STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676307	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Village Healthcare	204 Oak Drive South Lake Jackson, TX 77566

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867 Based on observation, interview and record review, the facility failed to complete a comprehensive, accurate, standardized reproducible assessment for 2 (Resident #26 and #35) of 15 residents reviewed for comprehensive assessments. This failure could place the residents at risk of not having all medical needs assessed and met. Findings included: Resident #26 Review of Resident #26's electronic face sheet undated Admission Record revealed an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Essential hypertension (high blood pressure), hypothyroidism (a condition where the thyroid gland does not produce enough thyroid hormone.) , vitamin B12 deficiency anemia, diverticulosis of large intestine (An inflammation or infection of the pouches formed in the colon), Renal failure, diabetes mellitus, muscle weakness (generalized), difficulty in walking, major depressive disorder, dementia, and anxiety, and cognitive communication deficit. Review of Resident #26's Significant change MDS assessment dated [DATE] revealed a BIMS score of 5, indicating her cognition was severely impaired. Her Functional Status indicated she required extensive assistance with her ADLs. Record review of section L of the MDS reflected she was checked none of above indicating no problem on an all section of oral dental health. Record review of Resident #26's care plan dated 02/13/20 revealed Resident #26 had oral/dental health problems r/t Poor oral hygiene. Date Initiated: 02/13/2020. No revision date. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 02/20/2020. Coordinate arrangements for dental care, transportation as needed/as ordered. Date Initiated: 02/20/2020. Monitor/document/report to MD PRN s/sx of oral/dental problems needing attention: Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded, decayed, Tongue (black, coated, inflamed, white, smooth), Ulcers in mouth, Lesions. Date Initiated: 02/20/2020. Provide mouth care as per ADL personal hygiene. Date Initiated: 02/20/2020. (continued on next page)

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the social worker's notes dated 12/15/23 at 10:46 AM read in part family requested dental services for resident. Contracted local dental services. Resident is a private pay; information provided and will follow up. Observation and attempted interview on 03/05/23 at 12:40 PM, revealed Resident #26 was sitting on her wheelchair in her room. An attempt was made to have an interview with her but failed as she could only answer yes and no questions. Observation revealed she had two teeth on each side of her lower oral cavity. Observation revealed she ate 30% of served meal (puree regular diet) During an interview with facility's social worker on 03/05/24 at 4:00PM revealed Resident #26's family had requested for dental service in the past because Resident #26 had lost her dentures. She said she provided the information to the responsible party since Resident #26 was a private pay resident and the responsible party declined services at that time. The Social Worker said the resident's responsible party requested again and she would include resident on the next visit. Resident #35 Record review of Resident #35's electronic face sheet revealed an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included displaced intertrochanteric fracture of right femur, dementia, mood disturbance, anxiety, muscle wasting and atrophy, malnutrition, anemia and muscle weakness, age-related osteoporosis, lack of coordination, cognitive communication deficit (lack of communication). Record review of Review of Resident #35 's admission MDS dated [DATE] revealed a BIMS score of 9, indicated she was moderately impaired on cognition. Her Functional Status indicated she required extensive assistance with her ADLs. Record review of section L of the MDS revealed section A-G were left blank. Section Z was checked none of the above indicated no concerns on all section of oral dental health. Observation and interview on 03/04/24 at 10:00AM revealed she was in bed. Her responsible party was with her. During an interview, resident responded that she was doing fine with her hand over her mouth. Resident #35 looked at her responsible party and did not speak. Her responsible party said he came in to assist Resident #35 with her meals sometimes. He said Resident #35 have hard time eating sometimes depending on what was served . He said Resident #35 lost her dentures at the hospital and the retainers that she had does not fits very well. He brought out the retainer from Resident's nightstand and gave them to her. He said he had not been asked about dentures or natural teeth. During an interview with the facility social worker on 03/05/23 at 4:00pm, she said Resident #35 was a new resident and she was not aware that she needs dental services. During an interview with the MDS Coordinator on 03/06/24 at 2:45 PM, she said she thought Resident #35 had her natural teeth and did not assess her for dental. She said acknowledged that Resident #26's had lost her dentures prior to being admitted to the facility and family had requested for oral denture services. She said she would follow up and update the MDS to reflect her oral denture status. Facility's policy on accuracy of MDS assessment on 03/06/24 at 4:00PM the facility's Administrator and the MDS Coordinator said the facility followed the RAI manual and no policy .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867 Based on observation, interview, and record review, the facility failed assure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment for one (Resident #14) of 15 residents reviewed accuracy of assessment in that: The facility failed to accurately assess Resident #14 her fall and for use of catheter on her significant change MDS assessment dated [DATE]. This failure could place residents at risk of unnecessary medical expenses due to inaccurate records, and not receiving needed services to improve their health and psychosocial wellbeing. Findings included: Resident #14 Record review of Resident #14's electronic face sheet on 03/04/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]/24 her diagnoses included Essential (primary) hypertension (high blood pressure), hypothyroidism (decreased production of thyroid hormones), dementia, repeated falls, back pain, bipolar disorder, psychotic disorder with delusions and hallucinations, and generalized anxiety disorder. Record review of Resident #14's significant change MDS dated [DATE] revealed her BIMS score was 3 indicated her cognition was severely impaired. Section H - (100) bowel and bladder were coded as having an indwelling catheter. Section H-300 urinary continence was coded as always incontinence. Record review of physician orders dated 01/25/24-03/06/24 revealed no others for urinary catheter. Record review of Facility's accident and incident log indicated Resident #14 had a fall on 12/11/23. Record review of facility accident and incident log from 09/04/23 through 03/04/24 revealed Resident # 14 had an unwitnessed fall on 12/11/23. Record review of Resident #14's accident and incident's fall assessment dated [DATE] read in part Nurse called by another resident to station, Resident #14 was by nurses' station between wheelchair and sofa chair resident #14 on her buttocks legs in front No injuries noted . Observation on 03/04/24 at 9:15 am, revealed Resident #14 was in her room sitting on her bed. Observation revealed no catheter. She was alert and oriented. Attempt was made to have an interview but could only answer yes and no questions . was with her. During an interview on 03/05/23 at 9:00AM, LVN B said Resident #14 did not have a catheter and (he/she) had not seen her with one. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA E on 03/05/23 at 11:00AM, she said she had not seen Resident #14 with catheter. During an interview with MDS Coordinator on 03/ 5/24 at 2:00 PM, she said Resident #14 did not have catheter. She looked at the MDS and said nothing. She looked at section J and said the fall was an overlook. She said Resident #14 should have been assessed for her fall on the MDS. She said not assessing resident accurately may prevent residents from getting needed services. Record review of facility's provided policy on accuracy of resident assessment dated 2001 revised November 1019 Redid not address accuracy of resident assessment.