STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675078	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oasis at Galleria LLC	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)
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** 41469 Based on observation, interview, and record review, the facility failed to ensure one of three residents (Resident #1) received adequate supervision and that the resident environment remained as free of accident hazards as is possible, in that: The facility failed to ensure Resident #1 was served coffee at a safe temperature which resulted in a burn to her left hand. The facility failed to ensure a temperature log was kept to document temperatures of coffee prior to distribution and service to residents. An immediate jeopardy of past non-compliance was identified on 11/13/2024 at 1:30PM. The IJ template was provided to the facility Administrator on 11/13/2024 at 2:50PM. The Immediate Jeopardy was determined to have existed from 10/20/24 to 10/22/2024 due to the facility's implemented actions that corrected the non-compliance prior to survey entry. This failure injured Resident #1 and placed other resident at risk of injury, burns, pain, anxiety, and a decreased quality of life. Findings included: Record review of Resident #1's face sheet revealed a [AGE] year-old female who was admitted into the facility on [DATE] and was diagnosed with dementia (decline in mental ability), schizoaffective disorder (chronic mental illness involving delusions and hallucinations), muscle wasting atrophy (muscle mass decrease), and spastic hemiplegia (type of cerebral palsy causing muscle tightness and paralysis) affecting left dominant side. Record review of Resident #1's MDS assessment, dated 09/11/2024, reflected the resident had a BIMS score of 11 indicating moderate cognitive impairment. It also reflected the resident's ability to ambulate by manual wheelchair and her need for supervision or touching assistance for eating. Record review of Resident #1's care plan, dated 07/09/2022, revealed the resident had an ADL self-care performance deficit and needed set-up help and supervision while eating. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's nurses note, dated 10/20/2024, reflected, .Resident came to the nurses station complaining of a burn. She reported that she had went to the kitchen for coffee and received a hot cup with no lid. Nurse observed reddened skin on the Left hand and wrist. Tylenol was given along with an ice pack to the hand. Resident seemed a bit anxious after the incident. Vitals assessed and found to be WNL and are as follows: BP:130/69 HR: 76 . Record review of the facility's investigation report, form 3613A, dated 10/28/2024, reflected the perpetrator, [NAME] A, was alleged to have given Resident #1 a cup of coffee without a lid on it which resulted in Resident #1 spilling it on her left hand and causing redness. It also reflected in the investigation summary that the resident had a history of removing the lid from drinks and spilling it on herself. There was conflicting reports given by Resident #1 and [NAME] A as to whether there was a lid on the coffee or not prior to serving. Record review of Rresident #1's wound assessment, dated 10/25/2024, revealed Resident #1 acquired a burn wound of the left hand full thickness measured at 6 x 2 x 0.1 cm with open ulceration area of 8.2cm out of 12 cm total surface area, light serious exudate, 70 % granulation tissue and 30% intact normal colored skin. The Wound Physician noted there was, . no indication of pain associated with this condition . and the wound had . improved evidenced by decreased surface area . The treatment plan included silver sulfadiazine once daily for 27 days and gauze roll once daily for 30 days. Record review of Resident #1's care plan, dated 10/21/2024, reflected resident had burn to left hand from spilled hot coffee measuring 6 cm x 7.5 cm x 0.1 cm and the goal was to have resident's skin concern heal without complications over the next 90 days with interventions, including treatments, pain, medication, and monitoring for skin breakdown. Interview and observation of Resident #1, on 10/29/2024 at 3:25PM, revealed the resident was lying in bed with bandages wrapped around her left hand. The resident stated she had the bandages because she was burned by hot coffee, but was no longer in pain at that time. In a phone interview with [NAME] A on 10/30/2024 at 2:49 PM, he stated Resident #1 often came to the kitchen to request for coffee and he gave it to her every time she asked. He stated she was the only resident to do so. He stated he was taught to give coffee to residents with a lid on the coffee mug. He stated he never checked coffee temperatures prior to serving the coffee. He stated on 10/20/2024, Resident #1 requested for coffee beyond their breakfast time, so he made a fresh batch of coffee for her, poured in the cup and put a lid on it prior to handing it to her. He said at that moment, Resident #1 wanted to drink her coffee right then and there. He observed her remove the lid immediately, and a result, she spilled some of the coffee on herself. He stated he did not see the risk of serving her coffee then because the cup had a lid on it. He stated he did not know the resident burned herself until after he was told by the nurse shortly after the incident. [NAME] A stated the Dietary Manager did not train him on the specifics of temping and serving coffee until after the incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview with the Dietary Manger, on 10/30/2024 at 3:10 PM, he stated all of his staff, excluding [NAME] A who was recently hired back onto the team, were aware of Resident #1's behaviors of asking for coffee throughout the day, including beating on the kitchen door to request for coffee. He said, prior to [NAME] A being hired, he verbally trained his staff to not give her coffee unless a nurse was present with her at the time of the request due to how disruptive it was to their meal service process and because of Resident #1's habit of immediately pouring the coffee from the facility cup to her personal steel cup. He stated he never did an in-service related to temping coffee because they never had an incident before that would necessitate it. The Dietary Manager said he did not see a risk because they thought the way they were distributing coffee was okay. He also said that they had lids in inventory. He stated that temperatures come out of the brewer around 145 degrees and they distributed the coffee when temped around 130 degrees. In an interview with the Regional Nurse Consultant on 10/31/2024 at 1:00 PM, she stated the kitchen staff should have kept a log of the temperature of the coffee prior to serving it because after the incident, there was no way to verify just how hot that coffee was to have caused Resident #1 to burn herself with it. In an interview with the Administrator on 11/01/2024 at 11:07 AM, she stated after looking into the incident, she believed the kitchen staff skipped steps, such as temping or cooling off the coffee prior to serving. The mistake resulted in Resident #1 getting burned, She pulled all the information on the case, talked with the dietitian, and helped setup and an in-service for all the staff. Record review of the facility's policy on Safety of Hot Liquids, dated 2018, reflected, . 1. The potential for burns from hot liquids is considered an ongoing concern among residents with weakened motor skills, balance issues, impaired cognition, and nerve or musculoskeletal conditions. 2. Residents with these or other conditions may suffer from accidental burns and related complications stemming from thinner, more fragile skin that may burn quickly and severely and take longer to heal. 3. Residents who prefer hot beverages with meals (i.e., coffee, tea, soups, etc.) will not be restricted from these options. Instead, staff will conduct regular Hot Liquids Safety Evaluations and update plan of care as applicable. 4. Once risk factors for injury from hot liquids are identified, appropriate interventions will be implemented to minimize the risk from burns. Such interventions may include: 1. Maintaining a hot liquids serving temperature of not more than 140 degrees Fahrenheit; 2. Serving hot beverages in a cup with a lid; 3. Encouraging residents to sit at a table while drinking or eating hot liquids; 4. Providing protective lap covering or clothing to protect skin from accidental spills; and 5. Staff supervision or assistance with hot beverages . Corrective Actions: Record review of the facility's in-service, titled Serving Hot Liquids, dated 10/22/2024, reflected training to all dietary staff detailing hot liquids were to be served between 135 degrees and 140 degrees and were to be served to residents only by clinical staff and not directly from the kitchen. It also reflected, . If a resident comes to the kitchen asking for coffee, they need to be redirected back to the appropriate nursing station for assistance . Coffee will be randomly tested for temperature before being given to staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of coffee temperature log, date ranging from 10/21/2024 - 10/30/2024, revealed the coffee temperature was being recorded daily once brewed and at meal service time, the coffee temperature was documented at 140 degrees each day. In an interview with Dietary Aide A, Dietary Aide B, and [NAME] on 10/30/2024 at 9:22 AM, they all stated that they were trained on hot liquids safety and knew not to hand coffee directly to residents without a nurse present. They also unanimously stated they were to document the temperature of the coffee once brewed and hand over the coffee to nursing staff once cooled down to 140 degrees prior to serving. In a phone interview with [NAME] A, on 10/30/2024 at 2:49 PM, he stated he was trained to no longer give resident's coffee, and to make sure nursing staff was present to distribute coffee to residents. He also stated the coffee temperature needed to be cooled down to 140 degrees and documented on the log before sending it out for the residents. In a phone interview with the Dietary Manager, on 10/30/2024 at 3:05PM, he stated following Resident #1's incident, he trained kitchen staff to ensure the temperature of the coffee out of the urn and prior to service were being documented. He stated the coffee should be temped at 130-140 degrees prior to allowing nursing staff to serve to residents. Observation and interview with Dietary Aide C, on 10/31/2024 at 7:10 AM, revealed coffee was brewed and temped at 157 degrees. Dietary Aide C documented the temperatures on the log. She reported that she was trained on hot liquids safety and knew she had to wait until the coffee temperature reached 140 degrees prior to serving. Observation on 10/31/2024 at 8:00 AM revealed Dietary Aide C temped the coffee at 140 degrees and reported to the present nursing staff that coffee was ready to be served. In an interview with Dietary Aide D, on 11/13/2024 at 9:56 AM, she stated she typically brewed and temped the coffee at around 160-180 degrees, transferred the coffee to the urn and waited for temperature to cool down to 140 degrees before putting out for meal service. She stated, preceding distribution of coffee, she made sure to confirm the temperature of the coffee with a nurse as a witness. Interview with [NAME] C on 11/13/2024 at 10:00AM, he stated he was trained on managing hot liquids following Resident #1's incident. She stated coffee was brewed between 160-180? and had to be cooled down to 140 degrees prior to meal service by the nursing staff. Observations of the kitchen on 11/13/2024 at 10:04 AM, revealed an unidentified resident came to the entrance of the kitchen requesting coffee and [NAME] C turned her away stating that she had to bring a nurse with her in order to receive coffee. Record review of in- service, titled Hot Liquids Safety, dated 10/21/2024, reflected training was provided to all nurses and nurse aides pertaining to distribution of hot coffee. The training detailed that staff were no longer allowed to reheat coffee for residents upon request. In an interview with CNA A, on 10/31/2024 at 1:29 PM, she stated she was trained on safety precautions for serving hot liquids and knew to set the coffee on the table in her room rather than passing it directly into her hands to prevent any spills and burns. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview CNA B, on 10/31/2024 at 1:50 PM, he stated he was trained on serving coffee and knew to make sure coffee was cool enough for residents to drink. He stated all residents were to be handed their coffee by nursing staff and they were not allowed to get coffee by themselves or from dietary staff. In a phone interview with the DON on 11/01/2024 at 11:54 AM, she stated she could confirm if there were rules in place for nursing staff to serve coffee but the distribution of coffee from the urns to the residents were typically always done by nursing staff . She stated staff have since been trained to ensure burn incidents did not happen again. In an interview with LVN A, on 11/13/24 at 2:05 PM, she stated she typically observed all mealtimes on her shift, and she had been trained to ensure that all residents were served by nursing staff only and the coffee was not too hot to them. In an interview with CNA C on 11/13/24 at 2:15 PM she stated she typically served residents coffee on the halls and was trained on hot liquid safety. She stated she ensured residents were served coffee from the urn using a cup with a lid. An immediate jeopardy of past non-compliance was identified on 11/13/2024 at 1:30PM. The IJ template was provided to the facility Administrator on 11/13/2024 at 2:50PM. The Immediate Jeopardy was determined to have existed from 10/20/24 to 10/22/2024 due to the facility's implemented actions that corrected the non-compliance prior to survey entry.