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	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oasis at Galleria	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 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents had a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely for 18 of 18 residents reviewed (CR #1, Resident #2, #3, #4, #5, #6, #7, #10, #21, #22, #23, #24, #25, #26, #27, #28, #29 and #30) and 4 of 4 Halls (A, B, C & D Halls) reviewed for clean, comfortable, homelike environment, and clean bed and bath linens. - The facility failed to maintain a clean and homelike environment for all residents across the facility. - The facility failed to provide adequate clean linens (towels & Sheets) to meet the needs of all residents across all units which resulted in residents (CR#1, Resident #2, #7, #5, #3) who reported they stuck to their mattress, felt cold, unclean, dirty, worthless, neglected, and left CR #1 in tears. - The facility failed to provide adequate clean linens as Residents #6, #10, #21, #22, #24, #25, #26, #27, #28, #29 & #30 were observed laying on bare mattresses. - The facility failed to ensure privacy curtains were in resident rooms (B-5, B-10, C-1, C-8, and D-11). - The facility failed to provide hot water which resulted in residents receiving cold showers or no showers at all. - The facility failed to provide hot water in resident rooms & showers (Rooms C6- C8, C-13, D-1, D-10, C Hall showers/sinks and D Hall Shower). An IJ that began on 02/11/25 was Identified on 03/07/2025. The template was provided to the facility on [DATE] at 04:08 PM. While the IJ was removed on 03/12/25 the facility remained out of compliance at a scope of widespread and a severity level of no actual harm that was not immediate due to the to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of decreased feelings of self-worth, emotional destress, mental anguish, decline in health and infections. Findings included: (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

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observations on 2/11/25 at 09:35 AM revealed, most residents in their rooms. Some residents were laying on bare mattresses due to the lack of linens in the facility. There was a total of six rooms observed. Observations on 2/11/25 at 11:28am revealed, the hallway and room closets at the end of A&B Hall and C&D Hall had no linen supplies. Water in the bathrooms were lukewarm; showers and sinks on C & D halls were lukewarm; sinks in the shower of the memory care unit had lukewarm water. Residents were laying on bare mattresses in rooms (B-4 & 5, B-12, C8, C6, D4). B-4, 5, & 10 had no privacy curtains. CR #1 Record review of CR #1's face sheet revealed CR #1 was initially admitted [DATE], readmitted [DATE], and discharged [DATE] with a diagnosis of anemia, coronary artery disease, congestive heart failure, hypertension, orthostatic, hypertension, renal failure, hepatitis, hyperlipidemia, COPD (lung disease), and respiratory failure. Resident was on dialysis. Record review of CR #1's MDS assessment revealed a BIMS Score of 13. CR #1 required supervision or touching assistance in the areas of eating and oral hygiene. CR #1 required partial, moderate assistance in toileting, and upper body dressing and personal hygiene. Record review of CR #1's Care Plan indicated the resident was at risk for skin break down. The goal was to remain clean, dry, intact without evidence of breakdown over the next 90 days. The target date was to 3/25. Interventions was to assess skin on a weekly basis and PRN (As needed) any breakdown, assist with repositioning as needed using padding between pressure areas. In an observation and interview on 02/12/25 at 08:30 AM, CR #1 was at a local hospital. He said while at the facility he was unable to take a bath every day because there was no hot water and no clean linens or towels. CR #1 stated that the facility washers were broken for the last two months and when his clothing went to the laundry, he could barely get all his items returned. CR #1 reported that he had an infection due to not having a shower and inadequate clean linens and not getting his IV bandage changed daily as ordered. CR#1 began to cry and said the situation in the facility was inhumane and it made him feel dirty and worthless. Resident #2 Record review of Resident #2's face sheet dated 02/12/25 revealed, a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included stroke, paraplegia (type of paralysis that affects the lower half of the body), depression, cognitive communication deficit and non-pressure chronic ulcer of the buttocks. Record review of Resident #2's annual MDS dated [DATE] revealed, a BIMS score of 9 indicating he had moderate cognitive impairment. He required moderate assistance from staff with shower/baths and footwear. Record review of Resident #2's care plan printed 02/12/25 revealed, focus- incontinent(bladder/bowel) and at risk for skin breakdown and pressure wound formation ; goal: clean, dry, odor free and dignity will be remained; intervention: check for incontinent episode during rounds, change promptly and apply protective skin barrier, observe for skin breakdown. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on 2/11/25 at 10:00 AM, Resident #2 stated the facility's washing machines were not working and have not been working for over 2 weeks. Resident #2 stated his own clothes have been lost. Resident #2 also stated the hot water has been out since 1/25/25 and just started working yesterday, 2/10/25, but the heat or air condition still does not work. Resident #2 stated he feels helpless and neglected at times because this should not be happening. He stated he could not take a shower because the water was cold. He stated same with wash ups in the sink. Resident #2 said he was a human being and felt he should be treated with more respect. Resident #7 Record review of Resident #7's face sheet dated 03/12/2025 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included diabetes, stroke, dementia, mild protein malnutrition, schizophrenia, bipolar disorder, anxiety, elevated blood pressure and non-pressure chronic ulcer of foot. Record review of Resident #7's quarterly MDS dated [DATE] revealed a BIMS score of 8 indicating she had moderate cognitive impairment. She required substantial assistance from staff for toileting, shower/baths, and lower body dressing. She required partial assistance with upper body dressing and personal hygiene. She was always incontinent of bowel and bladder. Record review of Resident #7's undated care plan revealed she was bedfast most/all the time and at risk for skin breakdown. Interventions included use position devices to prevent skin break down. An observation and interview on 03/06/25 at 11:30 AM revealed, Resident #7 in bed with no fitted sheet or flat sheet. There was a draw sheet beneath her and blankets on top of her. Resident #7 said the previous night nursing staff removed her fitted sheet because it was wet, and it was never replaced. She said she preferred to have a fitted sheet because without it her skin would stick to the plastic mattress, and she did not like it. Resident #7 and she preferred to have a top sheet and that there was always a problem with linen supplies. She said the facility did not have enough towels, diaper s or wipes and she did not understand why the facility was always out of the supplies that were needed. Resident #5 Record review of Resident #5's face sheet dated 03/11/2025 revealed, a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Hemiplegia (one sided paralysis), Hemiparesis (paralysis to one side of body) d/t stroke, presence of prosthetic heart valve, depression, anxiety, diabetes, muscle weakness, dementia, high blood pressure and contractures of the left upper arm. An observation on 02/11/25 at 11:28 AM revealed, Resident #5 laying on a bare mattress in his room. In an observation and interview on 02/11/25 at 12:06 PM, Resident #5 stated there has not been warm or hot water in the facility for at least two weeks. Resident #5 stated he last showered on Sunday (2/9/25). Resident #5 stated the shower was still too cold. Resident #5 said most of the time he was unable to take a shower because there were no clean linens and the staff told him the linens were being washed at a local washeteria. He said the facility was supposed to be like home and the treatment he got did not make him feel good. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An observation on 02/11/25 at 12:10 PM revealed, the water in Resident #5's bathroom was lukewarm. In an observation and interview on 03/07/25 between 9:55 AM and 10:25 AM, Resident #5 was observed in bed. He reported that his bed sheets had not been changed for a few days and prior to that he did not have sheets on his bed. Resident #5 said not having sheets was uncomfortable because his skin would stick to the mattress and on cold days the mattress made him cold. Resident #3 Record review of Resident #3's face sheet dated 03/11/2025 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included diabetes, cirrhosis of the liver (abnormal liver function), low blood pressures, muscle wasting and pain. Record review of Resident #3's annual MDS dated [DATE] revealed a BIMS Score of 12 indicating moderate cognitive impairment. An observation on 02/11/25 at 11:28 AM revealed, Resident #3 laying on a bare mattress in his room. In an observation and interview on 02/11/25 at 12:06 PM, Resident #3 said the facility's washing machine and dryer were not working so his family had to wash his clothing since the facility could not keep up with his clothes. He said the laundry room has lost his clothing items which was another reason his family washed his clothes. Resident #3 stated the last time he took a shower was last Sunday and it was cold. He stated he just couldn't wait any longer and had to bear with the uncomfortable shower to get clean. He stated the water was only lukewarm today, but for the last two weeks there has only been cold water. An observation on 02/11/25 at 12:10 PM revealed, the water in Resident #3's bathroom was lukewarm. In an observation and interview on 03/07/25 between 09:55 AM and 10:25 AM, Resident #3 was observed in bed. He reported that his sheets had not been changed for several days and prior to that he had no sheets. Resident # 3 said he felt unclean because he did not have clean sheets on his bed. Resident #6 Record review of Resident #6's face sheet dated 03/10/2025 revealed, a [AGE] year-old male admitted to the facility on [DATE] His initial admission was 11/21/2022 and his original admission was 02/26/2018. His diagnoses included acute respiratory failure with hypoxia (inadequate gas exchange by the respiratory system), dependence on supplemental oxygen, Hemiplegia (one sided paralysis), Hemiparesis (paralysis to one side of body), stroke, chronic obstructive pulmonary disease (a lung condition caused by damage to the airway), anemia (reduced number of red blood cells), depression, functional quadriplegia (inability to completely move), congestive heart failure (is a condition where the heart is unable to pump enough blood to meet the body's needs), hypertension (elevated blood pressure) and anxiety. Resident #6 was his own RP. Record review of Resident # 6's Quarterly MDS (minimum data set, resident assessment, and care screening) dated 02/11/2025 revealed, intact cognition as indicated by a BIMS score of 14 out of 15. He required total dependence on staff for lower body dressing and substantial maximum assist for upper body dressing and personal hygiene. He was always incontinent of urine and bowel. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of Resident #6's undated care plan revealed he was bedfast most/all the time and at risk for skin breakdown. Interventions included keep sheets clean and wrinkle free. An observation and interview on 3/6/2025 at 9:45 AM revealed, Resident #6 lying on an air mattress with a bath blanket and regular blanket. Resident #6 did not have a fitted sheet and his pillowcase was visibly dirty/soiled. He stated he did not have a fitted sheet because he was on an air mattress, so he was lying on a draw sheet. Resident #6 said he always had issues with clean linen. He stated there was never enough linen especially top sheets and the facility was always short on towels and blankets especially during a cold snap. Resident #4 Record review of Resident #4's face sheet revealed, a [AGE] year-old female admitted to the facility on [DATE] and initially admitted on [DATE]. Her diagnoses included Hemiplegia (one sided paralysis), Hemiparesis (paralysis to one side of body), stroke, end stage renal disease, dialysis dependent, diabetes, heart failure, anxiety, and depression. Record review of Resident #4's quarterly MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 13. She had impairment to one side of upper and lower body that interfered with daily functions. She required substantial assistance from staff for showers/baths, and partial assistance with dressing and personal hygiene. Record review of Resident #4's undated care plan revealed, focus: risk for skin breakdown and injury due to decreased mobility; goal: skin will remain clean/dry, intact without evidence of breakdown; intervention- provide pressure reducing and positioning devices on resident bed/wheelchair as indicated. In an interview on 2/11/ 25 at 6:30 PM, Resident #4 stated she has not had a hot shower in 2-3 weeks. Resident #4 stated the water was either cold, cool, or lukewarm. Resident #4 stated the washing machine has been out for at least 3 weeks and the staff take dirty clothes, linens, and towels to the local washeteria. Resident #4 stated she was afraid to send her personal items to the laundry because items were often missing or lost. Resident #10 Record review of Resident #10's faces sheet dated 03/11/25 revealed, a [AGE] year-old male whose initial admission date was 05/07/21 and re-admitted on [DATE]. The resident's diagnosis included: Down Syndrome, moderate intellectual disabilities, need for assistance with personal care, cognitive communication deficit and retention of urine. An observation on 02/11/25 at 11:28 AM revealed, Resident #10 laying on a bare mattress in his room. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An observation and interview on 3/7/2025 between 9:55 AM and 10 :25 AM in the secured unit revealed, Resident #10 was lying on the bare mattress. The resident was non-verbal and could not be interviewed so CNA G was asked why the resident's bed had no linens. CNA G said that the facility did not have enough clean linen on the unit. She said the laundry only had some sheets and bed pads, but it was not enough for every room. CNA G said it had been an ongoing issue and the facility did not have enough sheets and things for the residents. Residents #21-30 Observations on 02/11/25 at 11:28 AM revealed, the following additional residents not interviewed in their room laying on bare mattresses: 1. Resident #21 2. Resident #22 3. Resident #23 4. Resident #24 5. Resident #25 6. Resident #26 7. Resident #27 8. Resident #28 9. Resident #29 (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	10. Resident #30 An observation on 02/11/25 at 06:45 PM revealed, Resident #29's bed did not have a privacy curtain. Observations on 03/06/25 at 10: 25 AM revealed, the following residents did not have sheets on their beds. 1. Resident #26 2. Resident #10 3. Resident #28 In an observation and Interview on 2/11/25 at 4:37 PM, Maintenance stated he got a complaint about the water issue on January 30th, 2025, that there was water coming out of the ceiling; however, when he came to the facility there was hot water running out of the ceiling. Maintenance stated the circulation pump busted on Sunday. Maintenance stated on Monday morning he ordered the pump which arrived on the 3rd of February 2025. It was installed the same day. Maintenance stated the policy for temperatures were important for environmental issues for residents, them maintaining their hygiene, and because it's important for their health. Walk through Water Temperature Observation with Maintenance in the following areas: Room D-1 Sink - 81 degrees Room D-10 Sink - 100 degrees D Hall shower sink - 105 degrees D Hall Shower - 93 degrees Rooms C6-C-8 Sinks - 92.7 Degrees Room C-13 - 100 Degrees C-Hall Shower - 93 degrees C Hall Sink - 93.6 Degrees. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An observation on 02/12/25 at 7:05 PM revealed, enough linen for about 10 beds in the linen closet, dirty linen bags (waiting to be picked up and taken to the washeteria in the morning by laundry staff) at the end of each hall, and there were towels on staff carts in each hallway. An observation on 03/06/2025 at 9:00 AM revealed, there were no linens in linen closets in C Hall and D Hall. An observation on 03/06/25 at 10:38 AM revealed, there were no linens for beds on for Hall A. The linen closet was empty. An Observation on 03/06/25 at 11:00 AM revealed, the linen closet in C and D hall did not have linens. An observation and interview on 03/06/25 at 3:00 PM, 2 residential/standard size washing machines in use. An observation on 03/07/25 at 10:27 AM revealed, the linen closet on Hall A had no sheets, towels, or blankets. An observation on 03/07/25 at 11:02 AM revealed, the linen closet on Hall C had only 2 flat sheets on shelf. Observation on 3/6/25 at 10:38 AM of Hall A to check for linens on the bed. Rooms A6-8 did not have sheets on the bed. The linen closet for the hall was empty. In an interview on 2/11/25 at 10:15 AM, CW stated the residents were not being cared for. The CW stated residents were in soiled underwear or adult briefs a lot because the washing machines were broken and at certain times the staff were going to the washateria. The CW stated the trash outside of the facility hasn't been picked up in almost a month and it smelled and sometimes you could see rodents in the trash. The CW stated it was an eye sore for the neighborhood. In an Interview on 2/11/25 at 10:25 AM, LA stated his job was to do laundry. LA stated that the washing machines have been down since last Monday (2/3/25). LA stated the facility's dirty laundry was picked up daily and taken to the local washateria, where the linen, clothes, and towels were washed and returned to the facility. LA stated that the two domestic dryers in the facility were operable; however, the commercial dryer did not work. LA stated that the residents' clothes were organized by the resident's names that were labeled or marked on the inside of the clothes after being washed. He stated that the clothes without names came back to the laundry area and if a resident was missing clothing items or the CNAs knew that one of their residents were missing clothes, then they came here to the laundry area and retrieved the missing clothing items. LA stated that if a resident did not know or was not cognitive enough to know if they are missing clothes, then they probably would not be getting them. LA stated sometimes the CNAs would come get the residents clothes. When asked if he thought this was a good process, LA stated he did not know because he is only doing what he has been taught to do and at this point there has not been any complaining from the CNA's or residents. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on 2/11/25 at 11:32 AM, CNA A stated there was no clean linen in the facility today. CNA A stated the last day of clean linen was Sunday (2/9/25) when she last stocked for second shift. CNA A stated the process for the MCU was to stock the clean linens for the second shift. CNA A stated when she came on to the MCU yesterday morning (2/10/25), there were no clean linens, and the residents were laying on their bare mattresses. CNA A stated she sanitized the mattresses to ensure cleanliness. In an interview on 2/11/25 at 12:00 PM, CNA B stated the A-Hall had hot water for approximately a week. However, prior to that, the water was cold and as the temperature changed outside to a little warmer, the inside showers and sinks in the rooms became lukewarm. CNA B stated without towels the showers have become interrupted and a lot of residents haven't received showers. CNA B stated the facility's commercial washing machines were out for the last two weeks. CNA B stated the first shift CNAs were hardly able to give the residents their baths or showers because there were no towels, or the water was too cold, and the residents refused. CNA B stated there were no face towels in the facility for the residents. The only towels, when they were clean, were bath towels. In an interview on 2/11/25 at 12:05 PM, the Housekeeper stated she was aware of the facility running short on linens because the washing machines have been broken for a while but could not give an exact timeline of how long the machines have been inoperable. The housekeeper stated that the trash outside had not been picked up in 2 weeks. In an interview on 2/11/25 at 12:15 PM, CNA C stated some of the residents were on bare mattresses because the facility did not have linens. CNA C stated she has only worked at the facility for a week, and it has been like this since she started. CNA C stated she just continue to check on resident and ensure when the washed linen return to facility she makes the beds up and ensure resident has clean towels and clothing. In an interview on 2/11/25 at 03:00 PM, CNA D who stated there was a problem with getting clean towels. CNA D stated it was difficult to do an adequate job caring for residents when there were no towels to clean residents, or the showers were too cold to bath them. CNA D stated this weekend (Sunday 2/9/2025) there were no briefs for residents, wipes, or gloves and some residents had to wear a towel for briefs. She stated it was like this on the morning and afternoon shifts. In an interview on 2/11/25 at 6:15 PM, CNA E stated he worked Sunday morning (2/9/25) from 6:00am to 2:00 PM. CNA E stated there were no linens or towels during his shift. CNA E stated that there were no briefs for residents on his hall and had to retrieve some briefs from other resident halls. CNA E stated that there were no gloves or wipes in the facility; however, did not offer any additional information on how the residents were cleaned. In an interview on 2/12/25 at 2:15 PM, CNA F stated the resident and facility laundry was picked up in the morning around 5:30am to be taken to the local washateria and usually returned in afternoon by 3:00 PM with clean linens. She stated she brought her own gloves when she worked because she was aware that there was a shortage of supplies and other items. In an interview on 2/12/25 at 2:25 PM, LVN A stated she has observed at times there was no clean linens in the facility. She stated the washer has been broken for a while, so the dirty clothes and laundry must go to the local washateria and return to the unit around 3:00 PM. She stated when there were no sheets, towels were used on residents temporarily for briefs or sheets. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on 2/12/25 at 7:35 PM, the Administrator stated the facility's washing machines had been broken for 2 weeks. She stated parts have been ordered on 2/7/25. She stated until the parts arrive, the linens and towels had to be taken to the local washeteria for washing. The Administrator stated although the residents that were cognizant have stated they understand, she stated they should not have to be subjected to this because they were supposed to have linens and towels and not wait for them to be washed. She stated the facility has washed the private curtains and were in the process of hanging them in the rooms. In an interview on 3/6/25 at 12:55 PM, KL stated that sometimes clean linens were not available until the second shift, which started at 2:00 PM. They were always short on linens since last fall. It was not like that when KL first began working at the facility. KL reported that a complaint was made to management before, but KL felt being treated differently after reporting. KL did not report things much anymore afterwards because of fear of retaliation for reporting issues. KL ran out of briefs on the unit this morning but got some from another hall. KL stated normally we have briefs. KL stated that without necessary tools KL could not provide resident care fairly or not at all. In an interview on 3/6/25 at 3:00 PM, the Laundry Tech stated the washers were down one or two months ago and that was when he started taking the laundry to the washateria down the street. He stated his process was separating the linens from the towels and personal items were always bagged separately. He stated isolation bags would come in red or yellow bags and usually the nursing staff would hand deliver, so he knew whether to wash them or throw them away. He stated he would always wash contaminated isolation laundry last. There were 2 standard size washing machines in operation. He stated he washed the laundry the same way when using the machines at the washateria. He stated the transport driver would help him with transporting the laundry to washateria. He stated he never brought contaminated/isolation laundry to the washateria because he did not know how well they would be cleaned. He stated he did not know whether the nurses threw them away or not. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oasis at Galleria	2808 Stoneybrook Drive Houston, TX 77063

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on 3/7/25 at 11:49 AM, the Administrator stated that a shipment was received yesterday (03/06/2025) so that should have solved the problem of residents without any sheets or shortage of bed sheets. There should not be anyone without sheets today. Some CNAs are taking them to their hall and then another hall does not have enough until the next batch was washed. She stated that the facility was working on the distribution of linens. The laundry starts around 4:30 AM so that there are sheets available for each hall when the shift changes at 6am. She stated she was Not sure how the shortage happened but suspected that since the trash barrels and dirty linen barrels were the same color, someone may have been throwing out the sheets by mistake. She stated, the color of the barrels will be changed to prevent that from happening. The Administrator was asked the question if the company was experiencing financial problems that would prevent purchasing linens needed for the facility. She stated she was not aware of any problems and that the facility was very conscious of waste and did not want unnecessary purchases to be made. She stated that she did not think resident beds without bed sheets would affect the psychosocial well-being of the resident because the residents who were aware enough to understand that, know that it was us and not them. It was not their fault we were in short supply so they should not feel bad about themselves. When asked if there was a dignity issue, she stated nobody should be on a bare mattress and that the facility was working on the problem. She stated it was not a system failure with the linen process. She stated it was a hoarding thing because we were short for a long time and now the CNAs are worried, they will not have enough so they grab all they can. We have also found residents with extra linens in their room. When asked if the failure to provide services was neglect, she stated the facility had not failed to provide them, they are here, they are being moved by staff. Until we get an abundance, then they will stop doing it. It is a process of unlearning. She stated that neglect comes with intent and neglect was a willful act to not provide something. She stated Abuse and Neglect trainings for all new hires was part of the orientation and as coordinator, I make sure everyone was trained. We also do education multiple times a year. In an Interview on 3/7/25 at 2:17 PM, NP #2 stated the only health issue from not having sheets on the bed that she could think of was the skin rubbing on bare mattress could cause skin breakdown. For psychosocial affect, it would depend on if the resident had a preexisting mental health issue such as a phobia or an obsession with neatness. It may not affect some residents at all. It would be very individualized. In an interview on 3/7/25 at 2:24 PM, the DON said there was no health risk that she could think of regarding resident's not having linens on their beds. As far as dignity, some people prefer to have a sheet on them so that would bother them. She said she thought it only impacted how they thought about the facility staff, not how they think about themselves. The DON said she would be mad at the person that wasn't taking care of me if she was in the residents' situation. In an Interview on 3/7/25 at 2:35 PM, LVN A said I've seen residents without sheets on the bed sometimes. We wait for them to come around with fresh ones and then the bed gets made. I can't think of any health risks. Residents might get mad at us, but I have not seen anyone get upset with themselves. In an interview on 3/9/25 at 7:06 PM, TQ stated that it sucks that they don't have the supplies. TQ stated there were no gloves, no sheets, no briefs, no wipes, and no staff. TQ stated there were no gloves and cannot clean poop without them. TQ stated they need sheets, wipes, gloves, briefs, and staff. TQ stated they would scavenger hunt at night for these items. In the last couple of days, they have had supplies they need, and this was the first night they were fully staffed. (continued on next page)

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on 3/9/25 at 7:30 PM with Resident #8's RP, stated there had been times she visited, and they did not have sheets on the bed and the staff would go to look for sheets. Sometimes they found one and sometimes they said it was drying and could not put one on the bed. The RP stated Resident #8 had been wet during the evening of 3/9/25. She was going to try to move him because they need a system. Interview on 3/9/25 at 7:40 PM, RM stated most times they had problems with gloves, and they did not have the supplies. RM had to come to work bringing own supply of gloves to make sure gloves were available when needed. RM stated last week the CNA's complained about linen, wipes, and diapers. The CNA's tried to do what they could do. RM stated once they do not have the material to work with it affects the residents. The residents went without sheets. Some of the residents complained of being cold. They did not have enough things to cover them. Interview on 3/9/25 at 7:45 PM the Social Services stated she did not know what happened in the building. She stated all she knew was that the washer went out and the Administrator was taking the laundry aide to the laundromat/washeteria to wash the sheets. She stated she did not know what happened with the sheets. Record review of Facility provided invoice dated 02/04/25 revealed, the facility ordered linens and towels. Record review of Facility provided invoice dated 02/07/25 revealed, the facility ordered washing machine parts. Record review of the facility's undated policy on Abuse and Neglect - Clinical Protocol read in part: Definitions:2. Neglect as defined at 483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress . Record Review of the facility's undated policy Quality of Life- Homelike Environment reflected the following: Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. 2. The f[TRUNCATED]

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** Based on observation, interview and record review, the facility failed to ensure all residents were free from neglect for 18 of 18 residents (CR #1, Resident #2, #3, #4, #5, #6, #7, #10, #21, #22, #23, #24, #25, #26, #27, #28, #29 and #30) and 4 of 4 Halls (A, B, C & D Halls) reviewed for neglect. - The facility failed to provide adequate clean linens (towels & Sheets) to meet the needs of all residents across all units which resulted in residents (CR#1, Resident #2, #7, #5, #3) who reported they stuck to their mattress, felt cold, unclean, dirty, worthless, neglected, and left CR #1 in tears. - The facility failed to provide adequate clean linens as Residents #6, #10, #21, #22, #24, #25, #26, #27, #28, #29 & #30 were observed laying on bare mattresses. - The facility failed to provide hot water in resident rooms & showers which resulted in residents receiving cold showers or no showers at all. - The facility failed to ensure there was hot water in rooms C6- C8, C-13, D-1, D-10, C Hall shower, C-Hall sink, and D Hall Shower. - The facility failed to provide sufficient supplies (briefs, gloves, wipes) for resident care. An IJ that began on 02/11/25 was Identified on 03/07/2025. The template was provided to the facility on [DATE] at 04:08 PM. While the IJ was removed on 03/12/25 the facility remained out of compliance at a scope of widespread and a severity level of no actual harm that was not immediate due to the to the facility's need to evaluate the effectiveness of the corrective systems. Failure outside of IJ; - The facility failed to provide nursing services to Resident #6 after he sustained a skin injury to his finger. These failures could place residents at risk of decline in health, infection, amputation, emotional distress, and mental anguish. Findings included: Observations on 2/11/25 at 09:35 AM revealed, most residents in their rooms. Some residents were laying on bare mattresses due to the lack of linens in the facility. There was a total of six rooms observed. Observations on 2/11/25 at 11:28am revealed, the hallway and room closets at the end of A&B Hall and C&D Hall had no linen supplies. Water in the bathrooms were lukewarm; showers and sinks on C & D halls were lukewarm; sinks in the shower of the memory care unit had lukewarm water. Residents were laying on bare mattresses in rooms (B-4 & 5, B-12, C8, C6, D4). B-4, 5, & 10 had no privacy curtains. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	CR #1 Record review of CR #1's face sheet revealed CR #1 was initially admitted [DATE], readmitted [DATE], and discharged [DATE] with a diagnosis of anemia, coronary artery disease, congestive heart failure, hypertension, orthostatic, hypertension, renal failure, hepatitis, hyperlipidemia, COPD (lung disease), and respiratory failure. Resident was on dialysis. Record review of CR #1's MDS assessment revealed a BIMS Score of 13. CR #1 required supervision or touching assistance in the areas of eating and oral hygiene. CR #1 required partial, moderate assistance in toileting, and upper body dressing and personal hygiene. Record review of CR #1's Care Plan indicated the resident was at risk for skin break down. The goal was to remain clean, dry, intact without evidence of breakdown over the next 90 days. The target date was to 3/25. Interventions was to assess skin on a weekly basis and PRN (As needed) any breakdown, assist with repositioning as needed using padding between pressure areas. In an observation and interview on 02/12/25 at 08:30 AM, CR #1 was at a local hospital. He said while at the facility he was unable to take a bath every day because there was no hot water and no clean linens or towels. CR #1 stated that the facility washers were broken for the last two months and when his clothing went to the laundry, he could barely get all his items returned. CR #1 reported that he had an infection due to not having a shower and inadequate clean linens and not getting his IV bandage changed daily as ordered. CR#1 began to cry and said the situation in the facility was inhumane and it made him feel dirty and worthless. Resident #2 Record review of Resident #2's face sheet dated 02/12/25 revealed, a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included stroke, paraplegia (type of paralysis that affects the lower half of the body), depression, cognitive communication deficit and non-pressure chronic ulcer of the buttocks. Record review of Resident #2's annual MDS dated [DATE] revealed, a BIMS score of 9 indicating he had moderate cognitive impairment. He required moderate assistance from staff with shower/baths and footwear. Record review of Resident #2's care plan printed 02/12/25 revealed, focus- incontinent(bladder/bowel) and at risk for skin breakdown and pressure wound formation ; goal: clean, dry, odor free and dignity will be remained; intervention: check for incontinent episode during rounds, change promptly and apply protective skin barrier, observe for skin breakdown. In an interview on 2/11/25 at 10:00 AM, Resident #2 stated the facility's washing machines were not working and have not been working for over 2 weeks. Resident #2 stated his own clothes have been lost. Resident #2 also stated the hot water has been out since 1/25/25 and just started working yesterday, 2/10/25, but the heat or air condition still does not work. Resident #2 stated he feels helpless and neglected at times because this should not be happening. He stated he could not take a shower because the water was cold. He stated same with wash ups in the sink. Resident #2 said he was a human being and felt he should be treated with more respect. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #7 Record review of Resident #7's face sheet dated 03/12/2025 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included diabetes, stroke, dementia, mild protein malnutrition, schizophrenia, bipolar disorder, anxiety, elevated blood pressure and non-pressure chronic ulcer of foot. Record review of Resident #7's quarterly MDS dated [DATE] revealed a BIMS score of 8 indicating she had moderate cognitive impairment. She required substantial assistance from staff for toileting, shower/baths, and lower body dressing. She required partial assistance with upper body dressing and personal hygiene. She was always incontinent of bowel and bladder. Record review of Resident #7's undated care plan revealed she was bedfast most/all the time and at risk for skin breakdown. Interventions included use position devices to prevent skin break down. An observation and interview on 03/06/25 at 11:30 AM revealed, Resident #7 in bed with no fitted sheet or flat sheet. There was a draw sheet beneath her and blankets on top of her. Resident #7 said the previous night nursing staff removed her fitted sheet because it was wet, and it was never replaced. She said she preferred to have a fitted sheet because without it her skin would stick to the plastic mattress, and she did not like it. Resident #7 and she preferred to have a top sheet and that there was always a problem with linen supplies. She said the facility did not have enough towels, diaper s or wipes and she did not understand why the facility was always out of the supplies that were needed. Resident #5 Record review of Resident #5's face sheet dated 03/11/2025 revealed, a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Hemiplegia (one sided paralysis), Hemiparesis (paralysis to one side of body) d/t stroke, presence of prosthetic heart valve, depression, anxiety, diabetes, muscle weakness, dementia, high blood pressure and contractures of the left upper arm. An observation on 02/11/25 at 11:28 AM revealed, Resident #5 laying on a bare mattress in his room. In an observation and interview on 02/11/25 at 12:06 PM, Resident #5 stated there has not been warm or hot water in the facility for at least two weeks. Resident #5 stated he last showered on Sunday (2/9/25). Resident #5 stated the shower was still too cold. Resident #5 said most of the time he was unable to take a shower because there were no clean linens and the staff told him the linens were being washed at a local washeteria. He said the facility was supposed to be like home and the treatment he got did not make him feel good. An observation on 02/11/25 at 12:10 PM revealed, the water in Resident #5's bathroom was lukewarm. In an observation and interview on 03/07/25 between 9:55 AM and 10:25 AM, Resident #5 was observed in bed. He reported that his bed sheets had not been changed for a few days and prior to that he did not have sheets on his bed. Resident #5 said not having sheets was uncomfortable because his skin would stick to the mattress and on cold days the mattress made him cold. Resident #3 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of Resident #3's face sheet dated 03/11/2025 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included diabetes, cirrhosis of the liver (abnormal liver function), low blood pressures, muscle wasting and pain. Record review of Resident #3's annual MDS dated [DATE] revealed a BIMS Score of 12 indicating moderate cognitive impairment. An observation on 02/11/25 at 11:28 AM revealed, Resident #3 laying on a bare mattress in his room. In an observation and interview on 02/11/25 at 12:06 PM, Resident #3 said the facility's washing machine and dryer were not working so his family had to wash his clothing since the facility could not keep up with his clothes. He said the laundry room has lost his clothing items which was another reason his family washed his clothes. Resident #3 stated the last time he took a shower was last Sunday and it was cold. He stated he just couldn't wait any longer and had to bear with the uncomfortable shower to get clean. He stated the water was only lukewarm today, but for the last two weeks there has only been cold water. An observation on 02/11/25 at 12:10 PM revealed, the water in Resident #3's bathroom was lukewarm In an observation and interview on 03/07/25 between 09:55 AM and 10:25 AM, Resident #3 was observed in bed. He reported that his sheets had not been changed for several days and prior to that he had no sheets. Resident # 3 said he felt unclean because he did not have clean sheets on his bed. Resident #6 Record review of Resident #6's face sheet dated 03/10/2025 revealed, a [AGE] year-old male admitted to the facility on [DATE] His initial admission was 11/21/2022 and his original admission was 02/26/2018. His diagnoses included acute respiratory failure with hypoxia (inadequate gas exchange by the respiratory system), dependence on supplemental oxygen, Hemiplegia (one sided paralysis), Hemiparesis (paralysis to one side of body), stroke, chronic obstructive pulmonary disease (a lung condition caused by damage to the airway), anemia (reduced number of red blood cells), depression, functional quadriplegia (inability to completely move), congestive heart failure (is a condition where the heart is unable to pump enough blood to meet the body's needs), hypertension (elevated blood pressure) and anxiety. Resident #6 was his own RP. Record review of Resident # 6's Quarterly MDS (minimum data set, resident assessment, and care screening) dated 02/11/2025 revealed, intact cognition as indicated by a BIMS score of 14 out of 15. He required total dependence on staff for lower body dressing and substantial maximum assist for upper body dressing and personal hygiene. He was always incontinent of urine and bowel. Record review of Resident #6's undated care plan revealed he was bedfast most/all the time and at risk for skin breakdown. Interventions included keep sheets clean and wrinkle free. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An observation and interview on 3/6/2025 at 9:45 AM revealed, Resident #6 lying on an air mattress with a bath blanket and regular blanket. Resident #6 did not have a fitted sheet and his pillowcase was visibly dirty/soiled. He stated he did not have a fitted sheet because he was on an air mattress, so he was lying on a draw sheet. Resident #6 said he always had issues with clean linen. He stated there was never enough linen especially top sheets and the facility was always short on towels and blankets especially during a cold snap. Resident #4 Record review of Resident #4's face sheet revealed, a [AGE] year-old female admitted to the facility on [DATE] and initially admitted on [DATE]. Her diagnoses included Hemiplegia (one sided paralysis), Hemiparesis (paralysis to one side of body), stroke, end stage renal disease, dialysis dependent, diabetes, heart failure, anxiety, and depression. Record review of Resident #4's quarterly MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 13. She had impairment to one side of upper and lower body that interfered with daily functions. She required substantial assistance from staff for showers/baths, and partial assistance with dressing and personal hygiene. Record review of Resident #4's undated care plan revealed, focus: risk for skin breakdown and injury due to decreased mobility; goal: skin will remain clean/dry, intact without evidence of breakdown; intervention- provide pressure reducing and positioning devices on resident bed/wheelchair as indicated. In an interview on 2/11/ 25 at 6:30 PM, Resident #4 stated she has not had a hot shower in 2-3 weeks. Resident #4 stated the water was either cold, cool, or lukewarm. Resident #4 stated the washing machine has been out for at least 3 weeks and the staff take dirty clothes, linens, and towels to the local washeteria. Resident #4 stated she was afraid to send her personal items to the laundry because items were often missing or lost. Resident #10 Record review of Resident #10's faces sheet dated 03/11/25 revealed, a [AGE] year-old male whose initial admission date was 05/07/21 and re-admitted on [DATE]. The resident's diagnosis included: Down Syndrome, moderate intellectual disabilities, need for assistance with personal care, cognitive communication deficit and retention of urine. An observation on 02/11/25 at 11:28 AM revealed, Resident #10 laying on a bare mattress in his room. An observation and interview on 3/7/2025 between 9:55 AM and 10 :25 AM in the secured unit revealed, Resident #10 was lying on the bare mattress. The resident was non-verbal and could not be interviewed so CNA G was asked why the resident's bed had no linens. CNA G said that the facility did not have enough clean linen on the unit. She said the laundry only had some sheets and bed pads, but it was not enough for every room. CNA G said it had been an ongoing issue and the facility did not have enough sheets and things for the residents. Residents #21-30 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observations on 02/11/25 at 11:28 AM revealed, the following additional residents not interviewed in their room laying on bare mattresses: 1. Resident #21 2. Resident #22 3. Resident #23 4. Resident #24 5. Resident #25 6. Resident #26 7. Resident #27 8. Resident #28 9. Resident #29 10. Resident #30 An observation on 02/11/25 at 06:45 PM revealed, Resident #29's bed did not have a privacy curtain. Observations on 03/06/25 at 10: 25 AM revealed, the following residents did not have sheets on their beds. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. Resident #26 2. Resident #10 3. Resident #28 An observation on 02/12/25 at 7:05 PM revealed, enough linen for about 10 beds in the linen closet, dirty linen bags (waiting to be picked up and taken to the washeteria in the morning by laundry staff) at the end of each hall, and there were towels on staff carts in each hallway. An observation on 03/06/2025 at 9:00 AM revealed, there were no linens in linen closets in C Hall and D Hall. An observation on 03/06/25 at 10:38 AM revealed, there were no linens for beds on for Hall A. The linen closet was empty. An Observation on 03/06/25 at 11:00 AM revealed, the linen closet in C and D hall did not have linens. An observation and interview on 03/06/25 at 3:00 PM, 2 residential/standard size washing machines in use. An observation on 03/07/25 at 10:27 AM revealed, the linen closet on Hall A had no sheets, towels, or blankets. An observation on 03/07/25 at 11:02 AM revealed, the linen closet on Hall C had only 2 flat sheets on shelf. Observation on 3/6/25 at 10:38 AM of Hall A to check for linens on the bed. Rooms A6-8 did not have sheets on the bed. The linen closet for the hall was empty. In an interview on 2/11/25 at 10:15 AM, CW stated the residents were not being cared for. The CW stated residents were in soiled underwear or adult briefs a lot because the washing machines were broken and at certain times the staff were going to the washateria. The CW stated the trash outside of the facility hasn't been picked up in almost a month and it smelled and sometimes you could see rodents in the trash. The CW stated it was an eye sore for the neighborhood. . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an Interview on 2/11/25 at 10:25 AM, LA stated his job was to do laundry. LA stated that the washing machines have been down since last Monday (2/3/25). LA stated the facility's dirty laundry was picked up daily and taken to the local washateria, where the linen, clothes, and towels were washed and returned to the facility. LA stated that the two domestic dryers in the facility were operable; however, the commercial dryer did not work. LA stated that the residents' clothes were organized by the resident's names that were labeled or marked on the inside of the clothes after being washed. He stated that the clothes without names came back to the laundry area and if a resident was missing clothing items or the CNAs knew that one of their residents were missing clothes, then they came here to the laundry area and retrieved the missing clothing items. LA stated that if a resident did not know or was not cognitive enough to know if they are missing clothes, then they probably would not be getting them. LA stated sometimes the CNAs would come get the residents clothes. When asked if he thought this was a good process, LA stated he did not know because he is only doing what he has been taught to do and at this point there has not been any complaining from the CNA's or residents. In an interview on 2/11/25 at 11:32 AM, CNA A stated there was no clean linen in the facility today. CNA A stated the last day of clean linen was Sunday (2/9/25) when she last stocked for second shift. CNA A stated the process for the MCU was to stock the clean linens for the second shift. CNA A stated when she came on to the MCU yesterday morning (2/10/25), there were no clean linens, and the residents were laying on their bare mattresses. CNA A stated she sanitized the mattresses to ensure cleanliness. In an interview on 2/11/25 at 12:00 PM, CNA B stated the A-Hall had hot water for approximately a week. However, prior to that, the water was cold and as the temperature changed outside to a little warmer, the inside showers and sinks in the rooms became lukewarm. CNA B stated without towels the showers have become interrupted and a lot of residents haven't received showers. CNA B stated the facility's commercial washing machines were out for the last two weeks. CNA B stated the first shift CNAs were hardly able to give the residents their baths or showers because there were no towels, or the water was too cold, and the residents refused. CNA B stated there were no face towels in the facility for the residents. The only towels, when they were clean, were bath towels. In an interview on 2/11/25 at 12:05 PM, the Housekeeper stated she was aware of the facility running short on linens because the washing machines have been broken for a while but could not give an exact timeline of how long the machines have been inoperable. The housekeeper stated that the trash outside had not been picked up in 2 weeks. In an interview on 2/11/25 at 12:15 PM, CNA C stated some of the residents were on bare mattresses because the facility did not have linens. CNA C stated she has only worked at the facility for a week, and it has been like this since she started. CNA C stated she just continue to check on resident and ensure when the washed linen return to facility she makes the beds up and ensure resident has clean towels and clothing. In an interview on 2/11/25 at 03:00 PM, CNA D who stated there was a problem with getting clean towels. CNA D stated it was difficult to do an adequate job caring for residents when there were no towels to clean residents, or the showers were too cold to bath them. CNA D stated this weekend (Sunday 2/9/2025) there were no briefs for residents, wipes, or gloves and some residents had to wear a towel for briefs. She stated it was like this on the morning and afternoon shifts. (continued on next page)

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	675078	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oasis at Galleria	2808 Stoneybrook Drive Houston, TX 77063

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an observation and Interview on 2/11/25 at 4:37 PM, Maintenance stated he got a complaint about the water issue on January 30th, 2025, that there was water coming out of the ceiling; however, when he came to the facility there was hot water running out of the ceiling. Maintenance stated the circulation pump busted on Sunday. Maintenance stated on Monday morning he ordered the pump which arrived on the 3rd of February 2025. It was installed the same day. Maintenance stated the policy for temperatures were important for environmental issues for residents, them maintaining their hygiene, and because it's important for their health. Walk through Water Temperature Observation with Maintenance in the following areas: Room D-1 Sink - 81 degrees Room D-10 Sink - 100 degrees D Hall shower sink - 105 degrees D Hall Shower - 93 degrees Rooms C6-C-8 Sinks - 92.7 Degrees Room C-13 - 100 Degrees C-Hall Shower - 93 degrees C Hall Sink - 93.6 Degrees. In an interview on 2/11/25 at 6:15 PM, CNA E stated he worked Sunday morning (2/9/25) from 6:00am to 2:00 PM. CNA E stated there were no linens or towels during his shift. CNA E stated that there were no briefs for residents on his hall and had to retrieve some briefs from other resident halls. CNA E stated that there were no gloves or wipes in the facility; however, did not offer any additional information on how the residents were cleaned. In an interview on 2/12/25 at 2:15 PM, CNA F stated the resident and facility laundry was picked up in the morning around 5:30am to be taken to the local washateria and usually returned in afternoon by 3:00 PM with clean linens. She stated she brought her own gloves when she worked because she was aware that there was a shortage of supplies and other items. In an interview on 2/12/25 at 2:25 PM, LVN A stated she has observed at times there was no clean linens in the facility. She stated the washer has been broken for a while, so the dirty clothes and laundry must go to the local washateria and return to the unit around 3:00 PM. She stated when there were no sheets, towels were used on residents temporarily for briefs or sheets. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on 2/12/25 at 7:35 PM, the Administrator stated the facility's washing machines had been broken for 2 weeks. She stated parts have been ordered on 2/7/25. She stated until the parts arrive, the linens and towels had to be taken to the local washeteria for washing. The Administrator stated although the residents that were cognizant have stated they understand, she stated they should not have to be subjected to this because they were supposed to have linens and towels and not wait for them to be washed. She stated the facility has washed the private curtains and were in the process of hanging them in the rooms. In an interview on 3/6/25 at 12:55 PM, KL stated that sometimes clean linens were not available until the second shift, which started at 2:00 PM. They were always short on linens since last fall. It was not like that when KL first began working at the facility. KL reported that a complaint was made to management before, but KL felt being treated differently after reporting. KL did not report things much anymore afterwards because of fear of retaliation for reporting issues. KL ran out of briefs on the unit this morning but got some from another hall. KL stated normally we have briefs. KL stated that without necessary tools KL could not provide resident care fairly or not at all. In an interview on 3/6/25 at 3:00 PM, the Laundry Tech stated the washers were down one or two months ago and that was when he started taking the laundry to the washateria down the street. He stated his process was separating the linens from the towels and personal items were always bagged separately. He stated isolation bags would come in red or yellow bags and usually the nursing staff would hand deliver, so he knew whether to wash them or throw them away. He stated he would always wash contaminated isolation laundry last. There were 2 standard size washing machines in operation. He stated he washed the laundry the same way when using the machines at the washateria. He stated the transport driver would help him with transporting the laundry to washateria. He stated he never brought contaminated/isolation laundry to the washateria because he did not know how well they would be cleaned. He stated he did not know whether the nurses threw them away or not. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on 3/7/25 at 11:49 AM, the Administrator stated that a shipment was received yesterday (03/06/2025) so that should have solved the problem of residents without any sheets or shortage of bed sheets. There should not be anyone without sheets today. Some CNAs are taking them to their hall and then another hall does not have enough until the next batch was washed. She stated that the facility was working on the distribution of linens. The laundry starts around 4:30 AM so that there are sheets available for each hall when the shift changes at 6am. She stated she was Not sure how the shortage happened but suspected that since the trash barrels and dirty linen barrels were the same color, someone may have been throwing out the sheets by mistake. She stated, the color of the barrels will be changed to prevent that from happening. The Administrator was asked the question if the company was experiencing financial problems that would prevent purchasing linens needed for the facility. She stated she was not aware of any problems and that the facility was very conscious of waste and did not want unnecessary purchases to be made. She stated that she did not think resident beds without bed sheets would affect the psychosocial well-being of the resident because the residents who were aware enough to understand that, know that it was us and not them. It was not their fault we were in short supply so they should not feel bad about themselves. When asked if there was a dignity issue, she stated nobody should be on a bare mattress and that the facility was working on the problem. She stated it was not a system failure with the linen process. She stated it was a hoarding thing because we were short for a long time and now the CNAs are worried, they will not have enough so they grab all they can. We have also found residents with extra linens in their room. When asked if the failure to provide services was neglect, she stated the facility had not failed to provide them, they are here, they are being moved by staff. Until we get an abundance, then they will stop doing it. It is a process of unlearning. She stated that neglect comes with intent and neglect was a willful act to not provide something. She stated Abuse and Neglect trainings for all new hires was part of the orientation and as coordinator, I make sure everyone was trained. We also do education multiple times a year. In an Interview on 3/7/25 at 2:17 PM, NP #2 stated the only health issue from not having sheets on the bed that she could think of was the skin rubbing on bare mattress could cause skin breakdown. For psychosocial affect, it would depend on if the resident had a preexisting mental health issue such as a phobia or an obsession with neatness. It may not affect some residents at all. It would be very individualized. In an interview on 3/7/25 at 2:24 PM, the DON said there was no health risk that she could think of regarding resident's not having linens on their beds. As far as dignity, some people prefer to have a sheet on them so that would bother them. She said she thought it only impacted how they thought about the facility staff, not how they think about themselves. The DON said she would be mad at the person that wasn't taking care of me if she was in the residents' situation. In an Interview on 3/7/25 at 2:35 PM, LVN A said I've seen residents without sheets on the bed sometimes. We wait for them to come around with fresh ones and then the bed gets made. I can't think of any health risks. Residents might get mad at us, but I have not seen anyone get upset with themselves. In an interview on 3/9/25 at 7:06 PM, TQ stated that it sucks that they don't have the supplies. TQ stated there were no gloves, no sheets, no briefs, no wipes, and no staff. TQ stated there were no gloves and cannot clean poop without them. TQ stated they need sheets, wipes, gloves, briefs, and staff. TQ stated they would scavenger hunt at night for these items. In the last couple of days, they have had supplies they need, and this was the first night they were fully staffed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on 3/9/25 at 7:30 PM with Resident #8's RP, stated there had been times she visited, and they did not have sheets on the bed and the staff would go to look for sheets. Sometimes they found one and sometimes they said it was drying and could not put one on the bed. The RP stated Resident #8 had been wet during the evening of 3/9/25. She was going to try to move him because they need a system. Interview on 3/9/25 at 7:40 PM, RM stated most times they had problems with gloves, and they did not have the supplies. RM had to come to work bringing own supply of gloves to make sure gloves were available when needed. RM stated last week the CNA's complained about linen, wipes, and diapers. The CNA's tried to do what they could do. RM stated once they do not have the material to work with it affects the residents. The residents went without sheets. Some of the residents complained of being cold. They did not have enough things to cover them. Interview on 3/9/25 at 7:45 PM the Social Services stated she did not know what happened in the building. She stated all she knew was that the washer went out and the Administrator was taking the laundry aide to the laundromat/washeteria to wash the sheets. She stated she did not know what happened with the sheets. Record review of Facility provided invoice dated 02/04/25 revealed, the facility ordered linens and towels. Record review of Facility provided invoice dated 02/07/25 revealed, the facility ordered washing machine parts. Record review of the facility's undated policy on Abuse and Neglect - Clinical Protocol read in part: Definitions:2. Neglect as defined at 483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress . Record Review of the facility's undated policy Quality of Life- Homelike Environment reflected the following: Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. 2. The facility staff and management shall maximize, the extent possible, the characteristics of the facility that reflect a personalized homelike setting. These characteristics include: a.

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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** Based on observation, interview and record review the facility failed to accurately assess each resident's status for 1 of 1 resident (Resident #6) reviewed for accuracy of assessments. -The facility failed to document Resident #6's upper extremity impairment in the resident's quarterly MDS or care plan. This could place residents at risk of not having accurate assessments, which could compromise their plan of care. Record review of Resident #6's face sheet dated 03/10/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] His initial admission was 11/21/2022 and his original admission was 02/26/2018. His diagnoses included acute respiratory failure with hypoxia (inadequate gas exchange by the respiratory system), dependence on supplemental oxygen, Hemiplegia (one sided paralysis), Hemiparesis (paralysis to one side of body), stroke, chronic obstructive pulmonary disease (a lung condition caused by damage to the airway), anemia (reduced number of red blood cells), depression, functional quadriplegia (inability to completely move), congestive heart failure (is a condition where the heart is unable to pump enough blood to meet the body's needs), hypertension (elevated blood pressure) and anxiety. Resident #6 was his own RP. Record review of Resident #6's MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 14 out of 15, no presence of rejection of care, needed some help with self-care and no impairment for upper extremity functional limitation in range of motion. He needed supervision or touching assistance with eating and oral/personal hygiene, substantial/maximal assistance with upper body dressing and dependent for lower body dressing and putting on/taking off footwear. Resident #6's MDS listed diagnosis did not include any contractures. Record review of Resident #6's undated care plan revealed the skin injury to the finger on the left hand was not addressed. The resident's care plan only addressed bilateral feet contractures, his hand contractures or nail care were not documented. Focus: ADL self-care performance deficit related to impaired balance/coordination; intervention: personal hygiene- extensive assistance with 1-2 staff. An observation and interview on 03/10/25 at 04:30 PM revealed, Resident #6 lying in bed on his back. His left arm was bent at the elbow and his fingernails were severely contracted. There was nothing between his hand and his fingers. Resident #6 said the left hand does not work d/t a stroke. He stated he used to have a hand roll to keep his contraction from getting worse, but he lost that a long time ago. He said he was not bothered by it too much. In an interview on 03/11/25 at 11:08 AM, the MDS Nurse said the purpose of MDS to get assessment of pt for the state for reimbursement. The team is in charge of updating CP what triggers on MDS is updating and then team will care plan, update. We catch them as we can, MDS and CP . What are the risks, the care plan should have the weakness. She was responsible and just missed it on the MDS but knows it is in his CP. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview of 03/11/25 at 11:26 AM, the CNO said the MDS nurse is responsible for the MDS, but it was a multidisciplinary tool/assessment. She said the purpose of the MDS assessment is to drive the plan of care. She said incorrect MDSs could result in miss opportunities of care needed by residents. She said ideally the therapist who ordered the residents splint should have educated the nursing staff on the instructions to ensure the plan of care is followed correctly. The CNO said the purpose of a care plan, to identify areas of actual and potential problems and set forth interventions that may facilitate in resolution of those problems. The care plan is repeated re -evaluating if interventions are ineffective or resolution. She said the care plan tasks are discipline specific. Record review of the facility's undated policy Care Plans, Comprehensive Person-Centered read in part: Policy Statement - 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 . Record review of the facility's undated policy titled 'Comprehensive Assessments and the Care Delivery Process' revealed, 'Assessment and information collection includes (WHAT, WHERE and WHEN?). The objective of the information collection (assessment) phase is to obtain, organize, and subsequently analyze information. about a patient. a. Assess the individual. (1) Gather relevant information from multiple sources, including: (a) Observation. (b) Physical assessment; (c) Symptom or condition-related assessments (Braden, AIMs, falls, etc.); (d) Resident and family interview; (e) Hospital discharge summaries; (f) Consultant reports; (g) Lab and diagnostic test results; and (h) Evaluations from other disciplines (for example, dietary, respiratory, social services, etc.). (2) Complete the Minimum Data Set within 14 days after admission, within 14 days after it is determined that Information analysis steps include (HOW AND WHY?). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Define issues, including problems, risk factors, and other concerns (to which all disciplines can relate). (1) Determine CAAs that have been triggered during completion of the MDS; and (2) Expanding on the triggered CAAs and the data gathered in Step 1, begin to define problems and symptoms within the context of the overall clinical picture. For example, try to determine what precipitates, aggravates or causes problems instead of simply listing the problems. b. Define conditions and problems that are causing, or could cause, other problems. (1) Identify potential causes or contributing factors of problems and symptoms, including: (a) Medical; (b) Psychosocial; (c) Environmental; and (d) Functional. (2) Arrange conditions, problems and outcomes in their proper order based on the information gathered in steps 1 and 2. (3) Try to determine the interrelationship between existing problems. For example, does one symptom or cluster of symptoms seem to appear or worsen when another symptom or cluster of symptoms appears or worsens? (4) Determine the most plausible relationships between conditions and their causes. continues on next page c. Define current treatments and services; link with problems/diagnoses. (1) Identify the current interventions and treatments; and (2) Link these to problems and diagnoses they are supposed to be treating. d. Identify overall care goals and specific objectives of individual treatments. (1) Evaluate whether or not these treatments are accomplishing the anticipated results. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Make decisions about care and treatment. (1) Apply clinical reasoning to assessment information and determine the most appropriate interventions. Decision making leading to a person-centered plan of care includes: a. Selecting and implementing interventions, based on the results of the above. Monitoring results and adjusting interventions includes: a. Periodically reviewing progress and adjusting treatments. (1) Continue to define or refine the objectives of specific treatments as well as overall care and services. Comprehensive assessments are conducted and coordinated by a registered nurse with appropriate participation of other health professionals. Completed assessments (baseline, comprehensive, MDS, etc .) are maintained in the resident's active record for a minimum of 15 months. These assessments are used to develop, review and revise the resident's comprehensive care plan.'

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure services provided, met professional standard of quality for 1of 1 resident (Resident #6) reviewed for professional standards. - The facility failed to follow Resident #6's care plan by not applying a hand roll to his contracted left hand. This failure could place residents at risk of worsening of contractures, pain and deterioration of health. Findings included: Record review of Resident #6's face sheet dated 03/10/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] His initial admission was 11/21/2022 and his original admission was 02/26/2018. His diagnoses included acute respiratory failure with hypoxia (inadequate gas exchange by the respiratory system), dependence on supplemental oxygen, Hemiplegia (one sided paralysis), Hemiparesis (paralysis to one side of body), stroke, chronic obstructive pulmonary disease (a lung condition caused by damage to the airway), anemia (reduced number of red blood cells), depression, functional quadriplegia (inability to completely move), congestive heart failure (is a condition where the heart is unable to pump enough blood to meet the body's needs), hypertension (elevated blood pressure) and anxiety. Resident #6 was his own RP. Record review of Resident # 6's Quarterly MDS (minimum data set, resident assessment, and care screening) dated 02/11/2025 revealed a BIMS score of 14 indicating he was cognitively intact. He had lower extremity impairment on both sides of the body that interfered with daily function. He was coded for no impairment to the upper extremity. He required total dependence on staff for lower body dressing and substantial maximum assist for upper body dressing and personal hygiene. He was always incontinent of urine and bowel. Record review of Resident #6's undated care plan revealed the skin injury to the finger on the left hand was not addressed. The resident's care plan only addressed bilateral feet contractures, his hand contractures or nail care were not documented. Focus: ADL self-care performance deficit related to impaired balance/coordination; intervention: personal hygiene- extensive assistance with 1-2 staff. Focus: deficit in the ability of sitting balance and postural stability r/t weakness and disease process, revised on 11/25/2020. The goal - Resident #6 will maintain current level of function, sitting balance and postural stability through the review period. Target date was 04/08/2025. Interventions included, staff will apply range of motion (ROM) during tasks and roll to the left hand daily, revised on 08/12/2022. An observation and interview on 03/10/25 at 04:30 PM [NAME] in bed on his back. His left arm was bent at the elbow and his fingernails were severely contracted. There was nothing between his hand and his fingers. Resident #6 said the left hand does not work d/t a stroke. He stated he used to have a hand roll to keep his contraction from getting worse, but he lost that a long time ago. He said he was not bothered by it too much. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an Interview on 3/11/2025 at 10:30 AM, the DOR stated Resident #6 was receiving passive ROM to the left arm/hand by OT. She stated the POC included passive ROM. She stated she could not locate information on when the hand roll was first ordered. She did not say why he didn't have a hand roll. She stated the last overview was regarding his feet and that he was due for an evaluation on 3/11/2025. In an interview on 3/11/25 at 10:55 AM, Resident #6 said he had a splint with his name on it long ago and it disappeared he has been here x 8 years and when he goes to hospital things go missing. Interview on 3/11/2025 at 11:15 AM, LVN B stated the purpose of the care plan was to know Resident #6's needs and if there was a new interaction that needed to be put into place. She stated she was unsure as to who would be responsible and why Resident #6 did not have a hand roll to his contracted hand. She stated the hand roll would be for exercise. She stated the risk would be lack of movement and then he would need therapy to prevent further stiffness. Interview on 3/11/2025 at 11:25 AM, the CNO stated the purpose of a care plan was to identify areas of actual and potential problems and set forth interventions that may facilitate in resolution of those problems. She stated the care plan is repetitive and requires re -evaluating if interventions are ineffective or resolved. She said tasks are usually disciplined specific. The assigned discipline for the task will be reflected in the resident's ADLs or [NAME] (a documentation system that allows nurses to organize key resident information for their care plan). She stated staff have been educated on no skin on skin on contact. She stated a hand roll would aide in comfort and prevent skin breakdown. She stated the risks to the resident would be of macerated skin and impaired skin integrity. Record review of the facility's undated policy Care Plans, Comprehensive Person-Centered read in part: Policy Statement - 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 . Record review of the facility's undated policy on Using the Care Plan read in part: Policy Statement - The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oasis at Galleria	2808 Stoneybrook Drive Houston, TX 77063

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure that, for a resident who is unable to carry out activities of daily living, provide the necessary services to maintain grooming and personal care for 1 of 1 residents (Resident #6) reviewed for ADL care. -The facility failed to provide nail care to Resident #6, leaving him with long dirty nails that snagged on his clothing resulting in pain, injury and bleeding. This failure could place resident at risk of social embarrassment, isolation, infection, injury, pain, deterioration of health and a diminished quality of life. Findings included: Record review of Resident #6's face sheet dated 03/10/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] His initial admission was 11/21/2022 and his original admission was 02/26/2018. His diagnoses included acute respiratory failure with hypoxia (inadequate gas exchange by the respiratory system), dependence on supplemental oxygen, Hemiplegia (one sided paralysis), Hemiparesis (paralysis to one side of body), stroke, chronic obstructive pulmonary disease (a lung condition caused by damage to the airway), anemia (reduced number of red blood cells), depression, functional quadriplegia (inability to completely move), congestive heart failure (is a condition where the heart is unable to pump enough blood to meet the body's needs), hypertension (elevated blood pressure) and anxiety. Resident #6 was his own RP. Record review of Resident # 6's Quarterly MDS (minimum data set, resident assessment, and care screening) dated 02/11/2025 revealed a BIMS score of 14 indicating he was cognitively intact. He had lower extremity impairment on both sides of the body that interfered with daily function. He was coded for no impairment to the upper extremity. He required total dependence on staff for lower body dressing and substantial maximum assist for upper body dressing and personal hygiene. He was always incontinent of urine and bowel. Record review of Resident #6's undated care plan revealed the skin injury to the finger on the left hand was not addressed. The resident's care plan only addressed bilateral feet contractures, his hand contractures or nail care were not documented. Focus: ADL self-care performance deficit related to impaired balance/coordination; intervention: personal hygiene- extensive assistance with 1-2 staff. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 03/10/25 at 1:42 PM revealed, Resident #6 with unkempt hands/fingers. On his right hand he had dirty, long fingernails and his left hand was contracted with long dirty fingernails. His middle finger on the left hand was wrapped with a dressing that was held in place with scotch tape. The dressing was undated, and a circular red spot was seen through the dressing. Resident #6 said sometime in the previous week, he said his finger was injured when it got caught on his shirt as two CNAs quickly took off his long sleeve shirt due to an ant being on him. He said when his finger got caught it was painful and bled a lot, he said the fingernail was long and ripped off, so the nurse had to clip it off. Resident #6 he was given pain medication after the incident. He said the wound care nurse applied the dressing to finger. He stated it currently felt sore. Resident #6 did not know which day it happened and did not know the names of the CNAs or the wound care nurse. In an interview on 03/10/25 at 01:50 PM, CNA E said, if a resident was not diabetic the CNAs could trim their nails. He said he was unaware Resident #6 had an injury to his finger. CNA E went into the resident's room to look at his fingernails and said Resident #6's nails needed to be cleaned and trimmed and his current state was a risk of infection. In an interview on 03/10/25 at 2:05 PM, LVN B said she had only been at the facility for 3-4 weeks and that maybe the activities department oversaw resident fingernails. She said she was unaware of Resident #6's injury and the resident's fingernails need to cut and cleaned. LVN B said there was a risk of infection if Resident #6 were to scratch himself and fingernails should be cleaned and checked at least every week. LVN B said long dirty nails may make residents feel sad. In an Interview on 03/10/25 at 3:20 PM, the DON she stated that she started working on February 17. She said, nailcare for diabetics, podiatry care would take care of it, or the nurses would cut as needed. She said nursing staff are responsible for nail care. and nursing staff would do periodic rounds. (She said the managers would take care of that) And make rounds to see if anybody needed nail care. The importance of nail care was for dignity and to keep infections down. CNAs would also be part of monitoring for nail care. In an interview on 03/11/25 at 10:00 AM, the DON said she was investigating which CNAs worked with Resident #6 last week, but she did not know at the moment. She said she checked with staff, but no one would come forward about what happened to Resident #6's finger. Record review of Resident #6's order summary report as of 03/09/2025 revealed, there were no physician orders for nail care. Record review of Resident #6's progress notes for date range: 02/08/2025 to 03/11/2025 and uploaded on 03/10/2025 at 3:39 PM, revealed no documentation of nail care or refusal of nail care. Record review of Resident #6's ADL report for March 2025 printed 03/10/25 at 4:10 PM revealed, no documentation of nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility undated policy for Change in a Resident's Condition or Status read in part: Policy Statement - Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing/payments, resident rights, etc.). Policy Interpretation and Implementation .8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status . Record review of the facility's undated policy for Skin Assessment Monitoring Guidelines read in part: Policy - All residents will be assessed upon admission, quarterly and with a significant change in condition to identify risk factors that may lead to impaired skin integrity .Purpose: to prevent skin impairment by assessing risk factors in a timely manner. To gather accurate, objective and consistent data for the purpose of implementing an individualized Plan of Care designated to meet the resident's needs. To ensure consistency in the implementation of preventive measures to assist with maintaining skin integrity. To evaluate outcomes .6. If a skin concern is noted, do not assume that the nursing team is aware. Validate that there is a treatment or monitoring order, that physician and resident/representative are aware and care plan reflects area of concern. If it is determined to be a new area note on 24-hour report, add to Alert Charting. Notify resident/representative and Director of Nursing/designee, note new treatment/monitoring orders, revise care plan as indicated . Record review of the facility's undated policy for Accidents/Incidents/Events - Investigation and Reporting, read in part: Policy Statement - All accidents or incidents involving residents .etc., occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation 1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident/incident/event

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practices, the comprehensive care plan, and the residents' choices and based on the comprehensive assessment of a resident for 1 of 1 resident (Resident #6) reviewed for quality of care. - The facility failed to provide follow up care to Resident #6's left hand middle finger after an injury involving staff resulted in bleeding and pain. This failure could place residents at risk of pain and infection. Findings included: Record review of Resident #6's face sheet dated 03/10/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] His initial admission was 11/21/2022 and his original admission was 02/26/2018. His diagnoses included acute respiratory failure with hypoxia (inadequate gas exchange by the respiratory system), dependence on supplemental oxygen, Hemiplegia (one sided paralysis), Hemiparesis (paralysis to one side of body), stroke, chronic obstructive pulmonary disease (a lung condition caused by damage to the airway), anemia (reduced number of red blood cells), depression, functional quadriplegia (inability to completely move), congestive heart failure (is a condition where the heart is unable to pump enough blood to meet the body's needs), hypertension (elevated blood pressure) and anxiety. Resident #6 was his own RP. Record review of Resident # 6's Quarterly MDS (minimum data set, resident assessment, and care screening) dated 02/11/2025 revealed a BIMS score of 14 indicating he was cognitively intact. He had lower extremity impairment on both sides of the body that interfered with daily function. He was coded for no impairment to the upper extremity. He required total dependence on staff for lower body dressing and substantial maximum assist for upper body dressing and personal hygiene. He was always incontinent of urine and bowel. Record review of Resident #6's undated care plan revealed the skin injury to the finger on the left hand was not addressed. The resident's care plan only addressed bilateral feet contractures, his hand contractures or nail care were not documented. Focus: ADL self care performance deficit related to impaired balance/coordination; intervention: personal hygiene- extensive assistance with 1-2 staff. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 03/10/25 at 01:42 PM revealed, Resident #6 with unkempt hands/fingers. On his right hand he had dirty, long fingernails and his left hand was contracted with long dirty fingernails. His middle finger on the left hand was wrapped with a dressing that was held in place with scotch tape. The dressing was undated, and a circular red spot was seen through the dressing. Resident #6 said sometime in the previous week, he said his finger was injured when it got caught on his shirt as two CNAs quickly took off his long sleeve shirt due to an ant being on him. He e said when his finger got caught it was painful and bled a lot, he said the fingernail was long and ripped so the nurse had to clip it off. Resident #6 he was given pain medication after the incident. He said the wound care nurse applied the dressing to finger. He stated it currently felt sore. Resident #6 did not know which day it happened and did not know the names of the CNAs or the wound care nurse. An observation and interview of Resident #6 with the DON on 03/10/2025 at 4:30 PM revealed, the DON said she did not hear about any injury regarding Resident #6's left hand and she expected staff to report this to the nurse right away in an incident report and call the MD to get orders. The DON removed the dressing from Resident #6's left hand middle finger, using normal saline to loosen it from the dried blood stuck on the finger. Resident #6 winced in pain and said it was tender when touched. A large cut was observed just below the nail bed but there was no active bleeding. The nail below the dressing was short, and the fingertip had thick, dried, bumpy skin. The DON stated the risk of not reporting the injury would be missed treatment. She stated her next step would be to apply a clean bandage, call the NP and write an incident report. She stated the risk of an unreported injury would be a missed treatment for the resident. In an interview on 03/10/2025 at 4:45 PM, the CNO (Chief Nursing Officer) stated she would have to get more information as to why no incident report was made for Resident #6's skin injury. She stated her expectation would be that the incident report be written, actions to be completed as well as a root cause analysis. The CNO also expected the MD and family to be notified, interventions placed, MD orders to be put into action so the resident could get treatment and the care plan updated. Record review of Resident #6's order summary report as of 03/09/2025 revealed no physician order for treatment to the finger. Record review of Resident #6's medical chart on 3/10/2025 at 4:07 PM, revealed no change in condition form addressing the skin injury to the finger. There were no accident/incident reports or skin assessments addressing Resident #6's injured middle finger. Record review of Resident #6's progress notes for date range: 02/08/2025 to 03/11/2025 and uploaded on 03/10/2025 at 3:39 PM, revealed no documentation of the resident's skin injury to his middle finger of the left hand. Record review of the facility's undated policy for Accidents/Incidents/Events - Investigation and Reporting, read in part: Policy Statement - All accidents or incidents involving residents .etc., occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation 1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident/incident/event

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain medical records on each resident that were complete and accurately documented, in accordance with accepted professional standards and practices, for 1 of 1 resident (Resident #6) whose records were reviewed for accuracy and completeness. - The facility failed to document Resident #6's injury to his left middle finger in the resident's chart. This failure could place residents at risk of having incomplete or inaccurate records and inadequate care. Findings included: Record review of Resident #6's face sheet dated 03/10/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] His initial admission was 11/21/2022 and his original admission was 02/26/2018. His diagnoses included acute respiratory failure with hypoxia (inadequate gas exchange by the respiratory system), dependence on supplemental oxygen, Hemiplegia (one sided paralysis), Hemiparesis (paralysis to one side of body), stroke, chronic obstructive pulmonary disease (a lung condition caused by damage to the airway), anemia (reduced number of red blood cells), depression, functional quadriplegia (inability to completely move), congestive heart failure (is a condition where the heart is unable to pump enough blood to meet the body's needs), hypertension (elevated blood pressure) and anxiety. Resident #6 was his own RP. Record review of Resident # 6's Quarterly MDS (minimum data set, resident assessment, and care screening) dated 02/11/2025 revealed a BIMS score of 14 indicating he was cognitively intact. He had lower extremity impairment on both sides of the body that interfered with daily function. He was coded for no impairment to the upper extremity. He required total dependence on staff for lower body dressing and substantial maximum assist for upper body dressing and personal hygiene. He was always incontinent of urine and bowel. Record review of Resident #6's undated care plan revealed the skin injury to the finger on the left hand was not addressed. The resident's care plan only addressed bilateral feet contractures, his hand contractures or nail care were not documented. Focus: ADL self-care performance deficit related to impaired balance/coordination; intervention: personal hygiene- extensive assistance with 1-2 staff. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 03/10/25 at 01:42 PM revealed, Resident #6 with unkempt hands/fingers. On his right hand he had dirty, long fingernails and his left hand was contracted with long dirty fingernails. His middle finger on the left hand was wrapped with a dressing that was held in place with scotch tape. The dressing was undated, and a circular red spot was seen through the dressing. Resident #6 said sometime in the previous week, he said his finger was injured when it got caught on his shirt as two CNAs quickly took off his long sleeve shirt due to an ant being on him. He e said when his finger got caught it was painful and bled a lot, he said the fingernail was long and ripped so the nurse had to clip it off. Resident #6 he was given pain medication after the incident. He said the wound care nurse applied the dressing to finger. He stated it currently felt sore. Resident #6 did not know which day it happened and did not know the names of the CNAs or the wound care nurse. Interview on 03/10/2025 at 3:50 PM, LVN B stated she was unaware of Resident #6's injury to his left hand. She stated the dressing should have been dated. LVN stated she would have to check the progress notes to see if anybody wrote a note. She stated if skin injuries occurred, she would write an incident report, notify the DON, MD and family but she was unsure if this was done with Resident #6. LVN B could not explain why there was no documentation regarding Resident #6's injury and She said if left untreated Resident #6's finger could get infected. In an interview with the DON on 03/10/2025 at 4:30 PM, the DON said she did not hear about any injury regarding Resident #6's left hand and she expected staff to report this to the nurse right away in an incident report and call the MD to get orders. She stated her next step would be to apply a clean bandage, call the NP and write an incident report. She stated the risk of an unreported injury would be a missed treatment for the resident. The DON could not explain why there was no documentation regarding Resident #6's injury. In an interview on 03/10/2025 at 4:45 PM, the CNO (Chief Nursing Officer) stated she would have to get more information as to why no incident report was made for Resident #6's skin injury. She stated her expectation would be that the incident report be written, actions to be completed as well as a root cause analysis. The CNO also expected the MD and family to be notified, interventions placed, MD orders to be put into action so the resident could get treatment and the care plan updated. The CNO could not explain why there was no documentation regarding Resident #6's injury. Record review of Resident #6's medical chart on 3/10/2025 at 4:07 PM, revealed no change in condition form addressing the skin injury to the finger. There were no accident/incident reports or skin assessments addressing Resident #6's injured middle finger. Record review of Resident #6's progress notes for date range: 02/08/2025 to 03/11/2025 and uploaded on 03/10/2025 at 3:39 PM, revealed no documentation of the resident's skin injury to his middle finger of the left hand. Record review of the facility's undated policy for Accidents/Incidents/Events - Investigation and Reporting, read in part: Policy Statement - All accidents or incidents involving residents .etc., occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation 1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident/incident/event (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility undated policy for Change in a Resident's Condition or Status read in part: Policy Statement - Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing/payments, resident rights, etc.). Policy Interpretation and Implementation .8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status . Record review of the facility's undated policy for Skin Assessment Monitoring Guidelines read in part: Policy - All residents will be assessed upon admission, quarterly and with a significant change in condition to identify risk factors that may lead to impaired skin integrity .Purpose: to prevent skin impairment by assessing risk factors in a timely manner. To gather accurate, objective and consistent data for the purpose of implementing an individualized Plan of Care designated to meet the resident's needs. To ensure consistency in the implementation of preventive measures to assist with maintaining skin integrity. To evaluate outcomes .6. If a skin concern is noted, do not assume that the nursing team is aware. Validate that there is a treatment or monitoring order, that physician and resident/representative are aware and care plan reflects area of concern. If it is determined to be a new area note on 24-hour report, add to Alert Charting. Notify resident/representative and Director of Nursing/designee, note new treatment/monitoring orders, revise care plan as indicated .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, interviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. - The sinks and toilets were loose in residents' bathrooms (C-6, C-7, C-8, D-1, and D-9). - The outside trash dumpster area had trash bags, boxes, and other debris on the ground. The trash bin was too full to shut the cover. - The facility failed to maintain hot water in multiple resident rooms across multiple units. - The window screen for resident room C-16 had been cut open leaving jagged edges. The windowpanes were held in place with duct tape. This failure could affect residents by placing them at risk for diminished quality of life due to the lack of a well-kept environment. The findings included: Observation Rounds made on 02/11/25 at 9:25AM found Rooms C-6, C-7, C-8, D-1, and D-9 all have loose toilets and the sinks were dislodging from the wall. Observation on 2/11/2025 at 10:15 AM revealed trash spilling out the trash dumpsters outside the building, trash bags, and boxes strewn against the facility wall, and on the ground. There was an unpleasant smell. Observation on 3/7/25 at 8:59 AM of the window for room C16 from outside the building. The window consists of 9 windowpanes with a screen covering the window. The section of the screen covering the bottom 6 panes appeared to be jaggedly cut on three sides leaving a flap of screen approximately 17 inches wide dangling over the wind sill. The windowpanes were left visible and were held in place with duct tape. Part of the duct tape was hanging loose and appeared aged with dirt. There were leaves and dirt in the area between the screen and window. Observation on 3/7/25 at 10:19 AM of the window from inside room C16 revealed duct tape on the inside holding the windowpanes in place. There did not appear to be any outside air coming onto the room from the duct taped window. Interview on 2/11/25 at 10:15 AM with a CW who stated the trash outside of the facility had not been picked up in almost a month and it smelled; and sometimes you could see rodents in and around the trash bin. The CW stated it was an eye sore for the residents and neighborhood. Interview on 2/11/25 at 12:05 PM with the Housekeeper who stated the trash outside had not been picked up in about 2 weeks. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 2/11/25 at 4:37 PM with Maintenance who stated he got a complaint about the water issue on January 30, 2025. The original complaint was water coming out of the ceiling; however, when he came to the facility there was hot water running out of the ceiling. Maintenance stated the circulation pump busted on Sunday. Maintenance stated on Monday morning he ordered the pump which arrived on the 3rd of February 2025. It was installed the same day. Maintenance stated the policy for temperatures were important for environmental issues for residents, them maintaining their hygiene, and because it's important for their health. Walk through Water Temperature Observation with Maintenance in the following areas: Room D-1 Sink - 81 degrees Room D-10 Sink - 100 degrees D Hall shower sink - 105 degrees D Hall Shower - 93 degrees Rooms C6-C-8 Sinks - 92.7 Degrees Room C-13 - 100 Degrees C-Hall Shower - 93 degrees C Hall Sink - 93.6 Degrees. Interview on 2/12/25 at 8:30 AM with CR#1 who stated the trash outside the facility hasn't been picked up in a month. CR#1 stated you could smell it inside the facility. CR#1 stated the trash was right at the dialysis door room and it had a really foul odor. CR#1 stated he has complained to staff and administrator and told they are working on this issue. In an interview on 2/12/2025 at 7:35 PM the Administrator stated the last time the trash had been picked up was last Wednesday. She stated that the facility had paid waste management and were waiting for the trash to be picked up. She stated she has tried calling a few times, but only got a recording. She stated Waste Management had indicated that they did receive a check; however, they would wait 10 days before coming to the facility due to past checks not clearing and the work being done. Interview 3/11/25at 9:50 AM with the, CEO. When asked about the condition of the window and screen for Room C16, he reported that there used to be an air conditioning unit in the window that was removed. The window and screen have not been replaced. The resident may decide she wants to have the unit back in the summer. Record review of invoices found the last trash pick-up was last Wednesday. Record Review of Maintenance Service Policy revealed the following: (continued on next page)

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	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oasis at Galleria	2808 Stoneybrook Drive Houston, TX 77063

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. Maintaining the building in good repair and free from hazards. Maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. Establishing priorities in providing repair service. Maintaining the grounds, sidewalks, parking lots, etc., in good order. Others that may become necessary or appropriate. 10. Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned. Record Review of Water Temperatures, Safety of Policy dated 6/3/2024 revealed the following: 1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 100-110 F, or the maximum allowable temperature per state regulation. 2. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log. 3. Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log.