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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675078 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/06/2025 |
| NAME OF PROVIDER OR SUPPLIER Oasis at Galleria | | STREET ADDRESS, CITY, STATE, ZIP CODE 2808 Stoneybrook Drive Houston, TX 77063 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safety for 1 (Resident #1) of 4 residents observed for cleanliness of rooms. Housekeeping failed to clean Resident #1's room prior to being admitted from the hospital to facility on 11/04/25. This failure placed residents at risk for cross contamination. Findings: Record review of Resident #1's face sheet dated 11/05/25 revealed a [AGE] year-old-male admitted to the NF initially on 05/07/25 and again on 11/04/25. Resident #1's diagnoses included the following: respiratory failure with hypoxia (low oxygen levels in the body), cerebral infarction (blood flow to a part of the brain is blocked), sepsis (bacterial infection in the body that could lead to organ failure and death), type 2 diabetes mellitus (when blood sugar in the body is too high), pneumonia (infection of the lungs), muscle wasting and atrophy (shrinking and weakening of muscle tissue when not being used enough), traumatic subarachnoid hemorrhage (bleeding in the space around the brain due to an injury), hypertension (elevated blood pressure), heart disease, neuromuscular dysfunction of the bladder (when the nerves and muscles that control the bladder is not working properly causing the bladder to not empty adequately), altered mental status, restlessness and agitation, tracheostomy (surgical opening made in the front of the neck directly into the windpipe and a small tube is inserted to help one breathe), and gastrostomy (surgical opening made directly into the stomach to allow for feeding through a tube). Record review of Resident #1's quarterly MDS dated [DATE] reflected that resident had a BIMS score of 3 indicating that resident[VT1] cognition was severely impaired. Further review section H (Bladder and Bowel) revealed that resident had an indwelling catheter and feeding tube. Section O (Special Treatments) revealed that resident was receiving oxygen therapy, suctioning, and tracheostomy care. Record review of Resident #1's Comprehensive Care Plan revised 10/24/25 reflected that resident was being care planned for risk of infection and recurrent infections. Record review of Resident #1's Physician Order Summary Report for November 1015 reflected the following orders: -Dated 05/31/25 Enhanced Barrier Precautions-Dated 11/05/25 Isolation for MDRO in sputum every shift Interview on 11/05/25 at 11:30AM with Housekeeping Director, she said she had been working at the facility since mid-April of 2025. She said the residents' rooms were cleaned once a day and as needed by sweeping and mopping the residents' floors, cleaning the light switches, counter tops of the bedside tables and nightstands. She said the trash was emptied as well. She said there was 1 housekeeper assigned to 2 halls and the facility had 4 halls. She said housekeeping did not strip the linen from the beds and that the nursing department did this and made the residents' beds. Observation on 11/05/25 at 10:45AM Resident #1 resting in bed to left side with eyes closed on scoop mattress. There was a used bottle of enteral feeding (Osmolite 1.2 cal) sitting on the night stand on the left side of resident bed dated 11/05/25 along with respiratory supplies. On top of the nightstand was white sand like debris. There was a purple top container of disinfectant sani-wipes sitting on the nightstand. Resident nightstand drawer was ajar with a used suctioning catheter size 14 French (unit measurement used to describe the outer diameter of the catheter) that was not enclosed but laying in drawer. Further observation was made of Resident #1's floors not clean with debris on the floor and underneath the bed. Bed B by the window was not made. The bed had a fitted sheet on the mattress with red brownish spots on the sheet and a used alcohol swab on the bed. Interview on 11/05/25 at 11:25AM with CNA G, she said she had been working at the facility for 2 months and worked the morning shift. CNA G said Resident #1 did not have a roommate. CNA G said resident room did not appear clean and organized and there was stuff all over resident room. CNA G said resident floor was dirty. CNA G said she did not know who placed the disinfectant sani-wipes in resident room and did not notice that earlier in resident room. CNA G said she had been off work for several days and worked another hall and therefore could not say when the last time resident room had been cleaned. Interview on 11/05/25 at 11:30AM with RN B, she said she worked at the facility on the morning shift from 6a-6p full time. RN B said Resident #1's room was not clean, the floor in resident room was dirty, and B bed was not clean or made. RN B said resident nightstand was cluttered and did not appear to be cleaned. RN B said she did not know who placed the disinfectant sani-wipes in resident room on the nightstand. RN B said she could not explain why there was a used suction catheter laying inside of resident nightstand drawer. RN B said she did not handle the respiratory supplies, but the respiratory therapist did. Further interview with RN B said she was the nurse that admitted Resident #1 back to the facility on [DATE]</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that its residents are free of any significant medication errors for 1 (Resident #1) of 4 residents reviewed for medication administration. RN B failed to call the hospital, ADON, and Administrator on 11/04/25 when she did not receive report from the hospital when Resident #1 returned to the facility from the hospital on [DATE]. The facility failed to administer Resident #1's IV Vancomycin 1gm evening dose on 11/04/25 and morning dose on 11/5/25. The facility failed to administer Resident #1's IV Meropenem 500mg every 4 hours when he returned to the NF on 11/04/25 from the hospital. The facility did not initiate the medication until 11/05/25 at 8:00PM. Resident #1 missed a total of 4 doses. This failure could place residents at risk of prescribed antibiotics not working effectively to treat residents' infections. Findings: Record review of Resident #1's face sheet dated 11/05/25 revealed a [AGE] year-old-male admitted to the NF initially on 05/07/25 and again on 11/04/25. Resident #1's diagnoses included the following: respiratory failure with hypoxia (low oxygen levels in the body), cerebral infarction (blood flow to a part of the brain is blocked), sepsis (bacterial infection in the body that could lead to organ failure and death), type 2 diabetes mellitus (when blood sugar in the body is too high), pneumonia (infection of the lungs), muscle wasting and atrophy (shrinking and weakening of muscle tissue when not being used enough), traumatic subarachnoid hemorrhage (bleeding in the space around the brain due to an injury), hypertension (elevated blood pressure), heart disease, neuromuscular dysfunction of the bladder (when the nerves and muscles that control the bladder is not working properly causing the bladder to not empty adequately), altered mental status, restlessness and agitation, tracheostomy (surgical opening made in the front of the neck directly into the windpipe and a small tube is inserted to help one breathe), and gastrostomy (surgical opening made directly into the stomach to allow for feeding through a tube). Record review of Resident #1's quarterly MDS dated [DATE] reflected that resident had a BIMS score of 3 indicating that Resident #1's cognition was severely impaired. Further review section H (Bladder and Bowel) revealed that Resident #1 had an indwelling catheter and feeding tube. Section O (Special Treatments) revealed that Resident #1 was receiving oxygen therapy, suctioning, and tracheostomy care, but was not on isolation or quarantined for active infections. Record review of Resident #1's Comprehensive Care Plan dated 10/24/25 reflected that Resident #1 was being care planned for being at risk for frequent infection with an intervention that included administering medication as order by the physician. Record review of Resident #1's hospital records dated 10/28/25 revealed that Resident #1 was receiving IV antibiotic vancomycin and Meropenem. The hospital physician electronically signed on 11/03/25 for Resident #1 to continue IV meropenem for pneumonia bacteremia and IV vancomycin for MRSA, final duration of antibiotic through 11/07/25. Record review of Resident #1's NF active Physician orders for the month of November 2025 included the following orders: Dated 11/05/25 Vancomycin 1gm IV every 12 hours for pneumonia and bacteremia. Dated 11/05/25 Meropenem 500mg IV 4 (four) times a day for MDRO Dated 11/05/25 Isolation for MDRO Record review of Resident #1's MAR for November 2025 reflected that Resident #1 did not receive his 1st dose of Vancomycin 1gm IV until 7pm on 11/05/25 at 7pm. The medication times on the MAR for the medication Vancomycin were 7:00AM and 7PM. The times for the meropenem was 10:00AM, 3:00PM, 8:00PM, and 2:00AM. Interview on 11/04/25 at 4:33PM with the RP of Resident #1 said Resident #1 was at the hospital and still receiving IV antibiotics to treat his infection. The RP said the hospital would be discharging Resident #1 back to the NF on 11/04/25. The RP said the hospital doctor wanted resident to continue on the IV antibiotics for several more days. Observation on 11/05/25 at 10:45AM revealed Resident #1 was resting in bed with his eyes closed to his left side with a pillow wedge to his back. Resident had a tracheostomy that was connected to continuous oxygen. There was no IV antibiotics being administered. Interview on 11/05/25 at 11:30AM with RN B, she said she worked at the facility on the morning shift from 6AM to 6PM. RN B said she was the nurse that admitted Resident #1 when he returned from the hospital on [DATE]. Interview on 11/05/25 at 3:18PM with RN B, she said when Resident #1 returned to the facility on [DATE] she did not know who took report on resident. RN B said she did not administer any antibiotics to Resident #1 due to no antibiotics being listed on Resident #1's medication list when he returned to the NF. RN B said she had informed the ADON about this around 2:00PM on 11/05/25. RN B said she learned on 11/05/25 that resident was supposed to be on the antibiotic Meropenem (antibiotic used to treat a variety of severe bacterial infections, particularly those caused by multidrug-resistant bacteria) 4 times a day. RN B said she needed to</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection control program to provide a safe, sanitary, and comfortable environment to help prevent the transmission of infection for 1 of 4 residents (Resident # 2,) reviewed for infection control in that: CNA D failed to don (to put on) disposable gown when providing direct care for Resident #2 who was on Enhanced Barrier Precautions on 11/05/25. This failure could place residents at risk for cross-contamination and unwanted infections. Findings include: Record review of Resident #2's face sheet dated 11/06/25 revealed a [AGE] year-old-female admitted to the NF originally on 06/29/24 and again on 07/02/25. Resident #2's diagnoses consisted of the following: heart disease, type 2 diabetes mellitus (high blood sugar levels), pneumonia (infection in the lungs), dysphagia (difficulty swallowing), gastrostomy (surgical procedure to insert a feeding tube in to the stomach to allow liquid nutrition and medicine), end stage renal disease (irreversible kidney disease where the kidneys are no longer able to function on their own), renal dialysis (medical procedure to remove waste from the blood), and cerebral infarction (blockage in the brain that cuts off blood flow to the brain). Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS score of 7 indicating that Resident #2's cognition was severely impaired. Record review of Resident #2's Comprehensive Care Plan dated 06/06/25 revealed that resident was being care planned for feeding tube being in place with intervention to wear abdominal binder. Record review of Resident #2's Physician Order Summary Report for the month November 2025 reflected the following orders: -Dated 05/31/25 Enhanced Barrier Precaution every day and night shift.-Dated 08/11/25 Every shift Nepro continuous pump assist via peg at 55ml/hr x 22 hours to provide a total 1946 ml/day, may give Glucerna 1.5 pending Nepro available. Observation on 11/05/25 at 10:18AM on Resident #2's door entrance was an EBP signage on the door with the door closed. The signage instructed staff to don PPE gown and gloves. There was a 3-drawer plastic storage bin by resident door entrance with gloves and blue disposable gowns inside of the drawers. Coming out of Resident # 2's room was CNA D with clear plastic bags in her hand. Inside of bag the surveyor did not see a blue disposable gown in the bag. Interview 11/05/25 at 10:18AM with CNA D, she said she had just finished providing incontinent care for Resident #2. CNA D said she did not put on a disposable gown while providing direct care for Resident #2. CNA D said she was supposed to do this for infection control and got in a hurry to get resident ready to go to dialysis. CNA D said she placed resident and herself at risk for infections. Observation on 11/05/25 at 10:20AM of Resident #2 resting in bed awake with feeding pump on the left of bed with feeding disconnected from resident. CNA D said she was about to transfer resident from bed to chair. Resident had a gastrostomy tube with dressing around gastrostomy site dated 11/05/25. Interview on 11/06/25 at 2:50PM the ADON said she was the facility's Infection Control Preventionist. The ADON said all nursing staff should be practicing Enhanced Barrier Precaution when providing direct care for a resident that had the following: gastrostomy tubes, Foley catheter tube, tracheostomy, IV lines, etc. ADON said the staff should be wearing gloves and gowns. The ADON said when the staff was not donning correct PPE there was risk for cross contamination. Record of the NF policy on Infection Prevention and Control Prevention revised April 04, 2025 reflected in part: .This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines .</p> | | |