating she did not know and then she walked away. In an interview on 07/29/2021 at 3:45 PM CNA M said she had Abuse/Neglect and Exploitation in-service a few days ago because Resident #1 gets out of hand. She said that Resident #1 goes to the desk and says horrible things. CNA M said she felt he was in the wrong place. CNA M said every day he comes out fussing. An anonymous staff interview on 09/13/21 at 10:00 revealed: Resident #1 was not on one-on-one supervision, was observed for aggressive behaviors and the resident's normal status was aggressive. The staff said, the resident was in a room by himself and normally walks around the facility unattended, staff are not required to walk with him. The staff said when the nursing staff feel he was a danger, they intervene but it can be random, the resident believes everything was his and he curses at people for no reason. The staff said, the facility knows he is not supposed to be here and the anonymous staff does not feel there was adequate supervision of Resident #1 to ensure the safety of the other residents. The anonymous staff said the resident had a sitter in the past, but now he does not, you can't control him, he is everywhere. In an observation and interview with an anonymous staff interview on 09/13/21 at 10:10 AM revealed: Resident #1 came out of his room into the common area, where 3 other residents were present, and sat down in a chair facing the nursing station. Resident #1 continuously cursed incoherently at staff. The anonymous staff said Resident #1 wanders around the facility all the time, and even when he was on one-on-one supervision in the past, he would fight his sitter. He screams at other residents every other day. The anonymous staff said they do not believe the facility can do enough to make sure other residents are safe, since he was not on one-on-one supervision and he was allowed to roam the facility. The anonymous staff said that nursing staff have to use a medication cart to obstruct one of the entrances to the nursing station so that Resident #1 does not attack them from the back. The staff said Resident #1 had not hit them because they did not give him the opportunity. In an interview at 09/13/21 at 10:35 AM the DON said, Resident #1 was previously on one-on-one supervision in August (07/27/21 to 08/03/21), but it had been discontinued. The DON said there were not clear changes in his aggression that led to ending his one-on-one supervision, but he does not have aggressive behaviors on a daily basis. The DON said nursing staff know to monitor the resident, know what he was doing, anticipate his needs and take care of his triggers. She said recently the only incident the resident was involved in was with Resident #5 and it was reported to the state. The DON said that Resident #1 was not on one-on-one supervision because an interdisciplinary team decided that he was not a danger. She said the resident walks around the facility with a final destination in mind, but he does so unattended. The DON said, she does not feel Resident #1 was appropriate for the facility and in her professional opinion she is uncertain if they can keep staff and residents safe from him because he is unpredictable. In an observation and interview on 09/13/21 at 10:53 AM the surveyor said hello to the Resident #1 while standing in his doorway with nursing staff in an attempt to assess his reactions. Resident #1 cursed at staff and surveyor, he said, he said yal ain't nobody, f**k that and other incoherent expletives. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an observation on 09/13/21 at 10:55 AM, Resident #1 came out of his room yelling at staff. He slid behind the nursing cart blocking the back of the nursing station and continued to talk incoherently at the nursing staff, asking for shoes and clothes he was already wearing and called staff crazy crazy. After about 5 minutes, the nursing staff was able to redirect Resident #1 and he returned to his room. An observation and Interview on 09/13/21 at 12:06 revealed: Resident #1 was no longer in room, MA A said that the resident left his room unattended and most likely went to the dining room. The surveyor went to locate the resident in the dining room, the resident was observed to be sitting alone in the dining room unattended. An anonymous staff interview conducted on 09/17/21 at 01:30 PM revealed: Resident #1's behavior had worsened since 09/13/21 and the day before the resident ran down the hall after another resident that passed his room. They said Resident #1 ran down the hall and grabbed the resident saying mine, mine, staff chased him down the hall and got between the residents as Resident #1 grabbed at the other resident. The staff said after the investigation, Resident #1 had chased down the resident due to the fact that she was wearing his jacket. An observation and Interview on 09/17/21 at 01:58 PM revealed: Resident #1 attempting to exit his room with a sitter at his door . The sitter redirected the resident and he returned to his room. Record review of Resident #1's Physician's Orders dated 09/17/21 revealed: resident was on one-on-one observation at this time related to exhibiting signs and symptoms of verbal aggression effective at 01:30 PM. Resident #2 Record review of Resident #2's face sheet, printed on 07/29/2021 revealed a [AGE] year-old female admitted to the facility on [DATE] and initially admitted on [DATE]. Her diagnoses included soft tissue disorder, orthopedic aftercare, fracture of left femur, headache syndrome, muscle weakness, diabetes, major depressive disorder, hypertension, and Parkinson's disease . Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating she was cognitively intact. She required supervision only for walking in the corridor and supervision with set up only when resident moved to and returned from off-unit locations. She was steady at all times during transitions and walking. She had impairments to lower extremities. She used both a walker and a wheelchair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 07/29/2021 at 10:25 AM, Resident#2 said she did not feel safe at the facility. She said Resident #1 was dangerous. Resident #2 said I don't think he should be here, it's not right. The first time(07/08/21) was at the coffee cart which was outside my room, he grabbed my arm, it hurt, and I got a bruise. Resident #2 said on the next day the coffee cart was again in the hallway just outside her room. He pushed her and pushed the cart at her; she fell hit her head there was a lot of blood. Resident #2 said she went to the ER and they had to glue her scalp and after second incident she said she pressed charges. She said she told her therapist about her concerns and has not told anyone else in the facility about how she feels. She said they told her the facility will take care of it, but It took 3 days after the incident before he left the facility. Resident # 2 said a few days ago she saw him at bingo, he never comes to bingo, she said she was afraid he might hurt her again. Record review of the Provider Investigation Report revealed Resident #4 was a witness to 07/08/2021 incident between Resident #1 and Resident #2. In an interview on 07/29/2021 at 3:10 PM, Resident #4 said I don't know his name, but he lives in room [ROOM NUMBER]. Resident #4 said he saw Resident #1 hit Resident #2 with his fist the first time and said she got bruised up. He said the second time Resident #1 hit Resident #2 there were two constables and he thought they would take him away, but they didn't. He said today he saw Resident #1 walking around the halls and told Resident #2 to be careful as he's out again. He said Resident #1 does not like anyone, he does not like white people and the nurses don't mess with him either. Resident #4 said he tried to hit me about a month ago, but I told him if he does, I'll hit him with my cane. Resident #4 said he felt safe when Resident #1 was not in the building and he likes to go all over the building, and someone showed him how to get to the dining room a different way, so he did not go by Resident #1's room anymore. Resident #4 said something needs to be done about Resident #1, he's going to hurt these ladies one day. Resident #4 said he has seen that when Resident #1 enters the dining room the other residents will move away from him. Record review of Resident #2's facility progress notes dated 07/09/2021 at 6:45 AM, written by LVN A read in part . Per 2nd nurse observation she witnessed Resident #1 and Resident #2 playing tug of war with the coffee cart, Resident #1 then said bitch let me have it, let it go, then agitated Resident #1 pushed the cart so hard in Resident #2's direction, she lost balance off of both feet landed on the floor on her back, hit her head, sustained head injury, impact injury to bilateral hands, this writer observed as I arrived to the incident Resident #2 laying on the floor, 2nd nurse was trying to get agitated Resident #1 away from the area and calmed down, Resident #2's head was facing the back hallway and feet facing the nursing station, Resident #2 had on slippers and appropriately attired, Resident #2 walker noted in hallway, eyewear noted, 3rd nurse got on floor with Resident #2 to calm her down, and this writer called for emergency 911 transport for fall with head injury, vitals immediately started, Resident #2 was not moved due to head injury and bleeding noted, compression started, Resident #2 complained of her head hurting/pounding, and her hands hurting and her bilateral heels hurting. Resident #2 assisted per 911 EMS to stretcher and transported to nearest hospital . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 08/02/2021 at 1:50 PM, LVN A said she was the nurse assigned to Resident #1 on 07/09/2021. She said Resident #1 had a routine in the mornings: sweeping floor, then getting coffee. She said prior to the incident Resident #1 would go to end of hall where dietary would leave the coffee cart and he would roll the coffee cart to the nurse station. Another resident was at the coffee cart before he got there. She said during the incident, Resident #2 was knocked off balance by Resident #1 and she helped Resident #2. LVN A stated, It was a territorial thing. She said she did see him walk from his room and on way to cart. LVN A continued by stating she was unaware of the altercation between Resident #1 and Resident #2 the day before (7/08/2021). She said It was not mentioned in morning report. It was not mentioned in nurse to nurse report. It should have been communicated between the nurses (nurse leaving and nurse just coming on shift). If I knew about the altercation, I wouldn't have allowed Resident #2 to go down to that area where the coffee cart was. I only heard about the altercation , like it was a rumor. I float and I depend on my reports. Record review of Resident #2's facility progress notes dated 07/09/2021 at 7:14 AM, written by LVN D read in part . Resident #2 standing in room [ROOM NUMBER] doorway, dietary placed coffee cart near Resident #2's door. Resident #2 was standing in front of cart attempting to fix her a cup of coffee when Resident #1 walked down the hall to coffee cart and try to pull coffee cart away. Resident #2 then grab the cart both began to pull cart and began to yell when this nurse heard yelling from Resident #1 and Resident #2, went to see what was going on .Resident #1 took his hands off the cart and yelled BITCH LET IT GO, then Resident #1 pushed with both hands with force . Resident #2 fell straight backwards, this nurse removed Resident #1 while other nurses attended to Resident #2. 911 called and abuse coordinator called this nurse stayed with Resident #1 . In a telephone interview on 07/30/2021 at 8:55 AM, LVN D said the incident with Resident #1 and Resident #2 occurred in the morning of 7/9/2021. LVN D said Resident #1 was down the hall at the coffee cart outside Resident #2's room and both had their hands on the coffee cart. After the incident LVN D said she took Resident #1 back to his room. She said LVN A was Resident #2's assigned nurse and LVN A went to Resident #2 to administer first aid. LVN D said before the incident Resident #1 was just walking, and she did not notice any unusual behavior. Record review of Resident #2's hospital records dated 07/09/2021 revealed a CT (computer tomography) scan of the head and spine was performed for a fall with bleeding to the head area. X-ray of both hands was also performed. The findings were: Resident #1 had a moderate soft tissue bruise to back of her head and a small bruise to the left front of her scalp. The wound was closed. Interview on 07/29/2021 at 11:50 AM, the Administrator said the facility incident report from 7/8/2021 incident between Resident #1 and Resident #2, was a professional review and was unsubstantiated. In an interview on 07/30/2021 at 4:15 PM, the Administrator said actions were taken to protect Resident #1 from further abuse while an investigation was in process. She said the first time on 7/8/2021, we did observations on Resident #2, kept the residents apart and second time Resident #2 was sent to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 09/13/21 at 11:03 AM, the Administrator said after the first incident on 07/08/21 the staff interviewed the residents involved and referred Resident #1 to psych services ; she said Resident #1 was monitored for 6 hours by keeping him at the nursing station and one on one supervision was ended because the resident was not considered a threat to other residents. The Administrator said she did not believe that Resident #1 intentionally hurt Resident #2 and the interdisciplinary team decided that he no longer needed to be supervised one on one. She said there were no notes for the IDT meeting that decided to end one-on-one supervision of Resident #1. The Administrator said there was no policy on dealing with residents with combative behaviors or one-on-one supervision. She said decisions are made based on each individual situation, but residents who are known to be aggressive should be placed on one-on-one supervision. The administrator said prior to the incident on 07/08/21 Resident #1 was not known to have aggressive behaviors. The Administrator said in retrospect he should have remained on one-on-one supervision. In an interview on 09/13/21 at 11:30 AM, the Regional Nurse said looking back Resident #1 should have remained on one-on-one supervision after the incident with Resident #2 on 07/08/21 to protect Resident #2 and other residents but at that time he was not considered a risk to resident safety. Resident #5 Record review of Resident #5's face sheet dated 09/19/21 revealed: resident admitted to the facility on [DATE] with diagnoses which included: dementia, type 2 diabetes, difficulty swallowing, unsteadiness on feet, major depressive disorder, anxiety disorder, muscle weakness, hypertension, skin cancer and brief psychotic disorder. Record review of Resident #5's quarterly MDS dated [DATE] revealed: resident admitted from a hospital, usually makes himself understood, usually understands, wore corrective lenses, had moderately impaired cognition as indicated by a BIMS score of 11 out of 15 and had no potential indicators of psychosis, no hallucinations or delusions. The resident needed supervision with most ADLs, used a wheelchair/walker and was frequently incontinent of bladder and bowel. Record review of Resident #5's Care Plan revised 09/19/21 revealed: focus- risk for communication problem related to impaired cognition, goal- resident will be able to make basic needs known on a daily basis, interventions- discuss with resident/family concerns or feelings regarding communication difficulty, encourage resident to continue stating thoughts even if resident is having difficulty. Focus- uses anti-anxiety medications related to anxiety disorder, goal- resident will be free from discomfort or adverse reactions related to anti-anxiety therapy, interventions- administer anti-anxiety medications as ordered by physician, monitor for side effects and effectiveness every shift. Focus- risk for mood problems related to diagnoses of dementia, goal- resident will have improved sleep pattern by reporting adequate rest or fewer episodes of insomnia, interventions- administer medications as order. Monitor/document for side effects and effectiveness. Record review of facility accident/incident report dated 08/28/21 at 04:13 PM completed by the DON revealed: Incident Description Resident (Resident #5) was by the nursing station and decided to go to his room. While wheeling his wheelchair to go to him room another patient (Resident #1) started screaming at him and calling him names using B and F words. This patient is also screaming at him and they were about to fight when 2 nurses intervene to redirect them to their room (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility accident/incident report dated 08/28/21 at 04:13 PM completed by LVN B revealed: Resident #1 was cursing and using B and F words at another patient and even trying to fight the patient because the other patient (Resident #5) was passing his room. The patient did not go to his room, he was just passing, and this resident get mad and want to fight. Nurse and other staff were able to intervene and avoid the incident. In an interview on 09/13/21 at 10:25 AM, when Resident #5 was asked if he had any problems with anyone on his hallway he said, the guy next door is crazy he said Resident #1 walked around the facility by himself and had cursed him out before. Resident #5 said Resident #1 comes to his door regularly and tries to come into his room, but he won't let him in. He said that he does not feel safe because he (Resident #1) is crazy. In an interview on 09/17/21 at 01:35 PM, when Resident #5 was asked about the incident on 08/28/21 he said he tries to stay away from Resident #1. Resident #5 said I have the right to defend myself, he (Resident #1) can say whatever he wants in the hallway because I can close my door but don't want him coming to my room and messing with me. He said he finds Resident #1 scary and doesn't want to get in trouble with him, so he avoids going to places he is, leaves when he sees him and hopes Resident #1 is moved from the building. Resident #5 said someone has to do something about him he comes into his room every week. He said Resident #1 was came to his doorway earlier and cursed at him. In an interview on 09/13/21 at 11:03 AM, the Administrator said that on 08/28/21 Resident #1 and Resident #5 had an incident. She said that staff reported that Resident #1 cursed and yelled at Resident #5 as he walked past his room. The administrator said the incident was reported on 08/28/21. Record review of facility accident/incident report dated 08/28/21 at 04:13 PM completed by the DON revealed: Incident Description Resident(Resident #5) was by the nursing station and decided to go to his room. While wheeling his wheelchair to go to him room another patient (Resident #1) started screaming at him and calling him names using B and F words. This patient is also screaming at him and they were about to fight when 2 nurses intervene to redirect them to their room Record review of facility accident/incident report dated 08/28/21 at 04:13 PM completed by LVN B revealed: Resident #1 was cursing and using B and F words at another patient and even trying to fight the patient because the other patient was passing his room. The patient did not go to his room, he was just passing, and this resident get mad and want to fight. Nurse and other staff were able to intervene and avoid the incident. In an interview on 09/17/21 at 01:35 PM, when Resident #5 was asked about the incident on 08/28/21 he said he tries to stay away from Resident #1. Resident #5 said I have the right to defend myself, he (Resident #1) can say whatever he wants in the hallway because I can close my door but don't want him coming to my room and messing with me. He said he finds Resident #1 scary and doesn't want to get in trouble with him, so he avoids going to places he is, leaves when he sees him and hopes Resident #1 is moved from the building. Resident #5 said someone has to do something about him he comes into his room every week. He said Resident #1 was came to his doorway earlier and cursed at him. In an interview on 07/29/2021 at 11:05 AM, Resident #3 took a long pause when asked if he felt safe in the facility. He shook his head, looked down and turned his head away. He said there was a fell ow down the hall: Resident #1, he [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43049 Based on observation, interview, and record review, the facility failed to ensure that resident's environment remains as free of accident hazards as is possible, and residents received adequate supervision and assistance devices to prevent accidents : for 5 of 9 residents (Resident #1, Resident #2,Resident #3, Resident #4, Resident #5) reviewed for accidents and supervision. The facility failed to adequately supervise Resident # 1, who had a documented history of aggressive behaviors, to prevent repeated attacks of aggression, physical and mental harm to Resident #2 and Resident #5. The facility failed to put in place effective interventions to protect the psychosocial well-being of Resident #2, Resident #3, Resident #4, and Resident #5 by not preventing Resident #1 from approaching other residents, scaring them with his verbally and physically aggressive behaviors. An Immediate Jeopardy (IJ) was identified on 09/17/2021. While the IJ was lowered on 09/20/2021, the facility remained out of compliance at a severity level of actual harm and a scope of isolated due to the facility still monitoring the effectiveness of the Plan of Removal. These failures could affect residents by placing them at risk of minor and major injuries due to inadequate supervision. Resident #1 Record review of Resident #1's face sheet revealed a [AGE] year-old male admitted to the facility on admitted on [DATE]. His diagnoses included dementia, adjustment disorder, delusional disorders, alcohol induced mood disorder, substance abuse, autistic disorder, epilepsy, blindness in one eye, hearing loss, hypertension, and restlessness/agitation. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 7 indicating he had severe cognitive impairment. His speech was unclear. He sometimes made himself understood and sometimes understood others. He required supervision only for walking in the corridor and supervision with set up only when resident moved to and returned from off-unit locations. He had no impairments to upper or lower extremities. He had no physical or verbal behaviors symptoms towards others. Record review of Resident #1's admission MDS dated [DATE] revealed he had physical and verbal behavior symptoms directed towards others that occurred 1 to 3 days and other behavior symptoms not directed to others that occurred 1 to 3 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's undated care plan printed on 07/29/2021 revealed in part . he had potential to be physically aggressive. The goal: resident will demonstrate effective coping skills and the interventions included, to keep resident away from any resident that tends to cause distress. Monitor behaviors every shift. Document observed behavior and attempted interventions in behavior log. When the resident becomes agitated: intervene before agitation escalates . Resident #1 had potential to be verbally aggressive. The goal: the resident will verbalize understanding of need to control verbally abusive behavior through the review date. Interventions included, give the resident as many choices as possible about care and activities and monitor behaviors every shift . Record review of Resident #1's Physicians Order's from 11/04/20 (admission) to 09/17/21 revealed no changes to the frequency of behavioral management orders since admission: - Order initiated on 11/04/20 and discontinued on 08/02/21 read Behavior Management attempts document aggression, verbal outbursts, and or physical aggression, number of behavior episodes, interventions and outcomes every shift document details in progress note 0= none present, 1= not present. - Order initiated on 08/02/21 and ongoing as of 09/17/21 read: Behavior Management attempts document aggression, verbal outbursts, and or physical aggression, number of behavior episodes, interventions and outcomes every shift document details in progress note 0= none present, 1= not present. Record review of Resident #1's Physicians Orders 11/04/20 (admission) to 09/13/21 revealed: no active, completed or discontinued orders for one-on-one supervision. Record review of Resident #1's facility progress notes dated 07/09/2021 at 6:45 AM, written by LVN A noted, this nurse observed resident exit his room this morning as usual for the coffee cart, this morning another female resident was helping herself to coffee before he could, one on one side the cart and one on the other side of the cart, he called her outside her name, to be exact bitch give it here, let it go, when he did not get his way, he pushed the resident, the other resident lost balance and fell to the floor. Record review of Resident #1's hospital records with the admitted [DATE] and discharge date of [DATE], revealed in part . the patient was having paranoid delusions with the belief that people wanted to harm him, he physically assaulted another resident by knocking her down causing her to hit her head, verbally and physically threatening staff and other residents . Record review of Resident #1's Behavioral Hospital Discharge Summary dated 08/24/21 revealed: Reason for Termination, Other- Patient refused to participate in psychotherapy. Symptoms are being treated with medication .If patient shows the ability to benefit from treatment, he may be referred again for therapy if he remains in or returns to the facility. Record review of Resident #1's July MAR revealed in part . Depakote 500 mg by mouth two times a day for dementia (start date 07/06/2021 and discontinue date 07/28/2021); Zyprexa 5 mg by mouth two times a day for antipsychotic (start date 07/28/2021). Record review of Resident #1's Clinical Progress Notes revealed resident had at least 19 documented incidents of verbal and physical aggression from 07/30/21 to 09/17/21: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Progress Note dated 07/30/21 at 11:48 AM read: Continues to curse both staff and resident out. Continues on contact isolation but comes out often. Unable to reorient resident due to continuous confusion. 2. Progress Note dated 07/31/21 at 06:51 AM read: . resident cursed this nurse shut up b***h, you stupid, go on now, resident cannot be redirected easily. 3. Progress Note dated 07/31/21 at 09:26 AM read: . resident has been verbally inappropriate, saying things like you N*****s need to leave me alone, you stupid b***h, resident came to nursing station . took his pants down and bent over opening his buttocks cheeks exposing himself to staff. 4. Progress Note dated 07/31/21 at 11:33 AM revealed: Resident was adamant about leaving his room, cursing the sitter and this writer out with vulgar language, the resident then said you think I'm playing with you MF, and grabbed the broom from his closet, and [NAME] it back like a bat . 5. Progress Note dated 07/31/21 at 10:21 PM revealed: Patient is coming out of his room instead of staying in isolation as directed. When directed, he screamed at staff and called them name by using B and F words. He even tried to hit one of the nurses, he refused his medication because he said we tried to poison him which is not true. 6. Progress Note dated 08/01/21 at 10:42 PM revealed: Patient kept going to the kitchen disturbing the kitchen crew . while trying to redirect patient he got aggressive and screaming and cursing using B and F words. He even tried to hit writer, he finally calmed down and went to his room. 7. Progress Note dated 08/02/21 at 07:17 AM revealed: Resident out of his room started cursing staff and as staff wanted to redirect resident, resident started throwing punches on all staff randomly. Resident punched this nurse on her left shoulder, threw coffee on nurse's station, punched another staff and another staff lost 2 of her nails trying to redirect resident. 8. Progress Note dated 08/03/21 at 05:31 AM revealed: Resident came out from his room severally just walking up and down aimlessly. Writer was busy writing her notes and resident walked up to her and was cursing at her using all kinds of profanities. 9. Progress Note dated 08/03/21 at 06:49 AM revealed: This nurse tried to help resident with coffee, and he pushed, punched, tried to choke nurse from the back. Two other nurses came to the nurse's recuse. NP made aware. 10. Progress Note dated 08/08/21 at 06:00 AM revealed: Was a behavior observed? Yes. Observed patient walk out of his room behind the nursing station to the mobile coffee stand. Patient (pt) attempted to get some coffee but could not get the pump to work. CNA came to assist pt with coffee. Patient became aggressive with staff member and began to yell at her Patient redirected in his behavior and instructed to stop and informed he could not take all the sugar. Patient became aggressive and began to argue, curse and yell at staff member. Patient yelling and calling all staff members mother***er and B*****s. Patient instructed to go back to his room. Patient yelled at staff and eventually went to his room. 11. Progress Note dated 08/08/21 at 09:25 AM revealed: Was a behavior observed? Yes. Resident continues to curse staffing using M F words and does not follow orientation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	12. Progress Note dated 08/23/21 at 09:17 AM revealed: This nurse had to redirect resident after going up to another resident saying, I'm going to f**k him up, let him keep on, this nurse did not hear the conversation, I just redirected him back to his room and he complied. 13. Progress Note dated 08/28/21 at 04:13 PM revealed: Situation- resident was verbally abusive to another patient. 14. Progress Note dated 08/30/21 at 08:23 PM read: Late entry 6-2. Resident continues to be monitored for aggressive behaviors with none noted. Resident though intermittently will curse staff but then back to his room. Will continue to monitor. 15. Progress Note dated 09/04/21 at 06:57 PM read: Was behavior observed? Yes. 16. Progress Note dated 09/14/21 at 01:33 PM read: Resident continues to curse staff, stupid, I don't want to f . with you. Resident quietly puts himself on the floor and says pillow, pillow, pillow. Resident gets himself up and started counting his money still cursing staff. Unable to reorient resident and NP made aware by the DON. 17. Progress Note dated 09/14/21 at 07:40 PM read: Resident ran after another resident who had a jacket on and said mine, mine, mine. This nurse and a CNA ran after and stopped him from getting closer to the resident. Resident continued to curse nurse, funky M F unable to reorient resident as he was pacing up and down the hallway. 18. Progress Note dated 09/15/21 at 01:06 PM read: Resident continues to curse staff intermittently, stupid M F, you crazy, crazy, crazy. 19. Progress Note dated 09/17/21 at 01:33 PM read: Resident earlier this morning passed room [ROOM NUMBER] (Resident #5's room), looked into the room and said to the resident in the room n*****, n*****, n*****, M F. This nurse reminded resident not to curse residents especially one minding his business not saying a word to him. Resident said to this nurse, shut up ugly M F. In an observation on 07/29/2021 at 10:30 AM, Resident #1 walked rapidly out of his isolation room three times. His eyes were shifting in all directions. There were two nurses at the station and each time they redirected him back to his room. In an interview on 07/29/2021 at 10:35 AM, LVN C said Resident #1 has behaviors, he had OCD and he repeat things. He thinks he owns everything and does not want anyone else to have them, like the coffee cart. When asked how to do you monitor him if you are not at the nurse station to redirect him, LVN C threw her arms and shoulders up towards the air, indicating she did not know and then she walked away. In an interview on 07/29/2021 at 3:45 PM CNA M said she had Abuse/Neglect and Exploitation in-service a few days ago because Resident #1 gets out of hand. She said that Resident #1 goes to the desk and says horrible things. CNA M said she felt he was in the wrong place. CNA M said every day he comes out fussing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An anonymous staff interview on 09/13/21 at 10:00 revealed: Resident #1 was not on one-on-one supervision, was observed for aggressive behaviors and the resident's normal status was aggressive. The staff said, the resident was in a room by himself and normally walks around the facility unattended, staff are not required to walk with him. The staff said when the nursing staff feel he was a danger, they intervene but it can be random, the resident believes everything was his and he curses at people for no reason. The staff said, the facility knows he is not supposed to be here and the anonymous staff does not feel there was adequate supervision of Resident #1 to ensure the safety of the other residents. The anonymous staff said the resident had a sitter in the past, but now he does not, you can't control him, he is everywhere. In an observation and interview with an anonymous staff interview on 09/13/21 at 10:10 AM revealed: Resident #1 came out of his room into the common area, where 3 other residents were present, and sat down in a chair facing the nursing station. Resident #1 continuously cursed incoherently at staff. The anonymous staff said Resident #1 wanders around the facility all the time, and even when he was on one-on-one supervision in the past, he would fight his sitter. He screams at other residents every other day. The anonymous staff said they do not believe the facility can do enough to make sure other residents are safe, since he was not on one-on-one supervision and he was allowed to roam the facility. The anonymous staff said that nursing staff have to use a medication cart to obstruct one of the entrances to the nursing station so that Resident #1 does not attack them from the back. The staff said Resident #1 had not hit them because they did not give him the opportunity. In an interview at 09/13/21 at 10:35 AM the DON said, Resident #1 was previously on one-on-one supervision in August (07/27/21 to 08/03/21), but it had been discontinued. The DON said there were not clear changes in his aggression that led to ending his one-on-one supervision, but he does not have aggressive behaviors on a daily basis. The DON said nursing staff know to monitor the resident, know what he was doing, anticipate his needs and take care of his triggers. She said recently the only incident the resident was involved in was with Resident #5 and it was reported to the state. The DON said that Resident #1 was not on one-on-one supervision because an interdisciplinary team decided that he was not a danger. She said the resident walks around the facility with a final destination in mind, but he does so unattended. The DON said, she does not feel Resident #1 was appropriate for the facility and in her professional opinion she is uncertain if they can keep staff and residents safe from him because he is unpredictable. In an observation and interview on 09/13/21 at 10:53 AM the surveyor said hello to the Resident #1 while standing in his doorway with nursing staff in an attempt to assess his reactions. Resident #1 cursed at staff and surveyor, he said, he said yal ain't nobody, f**k that and other incoherent expletives. In an observation on 09/13/21 at 10:55 AM, Resident #1 came out of his room yelling at staff. He slid behind the nursing cart blocking the back of the nursing station and continued to talk incoherently at the nursing staff, asking for shoes and clothes he was already wearing and called staff crazy crazy. After about 5 minutes, the nursing staff was able to redirect Resident #1 and he returned to his room. An observation and Interview on 09/13/21 at 12:06 revealed: Resident #1 was no longer in room, CMA A said that the resident left his room unattended and most likely went to the dining room. The surveyor went to locate the resident in the dining room, the resident was observed to be sitting alone in the dining room unattended. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An anonymous staff interview conducted on 09/17/21 at 01:30 PM revealed: Resident #1's behavior had worsened since 09/13/21 and the day before the resident ran down the hall after another resident that passed his room. They said Resident #1 ran down the hall and grabbed the resident saying mine, mine, staff chased him down the hall and got between the residents as Resident #1 grabbed at the other resident. The staff said after the investigation, Resident #1 had chased down the resident due to the fact that she was wearing his jacket. An observation and Interview on 09/17/21 at 01:58 PM revealed: Resident #1 attempting to exit his room with a sitter at his door . The sitter redirected the resident and he returned to his room. Record review of Resident #1's Physician's Orders dated 09/17/21 revealed: resident was on one-on-one observation at this time related to exhibiting signs and symptoms of verbal aggression effective at 01:30 PM. Resident #2 Record review of Resident #2's face sheet, printed on 07/29/2021 revealed a [AGE] year-old female admitted to the facility on [DATE] and initially admitted on [DATE]. Her diagnoses included soft tissue disorder, orthopedic aftercare, fracture of left femur, headache syndrome, muscle weakness, diabetes, major depressive disorder, hypertension, and Parkinson's disease . Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating she was cognitively intact. She required supervision only for walking in the corridor and supervision with set up only when resident moved to and returned from off-unit locations. She was steady at all times during transitions and walking. She had impairments to lower extremities. She used both a walker and a wheelchair. In an interview on 07/29/2021 at 10:25 AM, Resident#2 said she did not feel safe at the facility. She said Resident #1 was dangerous. Resident #2 said I don't think he should be here, it's not right. The first time(07/08/21) was at the coffee cart which was outside my room, he grabbed my arm, it hurt, and I got a bruise. Resident #2 said on the next day the coffee cart was again in the hallway just outside her room. He pushed her and pushed the cart at her; she fell hit her head there was a lot of blood. Resident #2 said she went to the ER and they had to glue her scalp and after second incident she said she pressed charges. She said she told her therapist about her concerns and has not told anyone else in the facility about how she feels. She said they told her the facility will take care of it, but It took 3 days after the incident before he left the facility. Resident # 2 said a few days ago she saw him at bingo, he never comes to bingo, she said she was afraid he might hurt her again. Record review of the Provider Investigation Report revealed Resident #4 was a witness to 07/08/2021 incident between Resident #1 and Resident #2. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 07/29/2021 at 3:10 PM, Resident #4 said I don't know his name, but he lives in room [ROOM NUMBER]. Resident #4 said he saw Resident #1 hit Resident #2 with his fist the first time and said she got bruised up. He said the second time Resident #1 hit Resident #2 there were two constables and he thought they would take him away, but they didn't. He said today he saw Resident #1 walking around the halls and told Resident #2 to be careful as he's out again. He said Resident #1 does not like anyone, he does not like white people and the nurses don't mess with him either. Resident #4 said he tried to hit me about a month ago, but I told him if he does, I'll hit him with my cane. Resident #4 said he felt safe when Resident #1 was not in the building and he likes to go all over the building, and someone showed him how to get to the dining room a different way, so he did not go by Resident #1's room anymore. Resident #4 said something needs to be done about Resident #1, he's going to hurt these ladies one day. Resident #4 said he has seen that when Resident #1 enters the dining room the other residents will move away from him. Record review of Resident #2's facility progress notes dated 07/09/2021 at 6:45 AM, written by LVN A read in part . Per 2nd nurse observation she witnessed Resident #1 and Resident #2 playing tug of war with the coffee cart, Resident #1 then said bitch let me have it, let it go, then agitated Resident #1 pushed the cart so hard in Resident #2's direction, she lost balance off of both feet landed on the floor on her back, hit her head, sustained head injury, impact injury to bilateral hands, this writer observed as I arrived to the incident Resident #2 laying on the floor, 2nd nurse was trying to get agitated Resident #1 away from the area and calmed down, Resident #2's head was facing the back hallway and feet facing the nursing station, Resident #2 had on slippers and appropriately attired, Resident #2 walker noted in hallway, eyewear noted, 3rd nurse got on floor with Resident #2 to calm her down, and this writer called for emergency 911 transport for fall with head injury, vitals immediately started, Resident #2 was not moved due to head injury and bleeding noted, compression started, Resident #2 complained of her head hurting/pounding, and her hands hurting and her bilateral heels hurting. Resident #2 assisted per 911 EMS to stretcher and transported to nearest hospital . In an interview on 08/02/2021 at 1:50 PM, LVN A said she was the nurse assigned to Resident #1 on 07/09/2021. She said Resident #1 had a routine in the mornings: sweeping floor, then getting coffee. She said prior to the incident Resident #1 would go to end of hall where dietary would leave the coffee cart and he would roll the coffee cart to the nurse station. Another resident was at the coffee cart before he got there. She said during the incident, Resident #2 was knocked off balance by Resident #1 and she helped Resident #2. LVN A stated, It was a territorial thing. She said she did see him walk from his room and on way to cart. LVN A continued by stating she was unaware of the altercation between Resident #1 and Resident #2 the day before (7/08/2021). She said It was not mentioned in morning report. It was not mentioned in nurse to nurse report. It should have been communicated between the nurses (nurse leaving and nurse just coming on shift). If I knew about the altercation, I wouldn't have allowed Resident #2 to go down to that area where the coffee cart was. I only heard about the altercation , like it was a rumor. I float and I depend on my reports. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #2's facility progress notes dated 07/09/2021 at 7:14 AM, written by LVN D read in part . Resident #2 standing in room [ROOM NUMBER] doorway, dietary placed coffee cart near Resident #2's door. Resident #2 was standing in front of cart attempting to fix her a cup of coffee when Resident #1 walked down the hall to coffee cart and try to pull coffee cart away. Resident #2 then grab the cart both began to pull cart and began to yell when this nurse heard yelling from Resident #1 and Resident #2, went to see what was going on .Resident #1 took his hands off the cart and yelled BITCH LET IT GO, then Resident #1 pushed with both hands with force . Resident #2 fell straight backwards, this nurse removed Resident #1 while other nurses attended to Resident #2. 911 called and abuse coordinator called this nurse stayed with Resident #1 . In a telephone interview on 07/30/2021 at 8:55 AM, LVN D said the incident with Resident #1 and Resident #2 occurred in the morning of 7/9/2021. LVN D said Resident #1 was down the hall at the coffee cart outside Resident #2's room and both had their hands on the coffee cart. After the incident LVN D said she took Resident #1 back to his room. She said LVN A was Resident #2's assigned nurse and LVN A went to Resident #2 to administer first aid. LVN D said before the incident Resident #1 was just walking, and she did not notice any unusual behavior. Record review of Resident #2's hospital records dated 07/09/2021 revealed a CT (computer tomography) scan of the head and spine was performed for a fall with bleeding to the head area. X-ray of both hands was also performed. The findings were: Resident #1 had a moderate soft tissue bruise to back of her head and a small bruise to the left front of her scalp. The scalp was closed. Interview on 07/29/2021 at 11:50 AM, the Administrator said the facility incident report from 7/8/2021 incident between Resident #1 and Resident #2, was a professional review and was unsubstantiated. In an interview on 07/30/2021 at 4:15 PM, the Administrator said actions were taken to protect Resident #1 from further abuse while an investigation was in process. She said the first time on 7/8/2021, we did observations on Resident #2, kept the residents apart and second time Resident #2 was sent to the hospital. In an interview on 09/13/21 at 11:03 AM, the Administrator said after the first incident on 07/08/21 the staff interviewed the residents involved and referred Resident #1 to psych services ; she said Resident #1 was monitored for 6 hours by keeping him at the nursing station and one on one supervision was ended because the resident was not considered a threat to other residents. The Administrator said she did not believe that Resident #1 intentionally hurt Resident #2 and the interdisciplinary team decided that he no longer needed to be supervised one on one. She said there were no notes for the IDT meeting that decided to end one-on-one supervision of Resident #1. The Administrator said there was no policy on dealing with residents with combative behaviors or one-on-one supervision. She said decisions are made based on each individual situation, but residents who are known to be aggressive should be placed on one-on-one supervision. The administrator said prior to the incident on 07/08/21 Resident #1 was not known to have aggressive behaviors. The Administrator said in retrospect he should have remained on one-on-one supervision. In an interview on 09/13/21 at 11:30 AM, the Regional Nurse said looking back Resident #1 should have remained on one-on-one supervision after the incident with Resident #2 on 07/08/21 to protect Resident #2 and other residents but at that time he was not considered a risk to resident safety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #5 Record review of Resident #5's face sheet dated 09/19/21 revealed: resident admitted to the facility on [DATE] with diagnoses which included: dementia, type 2 diabetes, difficulty swallowing, unsteadiness on feet, major depressive disorder, anxiety disorder, muscle weakness, hypertension, skin cancer and brief psychotic disorder. Record review of Resident #5's quarterly MDS dated [DATE] revealed: resident admitted from a hospital, usually makes himself understood, usually understands, wore corrective lenses, had moderately impaired cognition as indicated by a BIMS score of 11 out of 15 and had no potential indicators of psychosis, no hallucinations or delusions. The resident needed supervision with most ADLs, used a wheelchair/walker and was frequently incontinent of bladder and bowel. Record review of Resident #5's Care Plan revised 09/19/21 revealed: focus- risk for communication problem related to impaired cognition, goal- resident will be able to make basic needs known on a daily basis, interventions- discuss with resident/family concerns or feelings regarding communication difficulty, encourage resident to continue stating thoughts even if resident is having difficulty. Focus- uses anti-anxiety medications related to anxiety disorder, goal- resident will be free from discomfort or adverse reactions related to anti-anxiety therapy, interventions- administer anti-anxiety medications as ordered by physician, monitor for side effects and effectiveness every shift. Focus- risk for mood problems related to diagnoses of dementia, goal- resident will have improved sleep pattern by reporting adequate rest or fewer episodes of insomnia, interventions- administer medications as order. Monitor/document for side effects and effectiveness. Record review of facility accident/incident report dated 08/28/21 at 04:13 PM completed by the DON revealed: Incident Description Resident (Resident #5) was by the nursing station and decided to go to his room. While wheeling his wheelchair to go to him room another patient (Resident #1) started screaming at him and calling him names using B and F words. This patient is also screaming at him and they were about to fight when 2 nurses intervene to redirect them to their room Record review of facility accident/incident report dated 08/28/21 at 04:13 PM completed by LVN B revealed: Resident #1 was cursing and using B and F words at another patient and even trying to fight the patient because the other patient (Resident #5) was passing his room. The patient did not go to his room, he was just passing, and this resident get mad and want to fight. Nurse and other staff were able to intervene and avoid the incident. In an interview on 09/13/21 at 10:25 AM, when Resident #5 was asked if he had any problems with anyone on his hallway he said, the guy next door is crazy he said Resident #1 walked around the facility by himself and had cursed him out before. Resident #5 said Resident #1 comes to his door regularly and tries to come into his room, but he won't let him in. He said that he does not feel safe because he (Resident #1) is crazy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455725	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakmont Healthcare and Rehabilitation Center of Hu	8450 Will Clayton Pkwy Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 09/17/21 at 01:35 PM, when Resident #5 was asked about the incident on 08/28/21 he said he tries to stay away from Resident #1. Resident #5 said I have the right to defend myself, he (Resident #1) can say whatever he wants in the hallway because I can close my door but don't want him coming to my room and messing with me. He said he finds Resident #1 scary and doesn't want to get in trouble with him, so he avoids going to places he is, leaves when he sees him and hopes Resident #1 is moved from the building. Resident #5 said someone has to do something about him he comes into his room every week. He said Resident #1 was came to his doorway earlier and cursed at him. In an interview on 09/13/21 at 11:03 AM, the Administrator said that on 08/28/21 Resident #1 and Resident #5 had an incident. She said that staff reported that Resident #1 cursed and yelled at Resident #5 as he walked past his room. The administrator said the incident was reported on 08/28/21. Record review of facility accident/incident report dated 08/28/21 at 04:13 PM completed by the DON revealed: Incident Description Resident(Resident #5) was by the nursing station and decided to go to his room. While wheeling his wheelchair to go to him room another patient (Resident #1) started screaming at him and calling him names using B and F words. This patient is also screaming at him and they were about to fight when 2 nurses intervene to redirect them to their room Record review of facility accident/incident report dated 08/28/21 at 04:13 PM completed by LVN B revealed: Resident #1 was cursing and using B and F words at another patient and even trying to fight the patient because the other patient was passing his room. The patient did not go to his room, he was just passing, and this resident get mad and want to fight. Nurse and other staff were able to intervene and avoid the incident. In an interview on 09/17/21 at 01:35 PM, when Resident #5 was asked about the incident on 08/28/21 he said he tries to stay away from Resident #1. Resident #5 said I have the right to defend myself, he (Resident #1) can say whatever he wants in the hallway because I can close my door but don't want him coming to my room and messing with me. He said he finds Resident #1 scary and doesn't want to get in trouble with him, so he avoids going to places he is, leaves when he sees him and hopes Resident #1 is moved from the building. Resident #5 said someone has to do something about him he comes into his room every week. He said Resident #1 was came to his doorway earlier and cursed at him. In an interview on 07/29/2021 at 11:05 AM, Resident #3 took a long pause when asked if he felt safe in the facility. He shook his head, looked down and turned his head away. He