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	06/19/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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, interviews and record reviews, the facility failed to protect the resident's right to be free from abuse, neglect, and exploitation for two residents (Resident #111, #113 and #114) out of seven reviewed for abuse. The facility failed to protect Resident #113 and #114 from a physical altercation on 3/23/25. Resident #114 sustained redness and pain to the left eye and sent to the ER. The facility failed to address Resident # 114's continued threatening and aggressive behavior towards residents and staff. The facility failed to address Resident #113's inappropriate sexual behavior on 5/03/2024 towards an unknown female resident as documented in the medical records. An Immediate Jeopardy (IJ) was identified on 05/03/2025. The IJ template was provided to the facility on [DATE] at 1:58 PM. While the immediacy was removed on 05/08/2025 at 1:24 PM, the facility remained out of compliance at a scope of pattern and severity level of no actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. Failures outside IJ -The facility failed to ensure CNA A properly repositioned Resident #111 CNA A shuffling and adjusting his head on the pillow. these failures could place residents at risk of physical or psychosocial harm as a result of the abuse. Findings included: 1. Record review of Resident #113's face sheet dated 04/22/25 reflected a [AGE] year-old male first admitted to the facility on [DATE] and discharged on 03/28/25 to another facility. His diagnoses included dementia, persistent mood disorders, hypertension, chronic pain syndrome and muscle weakness. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #113's quarterly MDS dated [DATE] reflected he had a BIMS score of 6 out of 15 indicating severe impaired cognition. Section E revealed he had no behaviors or refusals of care. He used a wheelchair for mobility. He required supervision to moderate assistance with all ADLs. Record review of Resident #113's care plan with the closed date of 03/31/25 included: Focus - resident had moods that were not easily altered by staff intervention as evidenced by persistent mood disorder, symptoms and signs involving appearance and behavior. Date initiated as 05/06/24. Interventions included - document staff interventions, notify physician, psych referrals. Focus - Resident was taking psychotropic medications and at risk for adverse reactions and behaviors. Date initiated was 05/06/24. Interventions included - monitor for anxiety driven behaviors and report to physician. Monitor for psychosis driven behaviors such as aggressiveness, combativeness, and report to physician. Focus - he was resistant to care and at risk of injury as evidenced by refusal of baths at times. Date initiated was 09/06/24. Focus - He had episodes of inappropriate behaviors and at risk for future episodes and injuries as evidenced by not allowing housekeeping to clean room, refusing care (becoming aggressive at times). Date initiated was 11/27/24. Interventions included - give medications as ordered, monitor and chart behaviors every shift and report progress to physician. Provide psych consult per order. Focus - Resident reportedly hit his roommate in the eye. Date initiated was 03/23/25. Interventions included - refer to Medical Behavioral Hospital for inpatient geri psych placement. Immediately inform resident to stop and separate from others when resident becomes aggressive. Further review of Resident #113's care plan revealed sexually inappropriate behavior was not addressed. Record review of Resident #113's progress note on 5/3/24 at 2:26 PM written by LVN U read in part: Resident #113 was observed by the nurse inappropriately touching on a female resident while she was on her bed resting. The female resident had long pants and a top on. The resident was redirected back to his room .and stated, I will not do it again. The RP was notified .NP notified; orders received for psych consult. Record review of Resident #113's progress note on 5/04/24 at 3:20 AM written by LVN V indicated the resident was verbally and physically abusive to anyone in his path while trying to go into another residents room. The only intervention was to let his aggression run its course and keep other residents safe. Resident #113 proceeded to constantly hit/bang/kick the window and door of the secure door. The activity continued for 2 hours. Resident #113 was going room to room waking other residents by banging on doors and opening or closing doors. Interventions were attempted to redirect Resident #113 failed. At 3:20 AM Resident #113 finally went to bed and slept. Record review of Resident #113's Psychological Services progress note dated 5/12/24 at 10:24 AM indicated the focus of the session was emotional withdrawal, communication, and physical decline. Further review revealed sexually inappropriate behavior, or aggressive behavior was not addressed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #113's Psychological Services progress note dated 8/21/24 at 11:32 AM written by the LCSW indicated the resident was agitated when another resident wandered into his room. Further review indicated the resident did not like shared space and liked his privacy. Record review of a progress note on 11/24/24 at 6:05 PM written by LVN T indicated Resident #113 was following and yelling at his roommate calling him names as well as yelling at staff. Resident #113 would be upset when staff entered his room. He was redirected, told to calm down then continued to yell. Record review of Resident #113's progress note on 11/26/24 at 9:42 AM written by the Social Services Assistant indicated a care plan meeting with the RP was scheduled for 11/26/24 at 11:00 AM. Further review revealed there were no details regarding the outcome of the meeting. Record review of Resident #113's Psychological Services progress note dated 11/27/24 at 6:43 AM written by LCSW indicated he was agitated, frustrated with staff and another resident. Record review of Resident #113's Psychiatric progress note dated 2/6/25 written by the Psychiatric NP indicated the resident was improving but remained isolated and unable to tolerate a new roommate. Record review of progress note on 3/18/25 at 5:02 PM written by the ADON indicated Resident #113 was yelling, screaming and vocally aggressive to the nursing staff as he refused a shower. The ADON de-escalated the situation, and the resident later continued to refuse. The RP was notified. Record review of Resident #113's progress note on 3/23/25 at 12:07 PM written by RN F indicated at 12:45 PM the resident was observed threatening, grasping roommate in his wheelchair, telling roommate to leave the room. Record review of a progress note on 3/23/25 at 12:58 PM written by RN F indicated Resident #113 refused shower care and was reported to be hitting the staff. The resident was reoriented. Record review of Resident #113's progress note on 3/23/25 at 5:22 PM written by the SW indicated the SW left messages for the RP to report resident's increasingly aggressive behaviors. Further review indicated Resident #113 hit his roommate in the eye and they were immediately separated. Resident #113 remained in the office with SW while reaching out to a behavioral hospital for evaluation. Record review of Resident #113's progress note on 3/23/25 at 6:32 PM written by RN F indicated Resident #113 was reported by a CNA to be physically aggressive towards the roommate, verbally threatening and pushing the other resident's wheelchair. Record review of Resident #113's progress note on 3/23/25 at 7:47 PM written by RN F indicated the resident was kept separated from the roommate while waiting for transportation to behavioral center. Record review Resident #113's progress note on 3/23/25 at 9:44 PM written by LVN L indicated the resident was transported to the hospital at 9:00 PM accompanied by the RP. Record review of Resident #113's progress note on 3/23/25 at 11:40 PM written by the SW indicated the resident returned from the hospital. He was alert and calm and placed in a room alone. The resident was referred to Mental Health. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #113's progress note on 3/28/25 at 8:33 AM written by LVN L indicated the resident was transferred to another nursing facility. Record review of Resident #113's order summary report dated 04/22/25 indicated an order for behavior monitoring which included agitation, hitting, increasing complaints, kicking, cussing, aggression and refusing care every shift for use of Depakote starting 06/04/24. An order for Depakote 125mg tablet every 8 hours for mood disorder was started on 05/03/24. The last order change was on 02/26/25 for Depakote 250mg TID. An order for Memantine 5mg tablet twice a day for dementia was started on 5/16/24. An order for Melatonin 5mg at bedtime for insomnia was started on 5/20/24. In a telephone interview on 4/22/25 at 1:45 PM, LVN U stated the incident on 5/3/2024 when Resident #113 was inappropriately touching a female resident was reported to the Administrator at the time. LVN U did not recall the name of the female resident nor the details of what happened when asked about the inappropriate touching. In an interview on 4/22/25 at 2:25 PM the interim Administrator stated if a resident inappropriately touched another resident, they would be placed on 1:1 monitoring until sent out for evaluation, and that they did not need to be at the facility. In an interview on 4/23/25 at 9:20 AM, the Psychiatric NP stated it was concerning that Resident #113 even left his room. Had she known of Resident #113's sexual interaction with another resident, she would have assessed him and adjusted meds, have a talk with him and involve social services. He knew what he was doing, he was agitated and aggressive. The Psychiatric NP stated, he would have gotten away with it if he wasn't caught. If there were further events, he would have been discharged . Psychiatric NP stated she was not at the facility on 5/3/24 and did not start covering the facility until October 2024. The risks of having no interventions for behaviors would be residents could walk up to other residents, repeating the aggressive behavior and no one seeing it, and there would be risk of sexual abuse as well. She stated in the secure unit, every resident was supposed to be monitored, and there should not be residents with low BIMS scores wandering around. In an interview on 4/23/25 at 12:25 PM The DON stated sexual behavior should have been in the care plan for Resident #113. The MD should have been notified and the resident should have been transferred out for evaluation. The DON stated she was not at employee of the facility at the time of sexually inappropriate incident on 5/3/24. In a telephone interview on 4/23/25 at 3:20 PM, the SW revealed she was unaware of Resident #113 inappropriately touching a female resident on 5/3/2024. SW stated had she been notified, she would have talked to both residents involved. In an interview on 5/1/25 at 12:58PM, the Social Service Assistant stated she was not aware of Resident #113's sexual inappropriate behavior on 5/3/24. The Social Service Assistant stated if she had been aware then she would have immediately separated the residents, refer to psychologist and psychiatric services, and he would have to be removed from the facility. 2. Record review of Resident #114's face sheet dated 05/06/24 reflected a [AGE] year-old male first admitted to the facility on [DATE] and discharged on 03/26/25 to acute care hospital. His diagnoses included depression, personal history of suicidal behavior, dementia, tension headaches, hypertension, and hemiplegia (one sided paralysis). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #114's quarterly MDS dated [DATE] indicated he had a BIMS score of 9 out of 15 indicating moderate impaired cognition. Section E indicated he had no behaviors or refusals of care. He had impairment to one side of the upper body. He used a wheelchair for mobility. He required substantial assistance with most ADLs. Record review of Resident #114's undated care plan included: Focus - Resident had moods not easily altered by staff as evidenced by - history of suicidal behavior. Interventions included - notify physician if mood interferes with physical functioning, psych referral as needed. Focus - resident at risk for increased confusion and decline in ADLs as dementia progresses. Date initiated was 08/05/24. Interventions included - administer medications as ordered. Reorient resident daily as needed. Further review revealed verbal and physical aggressive behavior was not addressed nor was the physical altercation with the roommate Resident #113 on 03/23/25 addressed. Record review of Resident #114's chart revealed a progress note on 8/04/24 at 2:52 PM written by the SW indicated the Resident #114 reported a verbal altercation with another male resident resulting in an exchange of curse words. A referral to Psychiatry (Medication Management) was made on 8/4/24 by SW for anger outburst. Record review of Resident #114's Psychological Services progress note dated 8/27/24 at 4:55 PM written by the LCSW indicated a diagnosis of adjustment disorder with anxiety. Further review revealed anger outburst was not addressed. Record review of Resident #114's progress note on 11/12/24 at 2:07 PM written by The Social Service Assistant indicated he had agitation and verbal aggression towards his roommate. Resident #114 was then moved to a different room. Record review of Resident #114's Psychological Services progress note dated 11/21/24 at 5:12 PM written by the LCSW revealed verbal aggressive behavior was not addressed. Record review of Resident #114's progress note on 3/13/25 at 5:51 PM written by RN F indicated the resident was physically aggressive towards roommate and staff, threatening to kill the roommate. The resident refused collection of urine for test. The NP, DON and ADON were notified. Record review of Resident #114's progress note on 3/13/25 at 6:35 PM written by the DON indicated the resident was throwing drink containers out the door and at passing residents, yelling, cursing, and threatening staff. The resident was transferred to the ER for evaluation and the RP was notified. The resident returned to facility on 3/14/25. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #114's facility Behavioral Health note on 3/14/25 written by the Psychiatric NP for Medication follow up for dementia indicated Resident #114's medications were not adjusted at the ER visit, and he was tolerating medications with no problems. Further review indicated the resident expressed frustration regarding recent medical experiences including visit to the hospital. Further review indicated Resident #114 had psychiatric history of: combative, physical aggression, and confusion. Record review of Resident #114's progress note on 3/23/25 at 6:02 PM written by RN F indicated the resident told the nurse he was hit in his eyes by the roommate. Further review indicated he had discoloration to the left eye and the NP, RP, Administrator, DON and SW was notified. Record review of Resident #114's progress note on 3/23/25 at 7:35 PM written by SW indicated that Resident #114 verbally reported that his roommate hit him in the eye. Record review of the facility PIR (Provider Investigation Report) dated on 03/31/25 and signed by the acting Administrator at the time, indicated the incident of abuse by resident-to-resident altercation occurred on 03/23/25 at 4:30 PM involving Resident #113 and #114. The PIR indicated the incident was reported to the State on 3/24/25 at 5:00 PM. The report indicated Resident #114 alleged that the roommate, Resident #113 hit him in the eye and that it was not witnessed by any staff member. Resident #114 had redness to the left eye lid, denied pain and Resident #113 was unable to be interviewed to recall the incident. Each resident was sent out to the ER for evaluation. There were no delayed injuries for Resident #114 and Resident #113 was returned from psych hospital. The PIR indicated the incident occurred in the secure unit and that Resident #114 did not have capacity to make informed decisions and had the history of verbal and physical aggression as well as wandering. The PIR indicated that Resident #113 had a history of verbal and physical aggression as well as wandering. The PIR indicated the investigation findings were unconfirmed and the facility planned to find alternate placement for Resident #113 due to increasing behaviors. Further review indicated an emailed progress note dated 03/24/25 at 10:39 PM indicating Resident #114 was evaluated by the facility's LMSW and LCSW Therapists on 3/24/25. The progress note indicated Resident #114 reported that the roommate would sometimes become confused and agitated. Further review of the progress note indicated Resident #114 was calm and in no distress during the session. The PIR included the facility incident report dated 3/23/25 at 12:58 PM written by RN F. The incident report indicated RN F was notified by the CNA of Resident #113's physical aggression towards his roommate and that RN F observed Resident #113 verbally threatening and pushing the other resident's wheelchair in the hallway. The immediate actions taken residents were separated, kept away from each other by RN F and the attending staff in the unit. The DON and SW were notified. Further review of the PIR revealed no indication as to whether or not the Ombudsman and Law Enforcement were notified. The PIR did not include any statements by staff members. Record review of Resident #114's Order Summary Report dated 04/22/25 indicated an order for Venlafaxine extended release 37.5mg capsule daily for depression was started on 11/27/24. The most recent dose change was Venlafaxine extended release 75mg on 03/01/25. An order for Memantine 5mg tablet daily for dementia was started on 08/13/24. An order to monitor for side effects of antidepressant medication use every shift started on 11/27/24. Resident #113 had bronchitis and was treated with an antibiotic Azithromycin 500mg tablet every 8 hours beginning on 03/14/25 and ending on 3/19/25. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 4/20/25 at 9:30 AM, MA D said she recalled the incident between Resident #113 and #114. MA D stated Resident #113 originally was in the room by himself, and Resident #114 had a roommate that was discharged . MA D stated both residents resided in the same room on the secure unit. MA D stated the main cause of the incident was that Resident #113 would not allow Resident #114 to get into the room. MA D stated she knew they were not a good match because they would have arguments. MA D stated room changes do not work well with residents in the secure unit. Interview on 4/20/25 at 10:00 AM, CNA T stated that on 3/23/25 the altercation between Residents #113 and #114 took place in the secure unit hallway just outside the dining room. Resident #113 said to Resident #114 why are you going into my room!. Resident #113 grabbed Resident #114, there was a scuffle between the two men. CNA T stated they were swinging at each other, and she was in the middle trying to separate them. She stated she could not see if Resident #113 struck Resident #114 in the eye but that Resident #114's eye was red, and it was not red prior to that. CNA T stated Resident #114 had a pair of fingernail clippers in his hand. He was not supposed to have it; she did not know how he got hold of one. CNA T stated Resident #114 was afraid of Resident #113 because he would call him names; CNA T stated she reported to the nurse on duty. CNA T stated Resident #113 had taken swings at her in the past due to refusal of care. CNA T stated she would document and report to nursing but did not provide dates or names of staff. CNA T A stated Resident #113 and #114 should not have been put together as roommates due to their aggressive behavior towards one another which included arguing with one another. CNA T stated Resident #113 would get upset thinking the roommate was taking his stuff. CNA T stated she did not get a chance to write a witness statement regarding the altercation on 3/23/25. In an interview on 4/21/25 at 11:20 AM, the Social Service Assistant stated since Resident #114 did not want to get out of bed, he was a good roommate for Resident #113 and facility census increased so the two had to become roommates. The Social Service Assistant stated Resident #113 would be aggressive to other roommates in the past but never physical prior to the incident with Resident #114. Resident #113 had 2-3 roommates prior, and it always ended up not working because he would block roommates from getting into the room. The Social Service Assistant stated it was all documented in his chart and had multiple care plans with the family; he just did not want a roommate. In an interview on 04/22/25 at 10:06 AM, RN F stated MA D notified her about the incident between Resident #113 and #114. RN F stated she immediately notified the SW, ADON, DON she then walked into the secure unit and in the hallway, she saw both residents. RN F stated Resident #113 was upset, he pushed Resident #114's wheelchair and Resident #113 said to Resident #114, you cannot do that! RN F stated Resident #113 would often talk loudly when upset. RN F stated she heard about Resident #113 going into Resident #114's things but she did not witness that. RN F stated before they were roommates, they were friends talking and visiting with each other. RN F stated this was why they thought they would be compatible. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 4/22/25 at 11:50 AM, MA D stated she heard the commotion in the hallway and saw CNA T separating the Residents #113 and #114. She heard Resident #113 say Trash, trash! and usually when he says these things she knows he was very agitated. She did see Resident #114 with fingernail clippers and heard Resident #114 say he was going to use it as he waved it in his hand. A nurse took the clippers away but she did not have the name of the nurse. She did provide a statement to Administrator for the incident. MA D stated there were other incidents where Resident #113 would block the door with his bed and not allow his roommates to enter, saying it was his room. Resident #113 would curse out the staff as well. Incidents like that were reported to administration. MA D could not recall dates or who it was reported to. In an interview on 4/22/25 at 2:25 PM with the interim Administrator and the DON, the interim Administrator stated that combative residents should not be put together and that they would agitate and possibly beat each other up. The interim Administrator stated nail clippers would not be allowed as they could cut themselves, or someone could wander into room, pick it up and use it as a weapon. The interim Administrator stated families may not always comply and if aware then the rooms would be searched. The DON stated she was not notified of the nail clippers. The DON stated she was aware Resident #114 was threatening to kill his previous roommate (before Resident #113 was roommate) and he was then transferred to hospital for observations and returned to the facility. The interim Administrator stated she would not have accepted him back if she were the Administrator at the time. The interim Administrator stated she was unable to locate the completed facility investigation for the resident-to-resident altercation on 3/23/25. In a telephone interview on 4/23/25 at 7:25 AM, the previous Administrator stated an internal investigation was completed for the resident-to-resident altercation incident on 3/23/25 and that she did conduct staff interviews. She stated the incident was unwitnessed and did not report to law enforcement because it was a verbal altercation, and the residents had dementia and were confused. She stated later that day, it was reported that Resident #114 had been struck by Resident #113 in the eye and that was when she sent Resident #114 out to hospital for evaluation. In an interview on 4/23/25 at 9:20 AM, the Psychiatric NP stated Resident #113 did not want to have roommates and would block the door. The Psychiatric NP stated she also followed Resident #114 and was not notified of Resident #114 threatening to kill the roommate. She learned about it much later. Resident #114 had an increase in antidepressant medication Venlafaxine on 2/27/25, and probably was not appropriate to be in the same room as Resident #113 due to behaviors. The risk would be that one day they would get on each other's nerves, and someone could get hurt especially if they were physical. In a telephone interview on 4/23/25 at 9:21 AM, The Psychiatric NP stated that she was the Psychiatric NP for both Resident #113 and #114. The Psychiatric NP stated Resident #114 was not aggressive, didn't bother anybody, and stayed in bed depressed. Resident #114 was more with it and that he did not have anything in common with anyone in the secure unit. She stated, at one time in January 2025, Resident #113 had a roommate and had witnessed he was annoyed with the roommate who was in bed and nonverbal. Resident #113 would accuse that roommate of taking his belongings. This behavior was discussed with her by the SW and DON. Prior to that, Resident #113 was fine with the curtain between his bed and the roommate's bed. Resident #113 would remain on his side. By February 2025, Resident #113 was in a room by himself. Resident #113 and Resident #114 seemed like they got along well and would be fine as roommates. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 4/23/25 at 12:25 PM the DON stated after altercation on 3/23/25, Residents #113 and #114 were placed in separate rooms and no increase in staff were made, when asked how the other residents were protected. The DON stated there were no further incidents. In a telephone interview on 4/23/25 at 3:20 PM the SW stated she was notified of the resident-to-resident altercation between Resident #113 and #114 on 3/23/25. The SW stated they were immediately separated and then she worked on trying to find a different place for Resident #113. The SW stated Resident #113 did not do well with roommates. In an interview on 4/24/25 at 9:05 AM, the DON stated Resident #114 would be verbal with staff and refuse care and that Resident #113 would stay in his room, and she did not know much about him but knew he refused care. The DON stated behaviors, whether verbal or physical, should be in care plan and MDS, so everybody knows about the behaviors. DON stated they should not have been roommates. The DON stated Resident #113 and Resident #114 had never been roommates in the past and that the decision to put them together was made by a previous Administrator. DON stated she was not notified of verbal or physical behaviors from either resident prior to the incident on 3/23/25. She stated Resident #113 was placed on 1:1 until transport to hospital and upon return was back to a room by himself. The DON stated Resident #113 had no behaviors while in hospital but should have been placed on 1:1 monitoring until he was transferred out for good. In an interview on 5/1/25 at 12:58PM the Social Service Assistant stated Resident #113 did not like it when staff would come into the room to clean up the roommate and would then be pretty aggressive towards staff. The Social Service Assistant stated after any incidents Resident #113 would have, the Social Service Assistant would call family every day for family to try and calm down Resident #113. It would work for a few days and then aggression would repeat. The Social Service Assistant stated other interventions were psych services, adjustment to meds and emergency visits. It was discussed with the family about transferring him out, but he needed a secure unit. There was never a concern about other residents' safety around Resident #113 as he didn't come out of his room. The Social Service Assistant stated having a roommate would be a risk because Resident #113 could cause chaos, agitation, and this would be more harmful to other residents. The Social Service Assistant stated, in reality the facility could not meet his needs, he needed his own room because anyone put into his room would be a disaster. This was shared with previous management but there was a time the facility was bed locked except for his room and the Administrator or Owner placed Resident #113 with another resident. The Social Service Assistant stated Resident #113 had three different roommates on different occasions. The Social Service Assistant stated the concerns about Resident #113 having a roommate to the Administrator/Owner and was told it was not a private room. The Social Service Assistant stated it was unsafe to have another resident room with him because the roommate would not get the needed care when Resident #113 would deny staff from entering. The Social Service Assistant stated after the first roommate, Resident #113 was by himself for about 6 months before he had roommates. Resident #114 was his last roommate. All staff were responsible for non-allowable items and cannot search a resident room without cause and consent. Record review of the facility policy for Abuse and Neglect, effective date of October 2022 read in part: .It is the policy of the facility to administer care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations Types of abuse: 1. Physical, 2. Verbal . (continued on next page)

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	675078	A. Building B. Wing	06/19/2025

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 - Some	Record review of the facility policy for Behavioral Assessment, Intervention and Monitoring, dated in 2001, read in part: .Policy Statement .5. Residents will have minimal complications associated with the management of altered or impaired behavior .Management 1. The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm 11. The director of nursing, or designee, will evaluate whether the staffing needs have changed based on acuity of the residents and their plans of care. Additional staff and/or staff training will be provided if it is determined that the needs of the residents cannot be met with the current level of staff or staff training . This failure resulted in an identification of an Immediate Jeopardy (IJ) on 5/03/25. The Administrator was informed and was provided the IJ template on 05/03/25 at 1:58 PM. Plan of Removal (POR) was requested. The following Plan of Removal was submitted by the facility and was accepted on 5/06/25 at 7:19 PM: F600 Introduction: On 5/3/2025 at 01:58PM, the surveyor issued an Immediate Jeopardy F600 (IJ) template notification stating Regulatory Services had determined that the facility failed to protect the resident's right for Resident #113 and Resident #114 to be free from abuse. The facility failed to protect Resident #114 from a physical altercation on 3/23/25 where Resident #114 was sent to the ER for a red eye. The facility failed to address sexual behaviors in the care plan for Resident #113. All current residents could be at risk because of the failure to provide supervision. At the Time of the IJ it was noted that: 1. Both residents #113 and #114 were discharged prior to the change in ownership of the facility. Access to resident records that were closed prior to the change are not accessible by the current provider. 2. Resident #113 has been discharged safely from the facility on 3/26/2025. 3. Resident #114 has been discharged safely from the facility on 3/28/2025 . 4. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Neither resident has returned to the facility. As a result of the IJ

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to have evidence that the alleged violation was thoroughly investigated for (Resident #113 and Resident #114) reviewed for freedom from abuse and neglect. The previous Administrator failed to have evidence that the alleged violation was thoroughly investigated by indicating whether the Ombudsman or Law Enforcement were notified and include witness statements from staff members when a resident-to-resident altercation between Resident #113 and #114 occurred on 3/23/25. This failure could place residents at risk for abuse from altercations and could place the residents at risk of harm. Findings included: Record review of the facility PIR (Provider Investigation Report) #572498 dated on 03/31/25 and signed by the acting Administrator at the time, indicated the incident of abuse by resident-to-resident altercation occurred on 03/23/25 at 4:30 PM involving Resident #113 and #114. The PIR indicated the incident was reported to the State on 3/24/25 at 5:00 PM. The report indicated Resident #114 alleged that the roommate, Resident #113, hit him in the eye and that it was not witnessed by any staff member. Resident #114 had redness to the left eye lid, denied pain and Resident #113 was unable to be interviewed to recall the incident. Each resident was sent out to the ER for evaluation. The PIR indicated the incident occurred in the secure unit and that Resident #114 did not have capacity to make informed decisions and had the history of verbal and physical aggression as well as wandering. The PIR indicated that Resident #113 had a history of verbal and physical aggression as well as wandering. The PIR indicated the investigation findings were unconfirmed and the facility planned to find alternate placement for Resident #113 due to increasing behaviors. The PIR included the facility incident report dated 3/23/25 at 12:58 PM written by RN F. The incident report indicated RN F was notified by the CNA of Resident #113's physical aggression towards his roommate and that RN F observed Resident #113 verbally threatening and pushing the other resident's wheelchair in the hallway. The immediate actions taken: residents were separated, kept away from each other by RN F and the attending staff in the unit. The DON and SW were notified. Further review of the PIR revealed no indication as to whether the Ombudsman or Law Enforcement were notified. The PIR did not include any statements by staff members. Record review of Resident #113's face sheet dated 04/22/25 reflected a [AGE] year-old male first admitted to the facility on [DATE] and discharged on 03/28/25 to another facility. His diagnoses included dementia, persistent mood disorders, hypertension, chronic pain syndrome and muscle weakness. Record review of Resident #113's quarterly MDS dated [DATE] reflected he had a BIMS score of 6 out of 15 indicating severe impaired cognition. Section E revealed he had no behaviors or refusals of care. He used a wheelchair for mobility. He required supervision to moderate assistance with all ADLs. Record review of Resident #113's care plan with the closed date of 03/31/25 included: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus - resident had moods that were not easily altered by staff intervention as evidenced by persistent mood disorder, symptoms and signs involving appearance and behavior. Date initiated as 05/06/24. Focus - Resident was taking psychotropic medications and at risk for adverse reactions and behaviors. Date initiated was 05/06/24. Interventions included - Monitor for psychosis driven behaviors such as aggressiveness, combativeness, and report to physician. Focus - He had episodes of inappropriate behaviors and at risk for future episodes and injuries as evidenced by not allowing housekeeping to clean room, refusing care (becoming aggressive at times). Date initiated was 11/27/24. Focus - Resident reportedly hit his roommate in the eye. Date initiated was 03/23/25. Interventions included - refer to Medical Behavioral Hospital for inpatient geriatric psychiatric placement. Immediately inform resident to stop and separate from others when resident becomes aggressive. Record review of Resident #114's face sheet dated 05/06/24 reflected a [AGE] year-old male first admitted to the facility on [DATE] and discharged on 03/26/25 to acute care hospital. His diagnoses included depression, personal history of suicidal behavior, dementia, tension headaches, hypertension, and hemiplegia (one sided paralysis). Record review of Resident #114's quarterly MDS dated [DATE] indicated he had a BIMS score of 9 out of 15 indicating moderate impaired cognition. Section E indicated he had no behaviors or refusals of care. He had impairment to one side of the upper body. He used a wheelchair for mobility. He required substantial assistance with most ADLs. Record review of Resident #114's undated care plan included: Focus - resident at risk for increased confusion and decline in ADLs as dementia progresses. Date initiated was 08/05/24. Further review revealed verbal and physical aggressive behavior was not addressed nor was the physical altercation with the roommate Resident #113 on 03/23/25 addressed. Record review of Resident #113's progress note on 3/23/25 at 12:07 PM written by RN F indicated at 12:45 PM the resident was observed threatening, grasping roommate in his wheelchair, telling roommate to leave the room. Record review of Resident #113's progress note on 3/23/25 at 5:22 PM written by the SW indicated the SW left messages for the RP to report resident's increasingly aggressive behaviors. Further review indicated Resident #113 hit his roommate in the eye and they were immediately separated. Resident #113 remained in the office with SW while reaching out to a behavioral hospital for evaluation. Record review of Resident #113's progress note on 3/23/25 at 6:32 PM written by RN F indicated Resident #113 was reported by a CNA to be physically aggressive towards the roommate, verbally threatening and pushing the other resident's wheelchair. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #113's Clinical Census dated 4/22/25 indicated on 3/11/24 he was in a semi-private room on the secure unit and on 3/11/25 he was moved into the same room as Resident #114. He remained in the same room, without Resident #114, until discharge from the facility on 3/28/25. Record review of Resident #114's undated Clinical Census indicated on 1/25/25 he was in a semi-private room in the secure unit, the same room Resident #113 was moved into on 3/11/25. Resident #114 was moved to a different room on the secure unit on 3/23/25, away from Resident #113 until discharge from the facility on 3/26/25. In an interview on 4/22/25 at 2:25 PM, the Interim Administrator stated she would report suspected allegations of abuse to the state and would include contacting the Ombudsman and the police. She stated the timeline for reporting Abuse was within 2 hours. The Interim Administrator stated she would include interviews with the staff working for the last 48 hours prior to the incident as well as conducting safe surveys with the facility residents and conducting staff in services on abuse and neglect. She stated she did not find the rest of the investigation report. She stated she searched but was blocked on the electronic health records. In a telephone interview on 4/23/25 at 7:25 AM, the previous Administrator stated an internal investigation was completed for the resident-to-resident altercation incident on 3/23/25, and she did conduct staff interviews. She stated the incident was unwitnessed, and she did not report it to law enforcement because it was a verbal altercation, and the residents had dementia and were confused. In an interview on 4/24/25 at 9:05 AM, the DON stated it was important to thoroughly investigate abuse allegations to establish coordination with the QAPI program. She stated the Administrator would review reportable incidents, any Abuse allegations, review injuries, and discuss what happened and what the facility actions were. She said there were no changes to the Abuse policy and Residents #113 and #114 had already left by the time the QAPI was completed. Record review of the facility policy for Abuse and Neglect, effective date 10/2022 revealed in part: .VII. Reporting/Response .Have procedures to: .All allegations of abuse will be reported to HHSC immediately after the initial allegation is received .1150 B Any owner, operator, employee, contractor, or manager of the LTC facility has the right to report to the State Agency (HHSC), and at least one local law enforcement agency, any reasonable suspicion of crime against an individual who is a resident .

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 2 (Resident #18 and Resident #33) of 7 residents reviewed for enteral nutrition. - The facility failed to provide treatment and services, which included an abdominal binder, to prevent complications of enteral feeding due to Resident #18's behaviors of pulling on and pulling out her G-tube which resulted in: the resident pulling out her G-tube on 2 occasions (11/12/24 and 04/15/25) which required hospitalization to place a new tube; and on 1 occasion (03/27/25) the resident pulling on her G-tube and an IV pole falling on her head on. - The facility failed to provide treatment and services, which included an abdominal binder, to prevent complications of enteral feeding due to Resident #33's behaviors of pulling out his G-tube which resulted in the resident pulling out his G-tube on 3 occasions (02/04/25, 02/12/25, 02/23/25 and 04/15/25) which required hospitalization to place a new tube. An IJ was Identified on 04/17/25. The template was provided to the facility on [DATE] at 12:33 PM. While the IJ was removed on 04/22/25 the facility remained out of compliance at a scope of pattern 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 injuries, hospitalization, and death. Findings Include: Resident #18 Record review of Resident #18's Face Sheet dated 04/15/25 revealed, a [AGE] year-old female who admitted to the facility 01/14/21 with diagnoses which included: dysphagia (difficulty swallowing), high blood pressure, contracture of the right hand/ left hand and left foot, Dementia with other behavioral disturbance and anxiety disorder. Record review of Resident #18's Quarterly MDS dated [DATE] revealed, severely impaired cognitive skills for daily decision making, upper and lower extremity functional limitations in range of motion, dependent on staff for all aspects of self-care (eating, oral hygiene, toileting hygiene, shower/bathing, dressing), dependent on staff for all aspects of mobility, no physical/verbal behavioral symptoms directed towards others and no behavioral symptoms not directed towards others. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #18's Care Plan printed 04/15/25 revealed, focus- requires the use of feeding tube and is at risk of aspiration (accidental inhalation of food/fluids into the airway), weight loss and dehydration. Feeding tube is related to dysphagia; intervention- administer tube feeding and water flushes as ordered, monitor/document/report to the physician as needed for the following complications related to tube feedings . tube dislodged. Focus initiated 12/29/22- inappropriate behaviors: resident has episodes of inappropriate behaviors of an causing her oxygen tubing from constantly falling off her face onto the floor. Interventions- monitor and chart behaviors every shift and report progress to MD. Focus- history of spitting and crying out at times according to staff and chary review; intervention- referred to mental health services as needed. Focus initiated 02/07/21- resident has impaired communication,[family]reports he is the only one that can get resident to verbally communicate; intervention-[family]will assist with translation when needed, staff will monitor for facial grimaces and body language. , focus- signs and symptoms of anxiety like hypersensitivity, paranoid, nervousness and is at risk for further episodes of anxiety and injury; intervention- medication as ordered, redirect resident from source of anxiety. Resident #18's care plan did not include the resident pulling on or pulling out her G-tube. Record review of Resident #18's Order Summary dated 04/15/25 revealed, she did not have an order for an abdominal binder, or orders for monitoring of increased movement, restlessness, or agitation. Record review of Resident #18's Progress Notes from to 04/15/25 revealed: *11/12/24 at 11:56 PM- CNA informed nurse during care that resident had pulled her G Tube from her abdomen. Nurse went to assess resident and she was found with tube laying on her abdomen without any s/s of pain or distress. DON and Attending notified *11/13/24 at 01:03 AM- EMS arrived to transport resident to hospital *03/27/25 at 05:32 PM- Resident #18 pulled her feeding tube and IV pole fell on her head. The resident had no bumps and bruises, and the NP was notified *03/28/25 at 09:40 AM- From incident yesterday evening pole fell on resident head right eye and forehead bruises was noted this morning, resident is already on neuro checks. NP was notified A.DON as well resident medication was administered. *04/15/25 at 05:47 PM- Patient pulled her G-tube out. Nurse sent patient to hospital for replacement . Record review of Resident #18's EMR revealed, no orders for monitoring of behaviors associated with Resident #18 pulling on and pulling out her G-tube. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation and interview on 04/15/25 at 09:50 AM revealed, Resident #18 in bed with contracted feet and hands. The resident had a bruise with a scab and dry blood on her forehead, with her bed low to the ground and fall mat on the left side of the bed. The resident had a firm grip on her G-tube tubing, pulling it tightly and her abdomen was observed to rise as she tugged on the tubing. The surveyor immediately exited the room to notify facility staff. When the surveyor returned to the room with MA A the resident was no longer pulling on her tube but continued to pull her legs up and move her hands. MA A said the resident returned to the facility that morning from the hospital. The resident had large tan bandage strips loosely placed on top of the site where her G-tube entered her abdomen, there was no abdominal binder or other assistive device preventing Resident #18 from pulling out her G-tube. An observation and interview with LVN J on 04/15/25 at 11:15 AM revealed, Resident #18 squirming/fidgety/restless in bed, with her legs pulled up. There was tube feeding residue, not previously seen, on the resident's sheets and incontinent brief. LVN J said Resident #18 readmitted to the facility in the morning she pulled out her G-tube. She said the resident did not have an order for an abdominal binder, and a binder was not used to protect Resident #30 from dislodging her G-tube. LVN J said, she can have an abdominal binder. In an interview on 04/15/25 at 11:23 AM, the NP said she started following Resident #18, 6 weeks ago. She said the residents restless, fidgety, and squirming behavior is what she considered her baseline. The NP said she originally thought the resident's behaviors were due to a UTI so Resident #18 was treated with a course of antibiotics, but the behaviors remained when the medication was completed so she now believed she needed psych services. The NP said residents with excessive restlessness and continuous activity were at risk of pulling out their G-tube, so they should have an abdominal binder covering the tube which would prevent them from easily pulling out the tube. The NP said the resident did not have an order for an abdominal binder because she had not received any reports that the resident consistently pulled on her G-tube. She said the failure to have an abdominal binder on a G-tube resident with excessive movement and restlessness placed the resident at risk for the G-tube dislodgement, danger if the IV pole holding the feed falls leading to injuries. In an interview on 04/15/25 at 12:27 PM, MA B said Resident #18 always moved around and was restless. She said the resident had never had an abdominal binder, but she probably could use it. In an interview on 04/15/25 at 12:30 PM, MA A said he had worked at the facility for 8 years and Resident #18's normal behaviors included: agitation and trying to pull out her G-tube. He said the resident did not have an abdominal binder, so he put a sheet on top her G-tube to prevent her from pulling on it. In an interview on 04/15/25 at 12:35 PM, the DON said Resident #18 was non-verbal. She said the resident had always been grabby and fidgety and received psych services. In an interview on 04/15/25 at 12:38 PM, LVN J said Resident #18 just returned from the facility after she pulled out her G-tube and the IV pole fell and hit her head. She said she received an order for an abdominal binder from the NP and was waiting for central supply to deliver the binder. An observation on 04/16/25 at 07:47 AM revealed, Resident #18 in bed, with no abdominal binder in place. The resident was restless and taking off her clothing. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 04/16/25 at 07:48 AM, MA A said there was an order for an abdominal binder for Resident #18, but she did not have one on because it had not arrived at the facility. In an interview on 4/16/25 at 07:50 AM, LVN J said Resident #18 did not have an abdominal binder on. She put in an order for an abdominal binder for Resident #18 yesterday, but it had not arrived. In an interview on 04/16/25 at 11:27 AM, LVN H said Resident #18 was one of her residents. She said even though the resident is bedbound she did not stay in one place, moved her arms and legs around a lot and is very fidgety. LVN H said she worked with Resident #2 for the past two years and off-course she pulls out her G-tube but the staff could not restrict her. She said she had previously notified nursing management of the resident pulling on and out her g-tube, but no changes were made. She said on 04/15/25 at around 4 AM when she checked on the resident, she saw that Resident #18's G-tube was dislodged and the IV pole was on the floor. In an interview on 04/16/25 at 02:18 PM, RN A said Resident #18 was always fidgety and liked to play and pull on her G-tube. She said Resident #18 did not have an abdominal binder on the night 04/15/25, and she was never educated or informed about any interventions that should be in place to protect Resident #18. RN A said due to resident's movement and preference to pull on her G-tube she had communicated her concerns with nursing management and thought the resident needed an abdominal binder, but nothing was done. In an interview on 04/16/25 at 08:27 AM, the DON said she started her position in February 2025 and Resident #18 always had behaviors that included pulling on her G-tube. She said in March 2025 the resident pulled on her tubing which caused the IV pole holding her feeding to fall and hit her in the head leading to an injury. After the incident, the resident had neuro checks in place to confirm she did not have a change in condition and the IV pole was moved to the other side of the bed. The DON said Resident #18's behaviors were discussed in an IDT meeting, and it was decided a GDR was contraindicated and the only intervention in place after the incident in March was the NP ordering labs. In an interview on 4/16/25 at 03:48 PM, the DON said an abdominal binder was ordered from their vendor, but it had not arrived yet, so the staff were monitoring Resident #18's behaviors. She said Resident #18's abdominal binder was expected to arrive on 04/17/25 . Resident #33 Record review of Resident #33's Face Sheet dated 04/17/25 revealed, a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included: chronic respiratory failure, asthma. Bipolar disorder, severe with psychotic features, paraplegia(paralysis of legs and lower injury), Gastrostomy and Tracheostomy (opening in neck to access the windpipe). Record review of Resident #33's Quarterly MDS dated [DATE] revealed, severely impaired cognitive skills for daily decision making. The resident had no behavioral symptoms present including physical or verbal behavioral symptoms towards others and no other behavioral symptoms towards others (hitting or scratching self, pacing, rummaging or disruptive sounds) (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #33's undated Care Plan printed 04/17/25 revealed, Focus- risk of aspiration r/t feeding tube in place; intervention- report N/V, absent bowel sounds to MD and RP. Focus- history of depression and is at risk of episodes of depression, adverse reactions and depression driven behaviors; intervention- monitor for impeding episodes of depression- document any noted in clinical record, prove psych consult per order. Record review of Resident #33's Order Summary dated 04/17/25 revealed, she did not have an order for an abdominal binder prior to 04/15/25. Record review of Resident #33's Progress Notes from 01/16/25 to 04/17/25 revealed, Resident #33 pulled out or pulled on his G-tube on the following days: 02/04/25- Residents G-tube was dislodged 02/12/25- Residents G-tube was dislodged and he was sent out to the Hospital 02/23/25- Resident pulled out his G-tube and was sent out to the hospital ER for G-tube placement. 02/25/25- Resident was found pulling on G-tube around 9 am. Resident was cleaned up and abdominal binder was applied. 04/15/25- Residents G-tube became dislodged and he was sent out to the hospital ER of G-tube placement. In an interview on 04/16/25 at 09:18 AM, the MDS Nurse said she had been in her current position for 8 to 9 years but worked in the facility for 19 years. In an interview on 04/17/25 at 11:31 AM, the DON said Resident #18's abdominal binder had not arrived at the facility yet. In an interview on 04/16/25 at 11:40 AM, the MDS Nurse said she was responsible for completing resident care plans. She said the care plan functioned as a plan of how to care for a resident. The MDS nurse said everything needed to care for a resident should be included, day to day tasks/care, wound status, behaviors, diagnosis, code status, and weight management. She said if a resident had behaviors, those behaviors should be included in their care plan with specific details that include the type of behaviors and should include goals and interventions. The MDS Nurse said incorrect care plans posed no risks to residents because nobody looks at the care plan except state. She said staff do not look at resident care plans to determine how to care for residents but received care information from reports, documentation, and verbal communications. The MDS nurse said she did not know about Resident #18's continuous behaviors of pulling at and on her G-tube and she only knew that the resident had once pulled on her IV pole causing it to fall and injury her. She said based on the behaviors she now knows Resident #18 displayed, the resident's care plan should have had a focus area addressing them. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 04/17/25 at 12:50 PM, the DON said she took the role at the facility in February. She said the purpose of the care plan is to provide guidance for patient care and resident needs. The DON said she was responsible for the accuracy and completion of the care plan, but the MDS nurse is the person who actually completes the care plan. She said each resident's care plan should address their: diet, code status, diagnoses, treatments received and behaviors. The DON said the care plan triggers everything the nurses do for the residents and lets them know what interventions they need to implement. She said inaccuracies in the care plan can result in missed treatments or interventions and in Resident #18's case it led to the resident pulling out her G-tube, injury, and hospitalization to replace her G-tube. The DON said she was not aware of Resident #18's behaviors of pulling on and out her G-tube, she was not aware those behaviors were not in the resident's care plan, but it should have been. Record review of the facility policy Assistive Devices and Equipment with no revision date revealed, our facility provides, maintains, train s and supervises the use of assistive devices and equipment for residents. 1- devices and equipment that assist with resident mobility, safety and independence are provided for residents. 2- recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident's record. An IJ was Identified on 04/17/2025. The template was provided to the facility on [DATE] at 12:33 PM. The following Plan of Removal submitted by the facility was accepted on 04/18/2025 at 07:52 PM and the Administrator was notified on 04/18/25 at 08:01 PM. {Facility Name] 4/18/2025 Plan of Removal F689 On 4/17/2025 at 12:33 PM, the surveyor provided an Immediate Jeopardy (IJ) template notification stating Regulatory Services had determined the facility failed to provide adequate supervision and assistance devices to prevent accidents. The facility failed to provide supervision and/or devices to prevent Resident #18 from pulling her G-tube which resulted in: an injury after the IV pole fell and hit her in the head and her G-tube being dislodged on 2 occasions. 1. Immediate Action: o The Director of Nursing immediately reassessed Resident #18 to validate the resident's G-tube was in place, patent, and medication/nutrition was being administered per provider orders. An abdominal binder ordered on 4/15/2025 after displacement was received 4/17/2025 and applied per provider orders. No other concerns were identified. Resident #18 tolerated the application of device well and exhibits no distress . o The MDS Coordinator updated and revised Resident #18 care plan to include provider orders for G-tube, any current/historical behaviors including agitation, fidgeting, and attempts to remove or dislodge the G-tube. Care plan revisions include interventions to prevent/reduce displacement of G-tube and requirement of documenting provider notification of any changes in behavior specifically related risk of G-tube displacement. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Start Date: 4/17/2025 Completion Date: 4/17/2025 Responsible: Administrator Immediate Action: o The Director of Nursing/Designee immediately conducted a review of all facility residents and determined 13 residents were currently receiving nutritional feeding through a G-Tube/Peg Tube. All 13 residents were immediately assessed to validate tubes were secure and patent. Further assessment included a 7 day look back record review to determine that there are no new changes in behavior, increased agitation, or fidgeting related to potential risk of G-Tube/Peg Tube displacement. o The Director of Nursing determined that 4 of the 13 residents receiving nutritional supplements via G-Tubes/Peg Tubes, including Resident #18, would potentially benefit from the use of an abdominal binder. The abdominal binders were previously ordered from the supply vendor and received, provider orders were obtained, and all abdominal binders have been applied to applicable residents and applicable residents are tolerating well with reduced risk of displacement. o It was identified in the expanded sample that 1 of the 13 residents [Resident #33] receiving nutrition via G-tube/Peg Tube had also displaced feeding tube on 2/4/25, 2/12/25, 2/23/25, and 4/15/25. After interview with staff, it was determined that residents is restless, and fidgets and these behaviors have been noted in a progress note dated 4/18/25. The MDS was opened with an ARD (Assessment Review Date) of 4/21/25 to capture these behaviors. The care plan has been revised. The resident is currently receiving physical therapy for range of motion and bed mobility. An occupational therapy eval has been requested. o The MDS Coordinator completed updates/revisions for the 13 resident care plans that included noting any current or historical behaviors (7 day look back) related to potential displacement of G-Tube/Peg tube and validated that if behaviors were identified, interventions included actions to take to reduce risk of displacement and documentation of provider notification. New orders for abdominal binders and monitoring for 4 of the 13 residents have been added to care plan interventions to assist in reducing the potential displacement of G-Tubes/Peg Tubes as applicable. Start Date: 4/17/2025 Completion Date: 4/18/2025 Responsible: Administrator Immediate Actions: o The QAPI Committee reviewed the policies and procedures regarding enteral feeding, safety precautions to validate accuracy. Added to the policy were recommendations to assist nursing staff when residents exhibit behaviors of attempts to remove tube i.e.: pulling, fidgeting, restlessness. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o The Director of Nursing/Designee provided training to nursing staff who provide care to residents who receive nutritional feeding via a tube. Staff will not be allowed to provide direct resident care until training has been provided. o Training included validating G-Tube/Peg Tube is secure, patent, and provider orders for med/nutrition are administered per orders. o If resident is exhibiting restlessness, agitation, or changes in behaviors related to obstruction/removal of a G-tube will be documented in the resident record which pulls to the 24 hour report and the Provider/Director of Nursing are to be promptly notified and increased supervision is implemented to maintain tube replacement and patency until root cause of increased restlessness, agitation, changes in behavior are determined. o Completed a return determination with nursing staff on proper placement of G-tube and securing abdominal binder to validate competency. Start Date: 4/17/2025 Completion Date: 4/17/2025 Responsible: Administrator Immediate Actions: o The Director of Nursing/Designee will monitor residents with G-Tubes/Peg Tubes including those that require supportive devices such as abdominal binders that reduce the risk of tube displacement q shift and as needed to validate correct placement and patency of tubes for residents who currently have provider orders. If concerns are identified, immediate corrective action will be implemented, provider notified, and applicable staff re-educated. o The Director of Nursing/Designee will monitor changes in behavior including increased agitation and restlessness daily to promptly determine a root cause and ensure appropriate interventions have been implemented timely on the care plan to reduce potential negative outcomes, including displacement of G-Tube/Peg Tube. o An ad-hoc QAPI meeting was held, and the facility medical director was notified of the deficient practice and plan of removal. The Plan of Correction will be reviewed monthly during the QAPI meeting for the next 3 months and as needed until a lesser frequency is deemed appropriate. Meeting minutes will be taken and maintained for 12 months. Start Date: 4/17/2025 Completion Date: 4/17/2025 Responsible: Administrator Monitoring of the POR. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation on 04/19/25 at 12:25 PM revealed, Resident #18 in bed with an abdominal binder on. An observation on 04/19/25 at 12:29 PM revealed, Resident #33 with an abdominal binder on. In an interview on 04/19/25 at 01:01 PM, MA B said she received training on G-tube safety on 04/16/25. She said the training addressed how to address active/agitated residents with G-tube, ensuring interventions like abdominal binders are in place, ensuring the resident is safe and administering medications as ordered if necessary. MA B said the training reinforced that G-tube residents with increased agitation could be at risk of dislodgement and the IV pole falling on them. In an interview on 04/20/25 at 06:45 AM, LVN H said she was trained on 04/17/25 about G-tube safety. She said Resident #18 moved around a lot and had a tendency to pull on and out her G-tube, . In an interview on 04/20/25 at 08:55 AM, MA A said he had not received any training on G-tubes, Care Plans or Accidents/Supervision. An observation on 04/20/25 at 08:57 AM revealed, Resident #22 in bed with an abdominal binder in place. An observation on 04/20/25 at 09:05 AM, revealed Resident #18 in bed with an abdominal binder in place. The resident was calm, in no immediate distress and did not have concerning body movement. In an interview on 04/20/25 at 09:00 AM, CNA K said she received training on G-tube safety in the previous week. She said if a resident with a G-tube was agitated they were expected to report it to the nurse and ensure an abdominal binder was on if there was an order. In an interview on 04/20/25 at 09:05 AM, LVN J could not answer what in-services she received and had to be prompted by the surveyor. She said she received training on G-tubes and care plans on 04/17/25 and 04/20/25. LVN J said when a resident on a G-tube has behaviors nurses are expected to document the incident in the chart and report it to management, while CNAs document behaviors in the POC and report it to their nurse. She said when residents with G-tubes become agitated they are at risk of dislodgment so nursing staff should initiate interventions like an abdominal binder if there is an order for one and notifications should be sent out. In an interview on 04/20/25 at 09:07 AM, the ADON said she completed training with staff on 04/17/25 regarding G-tube Placement, Behaviors and Abdominal binders. She said staff were educated that residents who are agitated, fidgety, constantly moving/irritated should be documents on having behaviors in the POC or the progress notes. The ADON said staff were trained that these residents are at risk of dislodgement and can also pull-down equipment. She said the training addressed reporting and documenting behaviors that increase risk of G-tube dislodgement, sending notifications and interventions that should be in place. The ADON said she also did training on resident care plans and how documentations played into the development of care plans, where to find a resident's care plan and how to review the interventions in place. She said this training was provided to CNAs, CMAs, Nurses, RTs, and anyone who provided care to residents., In an interview on 04/20/25 at 10:21 AM, LVN B said he had not received any training about G-tube safety and his knowledge was based on basic nursing. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 04/20/25 at 01:10 PM, the MDS Nurse said she received a 1-on-1 training from the Interim Administrator regarding care plan timing & accidents, incidents on 04/17/25 and training regarding G-tubes on 04/18/25. She said the training reinforced that she should know about resident behaviors such as pulling on and pulling out their G-tube and make sure there is the appropriate documentation. The MDS Nurse said behaviors should be tracked, orders should be in place for a binder, the binder must actually be used/in place on the resident and such orders must be in the resident's plan of care. The MDS nurse said even though the MDS is only a 7 day look back the behaviors should be documented in the resident's plan of care. The MDS nurse said she was educated that all behaviors should be documented in the care plan even if it were the resident's baseline behaviors because agitated residents are at risk of pulling out their G-tube which could result in rupture, injury, trauma, infection, and hospitalization. In an interview on 04/22/25 at 04:56 AM, RN A said she received training on G-tube safety the previous week and on 04/21/25. She said the training focused on preventing G-tube dislodgement with the use of a binder. RN A said when a resident with a g-tube is agitated or has increased movement nursing staff are expected assess the resident and if needed apply an abdominal binder or get an order for an abdominal binder. She said resident behaviors are to be documented in the resident's chart and interventions such as repositioning, medications administered as ordered, and notification sent to the MD/NP because increased behaviors/movement can place residents at risk of dislodgement, bleeding, bloating and infection. RN A said documenting any incidents that occur is important because it plays into the resident's care plan. In an interview on 04/22/25 at 05:01 PM, RN E said he received training on G-tube safety on 04/21/25. He said if a resident with a G-tube had behaviors such as fidgeting and pulling on the tube they should not be ignored, they should be assessed and interventions such as abdominal binders or PRN meds should be in place. RN E said if a resident even if these behaviors are continuous staff should document it whenever they see it because it plays into the care plan. In an interview on 04/22/25 at 05:05 AM, CNA X said he did not receive any training on G-tubes, care plans or behaviors in residents with behaviors but if a resident was observed pulling on their G-tube staff should ensure interventions like abdominal binders are in place, notification should be sent to their nurse and document the behaviors in the POC to prevent dislodgement. In an interview on 04/22/25 at 05:09, RT A said he had not received in-person training on G-tube safety but had received a text message on some trainings and asked if he could pull it up. RT A was not able to verbalize independently what the training he received was but read from his text that residents with increased agitation were at risk of dislodgement or injury so the nurse should be notified and the behaviors document. An observation on 04/22/25 at 05:20 AM revealed, Resident #18 in bed, with no abdominal binder on. In an interview on 04/22/25 at 05:25 AM, CNA A said she received training regarding G-tube safety on 04/20/25. She said when a resident with a G-tube was agitated or fidgety she is expected to observe them and document it in the POC. CNA A said Resident #18 did not have an abdominal binder on because it was only required when the resident was agitated which she was not at this time. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 04/22/25 at 05:29 AM, LVN B said he received training on G-tube safety on 04/21/25. He said residents with G-tubes that experienced behaviors were at risk for dislodgement, so they must notify the MD to receive an order for an abdominal binder or use one if order was in place. LVN B said Resident #18 did not have an abdominal binder in place because she only required one when she was agitated. In an interview on 04/22/25 at 08:50 AM, LVN D said she received training on G-tube safety on 04/21/25. She said residents with G-tubes that are fidgety are considered as having behaviors and that should be documented. In an interview on 04/22/25 at 09:18 AM, MA C said she had not received any training on G-tube safety. In an interview on 04/22/25 at 01:55 PM, MA C said she received training that day regarding residents with G-tubes displaying behaviors, communication & notifications of behaviors and the application of abdominal binders as ordered. She said if a resident with a G-tube was agitated they were at risk of G-tube dislodgement so interventions should be in place as ordered, nurse notified, and observations document ed in the residents POC. MA C said residents with behaviors like Resident #18 should have binders in place at all times except when care is provided. An observation on 04/22/25 at 02:00 PM, revealed Resident #22 sleeping in bed with her family member at her bedside. The family member said the resident currently had an abdominal binder on and had extra ones in her nightstand. In an interview on 04/22/25 at 02:18 PM, with the Interim Administrator and the DON, the Administrator said the facility performed an audit and identified 5 residents with a history of behaviors associated with pulling out their G tube. She said those resident's care plans have been updated, every shift monitoring has put in place and signs to have abdominal binders in place are located above the resident's beds. The Administrator said the facility failed to have a structure in place to track residents with behaviors. The DON said prior to the IJ notification the facility did not have interventions in place for G-tube residents with behaviors but now training was provided to CNAs, Nurses, RT about these behaviors, documenting behaviors, the use of abdominal binders and signage placed above the bed of residents that require abdominal binders. The DON said since the IJ notification the MDS nurse and

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure a resident who displayed or was diagnosed with a mental disorder or psychosocial adjustment disorder received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being for 3 of 8 residents (Resident # 30, Resident #42 Resident #52) reviewed for treatment and services for mental and psychosocial concerns. - The facility failed to provide appropriate treatment and services to prevent and correct Resident #30's escalating behaviors which resulted in a suicide attempt on 04/13/25 and the resident attempting to draw a police officer's firearm when she had to be forcefully restrained and removed from the facility. - The facility failed to provide appropriate treatment and services to prevent and correct Resident #52's escalating behaviors which resulted in suicide threats and an incident on 05/03/25 when the resident had to be forcefully restrained and removed from the facility. - The facility failed to provide treatment and services to correct Resident #42's continuous behaviors of pacing up and down the secure unit, banging on the doors, getting in residents and staff faces, touching their shoulder while asking if his RP was dead. An IJ was identified on 05/03/25. The template was provided to the facility on [DATE] at 01:58 PM. While the IJ was removed on 05/08/25 the facility remained out of compliance at a scope of pattern 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. The IJ was called again on 06/07/25. The template was provided to the facility on [DATE] at 07:03 AM. While the IJ was removed on 06/19/25 the facility remained out of compliance at a scope of pattern 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 minor and major injuries, suicide threats, attempted suicide, hospitalization, and death. Resident #30 Record review of Resident #30's Face Sheet dated 05/02/25 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included: spinal cord injury, anemia, nicotine dependence, Schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder), bipolar disorder (mental health condition characterized by extreme mood swings, ranging from periods of intense happiness or irritability (mania or hypomania) to periods of deep sadness or despair) with sever psychotic features (hallucinations (seeing or hearing things that aren't real), delusions (false beliefs), and disorganized thinking) and paraplegia(paralysis of the legs and lower body, typically caused by a spinal cord injury). (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #30's previous facility Progress Notes dated 12/26/24 at 02:21 PM revealed, Resident says she is hearing things and people talking about her. She is under mental distress. She is wanting to go to the psych hospital. Resident stated she no longer wanted to be here. Record review of the Resident #30's Quarterly MDS revealed, intact cognition as indicated by a BIMS score of 14 and use of antipsychotic medications during last 7 days. There were no evidence of an acute change in mental status, and no behaviors present. She had no potential indicators of psychosis such as hallucinations or delusions. Record review of Resident #30's undated Care Plan revealed, focus- history of being resistant to care at times and is at risk for injury; intervention- approach in a calm manner, talk while giving care. Focus- taking psychotropic medications and is at risk of adverse reactions and (depression, anxiety, and/or psychosis driven behaviors; interventions- monitor for psychosis driven behaviors such as aggressiveness, combativeness, manic episodes, observe and record any displayed behaviors or mood problems. Focus- Resident #30 verbalized suicidal ideations and became physically aggressive with police related to her diagnosis of bipolar and or anxiety, date initiated 04/13/25; interventions- provide medications as ordered, resident will be assisted with discharge planning as when needed, resident will be referred to inpatient geri psych placement as when needed, call 911 with request for the mental health team as/when needed. Record review of Resident #30's Progress Notes from 12/31/24 to 05/02/25 revealed : 01/01/25- EMS arrived at facility stating they received phone call from facility. This nurse was notified by CMA that this resident called EMS. Resident states that she is not feeling well and wants to go to the Hospital. Resident did not notify this nurse that she was not feeling well prior. Resident called EMS instead. EMS assessed resident. No abnormal findings. EMS spoke with resident about receiving care in facility before calling 911. Resident continues to state that she wants to go to the hospital. 01/02/25- Resident called 911 for pain pill when her pain was just due to be given to her, every effort to advise her to take her pain pill yield no result as she wants to go to hospital, NP made aware, administrator made aware, resident insisted on going to hospital, picked up in stable condition. 01/12/25- Note Text : On rounds at 7:04am resident did not complain of any discomfort, distress, or concerns, noted vaping in the room, was educated by this nurse that vaping is not proper and not allowed in the room, resident did not listen, but continue vaping. At about 7:54am, 911 ambulance arrived facility stated resident called them, complained of pain to lower back, sediment in urine, and brown urine output. Resident has UA result and labs pending ,this explained to resident Norco 5-325mg offered, resident refused, and still insisted going with 911 to the hospital, transferred by 911 to hospital ,per resident request. Resident is self-RP.NP notified. 01/22/25- SW informed nurse that resident was seen by Psych services today and was told that resident may be going through a manic episode. Resident is currently in bed with NAD. Given PRN pain medication. resident has no plan to harm herself stayed she is just little down today. MD informed stated to monitor for now and call her for any changes. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	01/24/25- Resident informed SN that she called 911 due to pain on her lower back. Education provided on pain management such as other ways to manage pain without medications such as deep breathing, exercise , music therapy and others , resident verbalized understanding but still want to get stronger medication . NP notified . patient has been medicated with Norco Tablet 5-325 MG every 4 hours as needed, last one was at 1034am. Sn will continue to monitor. 01/31/25- Resident signed herself out after requesting (2) cigarettes. Resident was then transported to the ER by ambulance. Family notified. DON Notified. 02/01/25 at 08:01 AM- Resident requested cigarette, received her cigarette, signed out to go smoke out front where she then called 911 and requested transport. Resident would not specify where she wanted to be transported to. 911 arrived around 0710 and took resident on a stretcher to the ER. 02/01/25 at 03:15 PM- Resident returned from the hospital . Resident still appears anxious upon return and immediately returned to nurses' station to sign out with (4) cigarettes as of 0325 resident is signed out of the facility. 02/13/25 at 10:49 PM- Resident called 911 by herself twice this evening at 7:30pm and 9:40pm stating that she wants to go to the hospital because she is having spasms. Charge nurse informed her that he can notify her doctor and see if she can be given some new orders, but she refused. EMS arrived the first time and resident refused to go to the hospital they intended to transport her to. The second time the EMS arrived and took resident to Hospital at 10:00pm. 02/24/25- Note Text: At 21:30 hrs (09:30 PM), resident called the EMS via 911, requesting to be taken to the emergency room due to spasm and pain. Resident had already received her scheduled pain medication (Norco) at 20:00 hrs. Resident had not complained to Charge Nurse about being in pain prior to her calling 911, and charge nurse was not aware that she had called EMS 911 until the emergency personnel showed up in the unit. Resident was taken to the emergency room as she requested by the EMS technicians at 21:40 hrs. 03/02/25- Resident complains of hearing voices making fun of her, she said had been going on for a while now, she stated that she did not complain initially because she thought they might go away, but they getting louder, depriving her sleep. This morning observed resident in her sleep saying, stop stop stop. Resident also have diagnosis of schizophrenia and mild sleep disorder.NP notified, order received to consult psych. Order carry out. 03/08-25- Resident called EMS via 911, and they took her to the hospital at 18:45 hours for complaint of pain. Resident's emergency contact (family member)' and facility DON notified. (continued on next page)

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	675078	A. Building B. Wing	06/19/2025

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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	03/19/25- Resident came to Charge nurse and requested for her nightly medication to be administered to her, which was done. After taking her medications, she informed the Charge Nurse that she had called 911 so she can be taken to the hospital due to pain. Charge Nurse advised resident to give her pain pill (Norco) which she just took, time to become effective but she refused, insisting to go to the hospital. Charge nurse noted ant acute distress on resident both in her speech and behavior. Resident then wheeled herself in her wheelchair to the reception area awaiting the arrival of EMS ambulance. Upon arrival to the facility, the EMS personnel spoke briefly with resident and loaded her on their stretcher without asking the charge nurse any questions or informing him where they were taking resident to. When charge nurse inquired from them where they were taking resident to, they simply told him the hospital name and continued on. Facility Director of Nursing was notified. 03/22/25 T 05:53 AM- Behavioral Note-Resident removed her brief after ADL change claimed is too big despite the brief been her size and the large size that could be used for her. 03/22/25 at 10:09 AM- : Resident was observed alert and oriented with behavior, screamed , yelled, took clothes off. Attempted to talked to resident several times with no effect. NP. was notified order given Alprazolam 0.5mh twice a day for fourteen days for anxiety. 04/13/25 at 01:39 AM signed by LVN H- Patient called 911 at 11:00pm and had been disturbing other patients from sleeping. The two EMS that came refused to take her to hospital stated she has no good reason to go to hospital. Patient received all her pain med and other prescribed med, throwing stuff on the floor including her phone. Patient is threatening to kill herself. Nurse notified the physician, DON, and Administrator. 04/13/25 signed by SW- SW informed per staff that this resident had verbalized wanting to kill herself. SW visited with this resident, and she verbalized I tied something around my neck but, I could still breathe. I want my Xanax back. I want my Xanax back. I am going to get my Xanax back. SW attempted to contact resident's [family member], , unable to reach and voicemail full. Resident began to yell and scream as she exited the office. Staff was present to maintain visual of her per SW request while 911 contacted with a request for the Mental Health Response team. Upon 911 arriving officer was provided with the aforementioned information. He spoke with resident, and she informed him that she wanted to kill herself. He called for assistance and another officer arrived whom also spoke with resident and then SW observed resident began to hit the officers resulting in them restraining her until approximately 4 more officers arrived. SW was informed per that she was being transported to Hospital and that the District Attorney would be contacted but they were doubtful any criminal charges would be filed against her. SW informed the DON and LNFA and was able to contact her [family member] and informed him. He verbalized understanding. Care Plan updated to reflect. Record review of Resident #30's Hospital Progress note dated 04/22/25 at 01:22 PM revealed, Resident #30 continued to throw tantrums and screamed, covering her face with her pillow. The resident was requesting IV pain medication. Record review of Resident #30's Hospital Progress note dated 04/23/25 at 12:01 PM revealed, Resident #30 continued to throw tantrums and requested IV pain medication despite being notified that she was on oral pain medication. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #30's Hospital Progress note dated 04/24/25 at 11:52 AM revealed, Resident #30 called 911 from her hospital room and pretend to sleep when the MD entered her room. Record review of Resident #30's Hospital Psychiatric Consultation note dated 04/24/25 at 12:00 AM, revealed Resident #30 had bipolar disorder with discrete periods of mania and discreet periods of depression. She had poor impulse control and a history of PTSD and had attempted fake suicide in the past on multiple occasions by either choking herself or overdosing on medications. Resident #30 had a history of ideas of persecution, thinking that people were going to hurt her or that something negative was going to happen to her. Resident #30 had a history of auditory hallucinations commanding her to wrap a cord around her neck or to overdose on Seroquel. In the past Resident #30 contemplated starting a fire in her apartment following the command of the voices she heard, and she wished she had a weapon to hurt hospital or nursing staff. Resident #30 was admitted to a behavioral hospital in February of 2021 and in November of 2023 she was admitted to the hospital after typing a collar on her neck to kill herself. Record review of Resident #30's Progress Notes on 05/01/25 at 02:48 AM revealed, Note Text : Resident called EMS and requested to be taken back to the hospital for evaluation. Resident indicated to EMS personnel that she feels nauseated, dehydrated, and is not getting enough pain medications. Resident had not complained to Charge Nurse about any of these concerns tonight. Resident had received her nightly medications as ordered, including her PRN Norco pain medication. Charge Nurse offered to call resident's PCP to see if there may be any new orders, but she refused, stating her preference to go to the hospital. Upon resident's insistence to go to the hospital, EMS personnel took her to hospital. Record review of Resident #30's Order Summary Report that included all orders since admission on [DATE] and printed 05/02/25 at 01:50 PM revealed, Resident #30 had no behavior monitoring and behavior intervention orders. Record review of a 30-day lookback of Resident #30's Behavior Monitoring and Interventions dated 05/09/25 revealed, no documented behaviors observed prior to 05/09/25. On 05/09/25 at 10:30 AM Resident #30 was screaming and expressed frustration and angers at others. An observation an interview on 05/02/25 at 01:12 PM revealed, Resident #30 sitting in a wheelchair at the nursing station. There were other residents around her and no nursing staff within 15 feet on both sides of the nursing station. The resident said she just returned to the facility from the hospital, and she felt better now. Resident #30 said the voices got too loud so she hit herself in the face and tied a pillowcase around her neck to harm herself to stop the voices, but she could still breathe. As Resident #30 talked to the surveyors she swayed left to right & back and forth in her wheelchair. Resident #30 said she did not notify any staff of the voices prior to trying to harm herself but when she went to the hospital, they fixed her meds, so she did not hear the voices anymore and she did not want to harm herself. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 05/02/25 at 12:33 PM, the SW said Resident #30 was young and had obsessive drug seeking behaviors r/t to complaints of significant pain. She said the resident would call the police 1-2 times a week and had been hospitalized at least 6-7 times since admission. The SW said Resident #30 always yelled at staff and yelled to go to the hospital. The SW said in April she was notified that Resident #30 wanted to hurt herself. She said she first talked to the resident on the phone and then again when she arrived at the facility. The SW said Resident # 30 told her she tried to hurt herself by tying something around her neck, but she could still breathe, the resident became loud and said she was going to hurt herself, so she called 911 for a mental health response team. She said when the police arrived Resident #30 wheeled herself away from them down the hallway as they spoke to her and when both police officers approached her, Resident #30 started to scream and fought the police. The SW said Resident #30 attacked the police, the police tried to restrain her, the police drew then their guns and pointed them at the resident and Resident #30 was eventually handcuffed. She said Resident #30 was a risk to other patients because of her unpredict ableness. In an interview on 05/02/25 at 01:05 PM, MA C said Resident #30's normal behaviors included verbal aggression/yelling towards staff and other residents. She said the resident propels herself around the facility in her wheelchair cursing and yelling. She said the resident was not on any increased behavioral monitoring, not on 1-on-1 monitoring and was not safe to be in a room with others. In an interview on 05/02/25 at 01:21 PM, LVN J said Resident #30's regular behaviors included yelling and screaming at others. She said Resident #30's former roommate, Resident #22, was scared of her because of her yelling and screaming In an interview on 05/02/25 at 01:27 PM, Resident #22 said she was scared by her former roommates yelling and screaming, She said Resident #30 yelled and screamed at night, startling her. In an interview on 05/02/25, Anonymous A said Resident #30's regular behaviors included yelling/screaming and calling Anonymous A out of her name. Anonymous A staff said Resident #30's behaviors were towards anyone including residents and staff. Anonymous A said in one incident Resident #30 was screaming and she came down the hallway in her wheelchair with no clothes on. Anonymous A said last April, the social worker called the authorities because of Resident #30's behaviors and when they arrived, Anonymous A saw the resident attempt to pull the police officer's firearm. Anonymous A said Resident #30 liked to yell, scream and throw stuff at people and it makes Anonymous A antsy. In an interview on 05/02/25 at 01:36 PM, the MDS Nurse said she did not know Resident #30 had a history of attempted suicide or aggressive behaviors. She said the resident was always nice, but she liked to go to the ER on a weekly basis since arriving in the facility. The MDS nurse had she known of the resident's behaviors she would have included it in her care plan. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 05/02/25 at 02:04 PM, the Psychiatric NP said Resident #30 had a lot of anxiety and would call 911 often. She said the resident seemed hyper-manic and had racing thoughts. The Psychiatric NP said no one notified her that the resident was aggressive, she was unaware that the resident yelled at others, but she could believe Resident #30 rolled down the hall naked because the resident was always inappropriately dressed in her room. The Psychiatric Nurse said the resident had never shown any signs of suicidal ideation, or that she heard voices, but Resident #30 expressed anxiety and depression. She said she was unaware of Resident #30's previous history of suicide attempts, and she would have to review the hospital notes because based on what was discussed the resident's behaviors were more severe. The Psychiatric NP said Resident #30 should have a lot more monitoring by the staff and she did not know why the resident never communicated any of these issues with her. She said she had not read Resident #30's readmission clinicals from 04/30/25 but she assumes the resident is safe since she was discharged . The Psychiatric NP said based on Resident #30's behaviors she was not a safe person, and she expected the resident to have frequent assessments, close monitoring, increased therapy visits and should be encouraged to verbalize her feelings. She said Resident #30 needed additional monitoring to make sure nothing occurs. In an interview on 05/02/25 at 02:22 PM, the DON said prior to readmission she or her designee are supposed to receive and review the resident's hospital clinicals, but she did not, she said she thought the admitting nurse did. The DON said to her knowledge Resident #30 was not having behaviors in the hospital and since her return there had been no medication changes. She said since the resident returned to the facility there have been no interventions in place beyond the standard shift monitoring and based on her documented history of behaviors Resident #30 was not safe to be in a room with Resident #18 who was unable to communicate. In an interview on 05/02/25 at 02:27 PM, the Administrator said she did not know about Resident #30's aggressive behaviors or significant history of suicide, all she knew was that the resident would go to the hospital often. She said now that she knew the contents of the hospital psych consult notes and the resident's history of attempted suicide, the resident should be placed on 1on1 monitoring for at least 72 hours, because she was a resident safety risk having her unsupervised and ambulating in her wheelchair around the facility. In an interview on 05/02/25 at 02:37 PM, CNA T said in April she saw the police go towards the SWs office and then Resident #30 came down the hallway in her wheelchair. She said at first the police were talking to Resident #30, when she started yelling and screaming so the police tried to restrain the resident at which point Resident #30 attempted to pull the police officers firearm. CNA T said prior to the incident in April, Resident #30's regular behaviors included rolling around the facility in her wheelchair yelling/screaming/cursing at other residents and staff. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 05/02/25 at 02:46 PM, LVN T said she was the nurse scheduled when Resident #30 arrived at the facility, but she was on break, so the resident was already in the room when she returned. She said upon readmission Resident #30 had been roaming the facility unattended asking for cigarettes and pain medications. LVN T said in April she observed Resident #30 come out of SWs office screaming fuck you and the SW called 911 mental health. She said when the police talked to Resident #30, she said she was not suicidal but had attempted suicide the night before. LVN T said Resident #30 rolled away from the police, started fighting the police and when they attempted to restrain the resident grabbed their handcuffs and she heard the police say, let go of the gun. She said the SW thought they were going to shoot Resident #30, so she told her to get out of the way for safety. LVN T said more police arrived and then the ambulance took the resident away. LVN T said Resident #30's behaviors included hollering/yelling at people, calling people out of their name, calling Black people the n word, and she did all of this sometimes while going down the hall but the incident in April was the first time it had escalated to this point. LVN T said Resident #30, propelled herself freely in the facility down the halls, always yelling at others. She said when the resident returned on 04/30/25 , she did not receive the discharge clinicals that listed Resident #30's extensive suicide history, and the resident was not ordered or placed on 1on1 observation or suicide watch. In an interview on 05/02/25 at 02:57 PM, the ADON said Resident #30 can be extremely aggressive. She said the resident goes in and out of the hospital and calls 911 when she wants her pain medications, and the provider is aware of her behaviors. The ADON said she heard the resident was aggressive especially during night shift. She said everyone was aware of Resident #30's behaviors including social services, and it was documented in the resident's chart. The ADON said while she does not think Resident #30 is a threat to herself or others, she possibly made other residents feel scared. The ADON said when a resident has made threats of or attempted suicide interventions like 1on1 monitoring should be in place when they readmitted to the facility, but she did not know if Resident #30 had any others for this. The ADON said the IDT/Managers/Administration had not discussed interventions needed to ensure Resident #30's safety but management should absolutely have had that conversation. In an interview on 05//02/25 at 03;41 PM, the DON said she did not know Resident #30 had a history of attempted fake suicide, suicide attempts by tying a cord around her neck, auditory hallucinations telling her to harm herself by tying something around her neck or overdose on medications, wished to have a weapon to harm hospital and nursing staff or attempted suicide in November 2023. The DON said did not read the hospital discharge record sent to the facility prior to the resident readmitting that had the psychiatric consult notes describing all of Resident #30's previous behavioral issues and she honestly does not know why she did not. The DON said now that she knows Resident #30 had this history of behaviors the resident should have been somewhere more appropriate and based on the new information the facility had not provided Resident #30 adequate care. She said prior to today (05/02/25) Resident #30's behaviors placed the safety of herself and other residents in jeopardy. In an interview on 05/03/25 at 01:37 PM, the DON said since the surveyor alerted the facility of Resident #30's extensive history of fake suicide attempts, actual suicide attempts, auditory hallucinations, desire to harm others the resident was placed on 1on1 observation. She said the resident has had a sitter at all times, had not had any new behaviors and was doing well today. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation and interview on 05/03/25 at 01:38 PM revealed, Resident #30 sitting in her wheelchair, writing in a notebook with headphones on. Resident #30 said she now had a sitter with her and has had no behaviors. She said she no longer heard voices since they put her on her proper meds in the hospital, but the doctor will take her off the medication in 10 days, and that is what keeps her calm. She said her Xanax helps her anxiety and bipolar and she was not drug seeking. Resident #30 said she was collating a list of songs for her online music store. In an interview on 05/03/25 at 01:42 PM, the DON said since Resident #30 had behaviors, received antidepressants and antipsychotic medications she should have had behavior monitoring orders. The DON said behavior monitoring orders are important for residents with behaviors in order to monitor for side effects or changes, and failure to have behavior monitoring orders would result in missed behaviors or change of condition. The DON looked through the resident's chart and said nope Resident #30 had no orders from her admission up until her suicide attempt on 04/13/25, and there were no orders entered when she returned to the facility on [DATE]. The DON said the lack of behavior monitoring played a part in the missed behavior monitoring and the missed residents change of condition. Resident #52 Record review of Resident #52's Face Sheet dated 04/24/25 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included: schizophrenia (mental disorder characterized by a breakdown in thought process, making it difficult to distinguish between reality and fantasy), and anxiety disorder. Record review of Resident # 52's Significant change in status MDS dated [DATE] revealed, severely impaired cognition as indicated by a BIMS score of 05 out of 15. Active diagnosis of anxiety disorder and schizophrenia, no presence of any behavioral symptoms such as physical (hitting, kicking, pushing), verbal (threatening, screaming, or cursing at others) and no other behavioral symptoms not directed toward others. Antipsychotics were received on a daily basis; no gradual dose reduction was attempted and there was no physician documentation indicating a GDR was clinically contraindicated. Record review of Resident #52's undated Care Plan revealed, focus- signs and symptoms of anxiety like hypersensitivity, paranoid, nervousness and is at risk for further episodes of anxiety and injury; intervention- medication as ordered. Focus initiated 01/07/25- psychotropic medications and is at risk for adverse reactions and behaviors; interventions- monitor for adverse reactions and hypnotic driven behaviors such as tiredness and weakness, monitor for psychosis driven behaviors such as aggressiveness, combativeness, and manic episodes. There was no focus areas addressing suicidal behavior or suicide threats. Record review of Resident #52's Progress Notes from 01/06/25 to 05/06/25 revealed: 01/19/25 at 04:53 PM signed by RN G- Resident has been very rude to RT she does not like her to enter room to give care to her roommate. She yells/curse and shout. Education given to resident that her room needs assistance and staff will provide assistance without bothering her, but resident stated now. Resident also continue to ask staff for cups thorough the shift. Education given to resident that she is currently NPO and cannot consume anything by mouth at this time for her safety. Education did not work. She continue to ask anyone walking pass her room. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	02/01/25 at 09:46 PM signed by RN G- Resident is currently crying and screaming she would like to go the hospital due to pain in her left legs. Resident was given all of her scheduled medication and Tylenol PRN. She also received her pain cream diclofenac cream applied to her ankle. Resident also propels herself around the facility not crying screaming she became very aggressive with staff. Screaming cursing and grabbing of laptop and other staff equipment she is not able to be redirected. 02/08/25 at 05:42 PM signed by RN G- Resident throw a cup a writer on this shift then later came and apologize. she also snatched the phone causing the cords to come undone and later apologize for that she stated she was in a bad mood due to her mother and boyfriend not answering the phone. She was educated not to throw things at staff or at all. She stated okay. 02/08/25 a6 06:56 PM signed by RN G- Resident still present with behaviors she snatched all of the cords and laptop and phone off the nurse station. She Started hitting another nurse on duty throwing stuff and cruising. Resident shouting, she will kill herself. 911 called at this time social worker present. 02/08/25 at 07:19 PM signed by the SW- This resident became physically aggressive with nursing staff by hitting, kicking, grabbing, and attempting to bite them. She then began to yell and scream I'm going to kill myself. I am going to kill myself. Attempts to verbally redirect unsuccessful. SW contacted her r/p, and she informed SW that she was having one of her episodes and in the past, she was sent to a Behavioral Hospital. SW contacted Behavioral hospital intake Dept via and was informed that they have no available beds till Monday. Recommended that she be sent to ER for assessment due to her aggression. 02/08/25 at 07:25 PM signed by the SW- Note Text : Resident was able to talk with her r/p and also to one of her male friends. They were able to get her to calm down and she again began to apologize for her behavior. She denied [TRUNCATED]

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests for one of four shower rooms, (Shower on Hall C), the nurse's stations (Station C & D), and on a towel on a Resident in Room D11 . The facility had live gnats in areas of the facility including the shower room on Hall C and on a towel on a Resident in Room D11. The facility had live roaches at station C & D Hall nursing station. This failure could place residents at risk for spread of infection, cross-contamination, and decreased quality of life. Findings included: An observation of Room D11 on 04/20/25 at 08:57 AM revealed, 5 gnats perched on a clean white towel that was placed on Resident #22s abdomen, and more than 3 gnats circling around the resident. The gnats did not move when the surveyor approached nor when the CNA removed the towel from the resident, wrapped the gnats in the towel and discarded the towel in the laundry room. An observation on 05/23/25 at 2:00 PM revealed gnats flying around in the shower room on Hall-C. An observation on 06/18/25 at 05:44 AM revealed, a small cockroach running across the counter at C & D Hall nursing station. RN A took a binder off the counter and killed the cockroach and said everyone had roaches. In an interview with Administrator on 06/04/25 at 11:01 AM, he stated he was aware that there were gnats in the facility, and he reported that pest control had been treating the facility and reported that they had last visited the facility a few days prior. He stated he would contact pest control to have them come out more often. Record review of the facilities pest control service inspection report dated 05/07/25 revealed, the facility was last treated for gnats/fruit/crane and the areas applied were the kitchen. Record review of the facilities pest control policy dated May 2008 revealed, Policy Statement: 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.