

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/15/2024
NAME OF PROVIDER OR SUPPLIER  Oasis at Galleria LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2808 Stoneybrook Drive Houston, TX 77063	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38644</p> <p>Based on observations, interviews, and record review, the facility failed to ensure the residents environment remained as free of accident hazards as was possible and ensure each resident received adequate supervision for two (Residents #4 and #10) of five residents reviewed for accidents and hazards.</p> <p>The facility failed to ensure Resident #4 had a fall mat in place at the bedside as indicated in her care plan.</p> <p>The facility failed to provide adequate supervision to Resident #10 when he fell from his wheelchair in his room.</p> <p>This failure could place residents at risk of falls with injury and hospitalization .</p> <p>The findings were:</p> <p>1.Record review of Resident #4's face sheet dated 9/15/24 revealed a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included, in part, dementia, pain, need for assistance with personal care, and chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs).</p> <p>Record review of Resident #4's quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15 which indicated severe cognitive impairment. She required assistance from staff with ADL care. She had 1 fall since admission or reentry or the prior assessment with no injury.</p> <p>Record review of Resident #4's care plan revised on 8/27/24 revealed she was at risk for falls and injuries as evidenced by an actual fall on 2/25/24 and 8/26/24. Interventions included to have a fall mat at the bedside (date initiated 2/26/24).</p> <p>In an observation on 9/15/24 at 1:24 p.m. revealed Resident #4 was asleep in bed on an air mattress. There were no fall mats on either side of the bed.</p> <p>In an observation on 9/15/24 at 4:46 p.m. of Resident #4 revealed she was in bed. There were no fall mats at the bedside.</p> <p>(continued on next page)</p>

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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 9/15/24 at 4:48 p.m. LVN S said Resident #4 fell around one month ago. She said the facility put the fall mat in place after she fell . She said she had a fall mat, but it was not there anymore. She said she would need to check the orders to verify but the fall mat should be in place, and she was unsure what happened. She said Resident #4 complained about the fall mat and did not want it there because the mat interfered with the tray. She said all staff should check if it was in place. She said she was unsure if there was a risk to the resident if the mat was not in place.</p> <p>In an interview on 9/15/24 at 4:53 p.m. CNA Y said Resident #4 did not need a fall mat because she did not move. She said no one told her she needed a fall mat.</p> <p>In an observation on 9/15/24 at 4:57 p.m. of Resident #4's room revealed there was a fall mat standing up against the other bed in the room.</p> <p>In an interview on 9/15/24 at 4:58 p.m. the DON said Resident #4 should have a fall mat to the right side of the bed and it was normally down. She said the facility put the fall mat in place because the resident had a fall and liked to lean to the side on her air mattress. She said the direction to put a fall mat down was located on the Kardex. She said she would start an in-service on reviewing the Kardex.</p> <p>In an observation on 9/15/24 at 5:02 p.m. the DON entered Resident #4's room and put her fall mat in place. The DON explained to the resident that the fall mat needed to be in place.</p> <p>In an interview on 9/15/24 at 5:05 p.m. the DON said the fall mat was an intervention. She said the mat would not prevent a fall but could prevent injury.</p> <p>2. Record review of Resident #10's face sheet dated 9/15/24 revealed a [AGE] year-old male who readmitted to the facility on [DATE]. His diagnoses included Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), epilepsy (seizures), blindness right eye category 5, blindness left eye category 5, chronic kidney disease, dementia, restlessness and agitation, weakness, and psychotic disorder with hallucinations.</p> <p>Record review of Resident #10's Fall Risk Evaluation dated 5/15/23 revealed he was alert or comatose, he had no falls in past 3 months of eval, he was chair bound, required restraints and assistance with elimination, his vision was poor, he had a balance problem while standing, decreased muscular coordination, and required use of assistive device. There was no noted drop in systolic blood pressure between lying and standing, no medication taken currently or within the last 7 days of assessment, no change in medication or dosage in past 5 days, and no predisposing disease. His fall risk was 7 out of 35.</p> <p>Record review of Resident #10's quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15 which indicated severe cognitive impairment. He required assistance from staff with ADL care. He had no falls since admission/entry or reentry or the prior assessment.</p> <p>Record review of Resident #10's Un-witnessed Fall incident report dated 9/7/24 at 3:28 p.m. written by LVN B read in part, .Nurse heard yelling coming from the hall went to make rounds and found patient on the floor he hit his head . Resident's vitals were taken, nurse cleaned his head with normal saline . Nurse was calling 911 because the resident hit his head .Injury: abrasion at top of scalp .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #10's care plan revised on 9/9/24 revealed he was at risk for falls and injuries as evidenced by blindness, unsteady gait, and decreased mobility. He had an actual fall on 9/7/24 (date initiated 6/10/23, revised on 9/9/24). Interventions were to anticipate needs - provide prompt assistance and assist resident in bed after being up (date initiated 6/10/23 and revised on 9/9/24). Ensure call light was in reach - answer promptly (date initiated 6/10/23). Resident #10 was at risk for injury from increased tremors, involuntary muscle movements, and decline in ADLs (initiated 3/22/24). Interventions were to observe for increased tremors, unsteady gait, etc. - report to the MD. (initiated 3/22/24).</p> <p>In an interview on 9/15/24 at 10:42 a.m. CNA D said if Resident #10 was in the wheelchair she had to watch him because he leaned and could slide. She said he did not get out of bed much, but his family member wanted him up for 30 minutes and then back to bed.</p> <p>In a telephone interview on 9/15/24 at 1:02 p.m. Resident #10's family member said on 9/7/24 she reviewed the camera located in the resident's room and saw the facility staff place the resident, who had advanced dementia, in his wheelchair at 12:15 p.m. She said no one checked on him afterward and he was left unattended until he fell (at 3:21 p.m. per the video footage).</p> <p>In an observation on 9/15/24 at 1:35 p.m. of video footage dated 9/7/24 at 3:21 p.m. revealed Resident #10 was in his room sitting in his wheelchair on top of a yellow pillow. He was leaning forward with his head down. He tapped his foot slightly on the floor and then immediately toppled forward on the floor headfirst. After falling to the floor, the wheelchair rolled backwards. No one else was observed in the room and a call light could not be seen in reach.</p> <p>In an attempted interview on 9/15/24 at 1:09 p.m. with CNA E who was assigned to Resident #10 on 9/7/24 on the 2 p.m. - 10 p.m. shift was unsuccessful.</p> <p>In an interview on 9/15/24 at 2:32 p.m. CNA Y said she was new to the facility and worked as needed. She said she worked 6 a.m. - 2 p.m. on 6/7/24, the day of the incident. She said the Medication Aide (name unknown) told her to get Resident #10 up in the wheelchair per family request. She said she got him up after lunch, around 1:00 p.m., cleaned him up, and sat him directly in front of the camera. She said that was her first time working with him by herself and never saw him in a wheelchair before. She said she understood residents could sit in the wheelchair for a maximum of 2 hours. She said there were no signs in the room that indicated he was a fall risk, and he did not have a fall risk band on his arm. She said she walked up and down the hall and conducted rounds approximately every 30 minutes and saw him before the end of her shift at 2:00 p.m. She said he was still sitting comfortably in the chair. She said things can happen after a round and did not know about the fall until later.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a telephone interview on 9/15/24 at 2:50 p.m. LVN B said she and CNA Y sat Resident #10 up in a wheelchair right after lunch around 12:00 p.m. She said he could normally sit up for an hour or two, but she told CNA Y to only keep the resident up for 30 minutes and put him back to bed per family request. She said around 2:15 p.m. to 2:30 p.m. she was sitting at the nursing station and heard screaming. She said she made a round and found the resident on the floor. She said Resident #10 should be a fall risk while sitting in the wheelchair because an aide told her days after the incident that he could tilt over and fall. She said that was the first time she saw the resident in the chair and never saw him tilt previously. She said she called 911 because he was bleeding from the forehead but there were no negative findings from the hospital tests. She said if the resident was in the wheelchair, it should be locked at all times to keep him safe and secure. She said he was unable to self-propel. She said nursing staff round every 2 hours.</p> <p>In an interview on 9/15/24 at 3:26 pm CNA Y said she did not hear the staff say to put Resident #10 back to bed after 30 minutes.</p> <p>In an interview on 9/15/24 at 3:38 p.m. the DON said Resident #10 was sent to the hospital after the fall but returned that night and was fine. She said his family member called the facility a few days later and was upset because the resident was up in the wheelchair for 3 hours, which the DON said was not an unreasonable amount of time. She said the resident was previously not known to fall and was at moderate risk of falls. She said she did question why he was left in the room. She said it was best practice to lock the wheelchair while he was in it for safety reasons because it could move. She said he was unable to move the wheelchair on his own. She said she did not think it would have made a difference, regarding his fall, if the wheelchair was locked or unlocked.</p> <p>In an interview on 9/15/24 at 3:57 p.m. the Administrator said she was notified of Resident #10's fall. She said when residents were up, they have a right to fall, and could not be restrained or tied to a chair. She said residents could fall even if they sat in front of the nursing station. She said the facility could not sit with Resident #10 for 24 hours and said 2-3 hours was not an unreasonable time to be in a chair. She said family requests could be honored but it would need to be care planned. She said the family member's request of the resident being up for 30 minutes was not care planned and was unreasonable for the facility. She said the resident's family member changed her mind weekly on the resident being up. She said wheelchairs should not be locked because it could be considered a restraint and safety risk. She said he was a fall risk because he was blind and that was the only fall he had.</p> <p>In a telephone interview on 9/15/24 at 4:21 p.m. CNA D said around 2 weeks ago Resident #10's family member requested that the resident start to get up in the wheelchair for lunch. She said while the resident was in the chair, she saw him lean to the side. She said the resident was contracted and he would lean over easily. She said she would tell him to sit back up and he sat back up. She said she would stay by him, not leave his side, and push the wheelchair all the way to the table so he would not tip over. She said someone would need to watch him if he was up in the wheelchair. She said she did not tell anyone because he was not tipping over and it was not bad, just a little slouch. She said she would report it if he was falling over in his chair. She said during her shift, nursing staff never left him in the wheelchair by himself. She said if the resident was left alone in the wheelchair, she could redirect him to sit back up during rounds. She said she would lock the wheelchair if he was sitting in it and pull him all the way up to the table so he would not fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 9/15/24 at 4:34 p.m. Administrator said no one told her Resident #10 was leaning in his wheelchair.</p> <p>In an interview on 9/15/24 at 5:07 p.m. the DON said she never saw Resident #10 up in the wheelchair. She said he may not be ready to be in the room but maybe at the nursing station or in activities. She said when he was up in the chair staff should anticipate his needs. She said she would want staff to report any leaning in the wheelchair to better anticipate his needs, update the care plan and Kardex, and individualize his care.</p> <p>Record review of the facility's Falls and Fall Risk, Managing policy dated 2018 read in part, .Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . 2. Resident conditions that may contribute to the risk of falls include . c. delirium and other cognitive impairment, i. functional impairments; j. visual deficits . Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.</p> <p>Record review of the facility's Care Plan, Comprehensive Person-Centered policy dated 2018 read in part, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident</p> <p>Record review of the facility's Wheelchair policy dated 3/4/2020 read in part, .it is the policy of this center to utilize wheelchairs for residents and to promote safety. Procedure . 1. Apply brakes to lock wheels of wheelchair for transfer; for resident with ability to propel wheelchair but lack intact cognition to unlock do not lock wheels to avoid restraining mobility .10. Permit the resident to remain in the wheelchair according to the physician's order or as tolerated .14. Leave resident in comfortable position with call light within reach .</p>		