

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER West Oaks Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 Green Crest Dr Houston, TX 77082	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that resident environment remains as free of accident hazards as is possible and receives adequate supervision to prevent accidents for 1 of 2 (Resident #24) residents reviewed for accident hazards.-The facility failed to ensure Resident #24 was transferred with a one-person assist when she was a two-person assist on 3/3/2026 and sustained an injury requiring stitches. This failure could place residents at risk of injury. Findings included:Record review of Resident #24's face sheet, dated 03/10/2026, revealed a [AGE] year-old female admitted [DATE] and re-admitted [DATE]. Her medical diagnoses included end state renal disease (severe kidney disease), morbid obesity (excess weight defined by a body mass index of 40 or higher which can lead to increased risk of heart disease or death), type 2 diabetes mellitus (high blood sugar), heart failure, peripheral vascular disease (a condition characterized by narrowing of arteries that reduce blood flow to the limbs, primarily the legs, leading to symptoms like leg pain and cramping) and anxiety disorder (disorder consisting of prolonged periods of worry and anxiousness).Record review of Resident #24's admission screening, dated 02/24/2026 and signed by ADON A, indicated she had a self-care deficit with the goal of maintaining or improving her ability to participate in her care with ADLs and an intervention of a 2-person assistance with transfer/toilet transfers. Record review of Resident #24's Comprehensive MDS, dated [DATE], indicated she scored a BIMS of 14, indicating high cognitive intactness related to memory and thinking. Further record review indicated Resident #24 required substantial to maximal assistance in bed mobility where the helper does more than half the effort like lifting or holding the trunk or limbs and provides more than half the effort for things such as chair or bed-to-chair transfer, sitting to lying, and lying and rolling left and right. Record review of Resident #24's progress notes for March 2026, indicated the following entries:-On 03/03/2026 at 2:43pm by a physician, she had bilateral heel ulcers. She had therapy precautions for falls/orthostatic (related to standing upright)/cardiac. High risk for falls if hypotension (low blood pressure) develops. Resident #24 was noted as having decline in performing ADLS and func (functional) mobility. -On 03/03/2026 at 2:57pm, she was seen for wound care that day.-On 3/3/2026 at 3:01pm Resident #24 was documented as having change in condition which was other change in condition. -On 3/3/2026 at 3:29 LVN A wrote that while being transferred to bed from her wheelchair with staff' assistance, the resident's right leg hit the grab handle of the bed causing a laceration to the right lower leg. Pressure was applied, actively bleeding. Area wrap with ace wrap.Intervention in placed resident is a two staff transfer. Area clean of any clutter. And maintain a safe transfer. Wound Care MD ordered Resident #24 to be transferred to the hospital. Record review of Resident #24's SBAR form dated 03/03/2026, she had a laceration to the right lower leg. Resident #24 had new pain rated at a level of 4 out of 10. Resident #24's primary care clinician was notified on 03/03/2026 at 2:30 p.m. and ordered the resident be sent to the ER. The summary of the event read in part, Resident was being transferred to her bed from wheelchair with staffs' assistance. Resident right leg hit the grab handle on the bed causing a laceration to right lower leg. Pressure apply actively bleeding. area wrap with ace wrap. Order by (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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER West Oaks Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 Green Crest Dr Houston, TX 77082	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	wound care MD to [NAME] resident to ER 911 called and Resident transfer to [hospital name] The document was signed by LVN A. Record review of Resident #24's hospital records, dated 3/4/2026 at 3:42 p.m., indicated Resident #24 told the MD that in the nursing while transferring from the wheelchair to the bed she accidentally had a leg injury resulting in the right leg laceration. Laceration was repaired and vital signs were stable. Resident #24 was admitted to the hospital due to hyperkalemia, with levels at 7.2, indicating high potassium levels. Resident #24 was alert and oriented x3. Record review of Resident #24's care plan, dated 03/09/2026, indicated she was care-planned for self-care deficit due to weakness with interventions including transfer/toilet transfers for 2-person assistance on 2/24/2026 and then 1-2-person assistance on 3/3/2026. Resident #24's care plan was revised on 03/12/2026 to reflect Resident #24 needed a 2-team member transfer/toilet transfer with a mechanical lift. Record review of Resident #24's therapy evaluation, dated 03/01/2026, indicated Resident #24 was referred for new onset of decrease in functional mobility, decrease in strength, decreased coordination, reduced dynamic balance and increased need for assistance from others. She required substantial or maximal assistance for chair or bed-to-chair transfer at baseline with the goal to improve ability to safely and efficiently transfer to and from a bed to a chair (or wheelchair) with setup or clean-up assistance with recognition of safety hazards. Record review indicated it was signed by PTA M on 3/3/2025 at 5:12 p.m. Record review of Resident #24's therapy encounter notes, dated 3/3/2025, indicated she worked on strengthening and balance exercise while seated in her wheelchair. Resident #24 used assist bar in pulling up to sitting and bringing both legs off the bed and transferred from bed to wheelchair with minimum assist and verbal cues for sequencing and hand placement. Resident #24 did not transfer from wheelchair to bed during this encounter. Record review indicated it was signed by PTA G on 3/3/2026 at 1:50pm. Record review of Resident #24's wound care doctor's visit notes, dated 03/03/2026, indicated she had a diabetic wound on the left and right foot, both healing or maintaining healing. Record review of the wound nurse's notes, dated 03/13/2026, indicated she measured Resident #24's wound laceration which was 10.94 cm in length and 1.66 cm in width. During an interview on 3/10/2026 at 10:15 a.m., during initial rounds, Resident #24 said she just returned from the hospital. She said CNA B was trying to transfer her from the wheelchair to her bed. Resident #24 said she told CNA B that she needed another CNA to help, but CNA B said she could transfer her without anyone else and instructed the resident to hold onto the gait belt, and while transferring her from the wheelchair to the bed, Resident #24's right leg got caught by an object in the bed and tore her leg. Resident #24 said she was sent to the hospital, where she received 18 stitches. Resident #24 said the facility was short of staff and sometimes it took 2 to 3 hours for staff to respond to her call light. In a later interview with Resident #24 on 3/12/2026 at 6:07 p.m., she said she told CNA B she wanted two people because she had always need two people assist transferring her, but CNA B said she was standing fine and that they both could do it without a second person. Resident #24 said she agreed to it, but she felt uncomfortable and she said she should not have agreed to having one person helping her. Resident #24 said she thought her leg hit the end of the assist bar. In an interview on 03/13/2026 at 9:33 a.m., Resident #24 said she was slipping off the bed and CNA B was assisting her to scoot closer to the center of the bed and when CNA B turned to help her get stable in bed that was when she lost balance and kicked out with her right leg. Resident #24 said she was not sitting stable at the time. She said there should have been two staff helping her back into bed. Resident #24 said due to her pressure ulcers on her foot she wanted to let it heal and she wanted to stay in bed for now and that she was told to stay in bed by hospital staff. During an observation and interview of Resident #24's wound on 03/10/2026 at 1:18 p.m., the WCN said Resident #24's injury ran down the center of her right leg. The WCN said last week someone was transferring Resident #24 from her wheelchair to her bed when she sustained the injury and was sent to the ER. Resident #24 returned 03/09/2026. The WCN got permission from Resident #24 to unwrap her bandage and began to unroll the outer wrap. Resident #24 had outer gauze around her right leg which the WCN unwrapped. The WCN then removed the tape covering the injury down her right leg, (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER West Oaks Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 Green Crest Dr Houston, TX 77082	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	which revealed a line of stitches about 2 inches from the end of her knees to around 3-4 inches above her ankle. Resident #24's left and right shins were a dark red and covered most of the shins. The WCN said from what she remembered, she called the wound care doctor who was still in the building after she heard about the injury. The wound care doctor assessed Resident #24's injury and sent her to the ER around 4:00 p.m. the end of day (03/03/2026). During an interview on 03/10/2026 at 2:18 p.m., the Administrator and DON said they were aware of Resident #24's injury. The DON said that CNA B was transferring Resident #24 to bed and Resident #24 was holding the assist bar with her right hand. The DON said CNA B was holding Resident #24 with the gait belt and the left side to assist her back into bed when Resident #24 lifted her right leg up which kicked the assist bar and caused the laceration. The DON said the staff told her Resident #24 received 18 stitches. The DON said Resident #24 was a 1-to-2-person transfer. The DON said depending on the resident's needs, strength in the moment, if the resident requested two people that was her right to have two staff assist her and that her aide would need to ask another staff to come in the room to assist the resident. The DON said LVN A was the nurse who saw Resident #24 after the injury and who assessed her. The DON said she took off the bar that was attached to Resident #24's bed and replaced it. During an interview on 3/10/2026 at 2:40 p.m., CNA B said on the day of the incident, Resident #24 was in her wheelchair and she was trying to put Resident #24 back to bed. CNA B said she positioned Resident #24 toward the bed and Resident #24 was holding on the to the assist bar on the right side of the bed. She said Resident #24 was able to pivot on her own during that transfer. CNA B said she used her gait belt to lift Resident #24 back into bed and Resident #24 was sitting on the bed closer to the middle with her feet dangling off. Resident #24 said Resident #24 then raised her right leg in a swinging motion and hit the bar . CNA B said the bar was not sharp but Resident #24 had fragile skin. CNA B said that Resident #24 was a 1-to-2 person assist because she could assist with transfers. CNA B denied Resident #24 saying she wanted another staff to help with the transfer. CNA B did not remember Resident #24's injury but knew she was bleeding. CNA B said she called the WCN and wound care doctor to come to Resident #24's room and assist. CNA B said that if the resident wanted two staff to help her, she would have said so, but CNA B denied Resident #24 ever told her that Resident #24 wanted another aide to assist in the transfer from wheelchair to bed. CNA B said that when she asked LVN A how many people Resident #24 needed for transfers, LVN A told her that Resident #24 was a 1-person assist now. Interview with the wound care doctor on 3/10/2026 at 3:15 p.m., she said she was called to Resident #24's room and evaluated the injury. The wound care doctor told staff that Resident #24 had a laceration and needed to be sewn up at a hospital. Resident #24 was not bleeding out but there was a gash. During an interview on 3/10/2026 at 3:40 p.m., Resident #24's RP said that Resident #24 had to have 18 stitches. Resident #24's RP said Resident #24 told her there was something at the bottom of the bar which caused her to be injured. Resident #24's RP said Resident #24 told her there was a missing cap at the end of the bar at the time of the injury, but it was there when Resident #24 got back from the hospital on [DATE]. Resident #24's RP said she did not know if there were two people assisting Resident #24, but the resident told the RP there was one aide helping her back into bed. Resident #24's RP said Resident #24 was usually a one to one and a half person assist due to weakness, and that Resident #24 had her first therapy sessions that week and she might have been tired when she got back into bed. During an interview on 03/10/2026 at 4:00 p.m., the DoR said all admissions were assessed for function and the facility would get authorization to evaluate and treat like for Resident #24. The DoR said Resident #24 was evaluated on 03/01/2026 for chair to bed transfer at a maximum assist, and was also evaluated for bed mobility, transfers and walking. The DoR said Resident #24 was just starting therapy so she would have been at a maximum assist level, indicating a resident required 1 to 2 people to assist with a task. The DoR said Resident #24 was not able to easily move on her own. The DoR said the assessment was done by PTA M on 03/01/2026. The DoR said Resident #24 had therapy on 3/2/2026 and 3/3/2026 before being discharged to the hospital. During an interview on 03/12/2025 at 1:14 p.m., the DoR said another assessment was done (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER West Oaks Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 Green Crest Dr Houston, TX 77082	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	for Resident #24 on 03/12/2026 and it was completed by PTA M. The DoR said Resident #24 required maximum encouragement during the evaluation. The DoR said Resident #24 completed a bed mobility assessment and refused standing and transfer assessments, saying that she feared her feet might bleed due to pressure ulcers she had upon admission. The DoR said the assessment indicated Resident #24 was modified independent which meant minimum help in bed for sitting to lying and lying to sitting. The DoR found that Resident #24 had no impairment with weight bearing with transfers, which meant she was able to stand on her own, so currently she did not have a medical limitation. The DoR said she found out about the incident on 3/4/2026 through a nurse's note in Resident #24's medical chart. The DoR said changing Resident #24's care plan to 1-2 person transfers on 03/03/2026 did not cause the DoR any concern, as Resident #24 was hospitalized for an unrelated issue at the time the care plan was updated. The DoR said if Resident #24 was sitting up in her chair after therapy, then she might have required more assistance getting back into bed and that therapy and nursing had different assessments they used to determine assistance and that nursing would make the final determination with the care plans. The DoR said since Resident #24 did not want to get out of bed for therapy on 03/12/2026 because she wanted her heel ulcers to heal before she walks on them, so she recommended nursing staff use a mechanical lift so Resident #24 could feel less anxious if she did want to get out of bed. During an interview on 03/10/2026 at 4:04 p.m., the Maintenance Director said he was not at the facility the week of 03/03/2026 and he had made no adjustments on Resident #24's bed since she returned on 03/09/2026. The Maintenance Director said he did not receive any work orders in his log for Resident #24 and that he never made any repairs or changes to Resident #24's bed. During an interview on 03/10/2026 at 4:20 p.m., Resident #24 said the facility added a cap to the assist bar and that she felt safe now. Resident #24 said she was told to stay in bed to let her stitches heal by the hospital doctors. During an interview on 03/11/2026 at 8:05 a.m., the DON said the change to Resident #24's care plan from a two-person to a one-to-two-person assist was completed by her before the incident. The DON based it on therapy notes dated 03/03/2026, a session Resident #24 had completed that morning when she sustained the injury in the afternoon. During an interview on 3/11/2026 at 8:14 a.m., LVN A said she was working the week Resident #24 sustained the injury. She said CNA B was working with Resident #24 that day. She said CNA B told her Resident #24 was bleeding from the leg. LVN A said she entered Resident #24's room and saw the laceration to Resident #24's leg, got the wound cart, pressure wrapped the wound to stop the bleeding, and asked another nurse to call emergency services because the bleeding was significant. LVN A said once emergency services was called, she put pressure on the wound. LVN A said she called the wound care doctor, who was in the facility, to the room to assess the wound and the wound care doctor said it was deep and ordered the resident be sent out. LVN A said at the time, Resident #24 was sitting on the bed, there was blood on the floor. When LVN A asked CNA B what happened, CNA B reported she was transferring Resident #24 to the bed, when Resident #24 grabbed the assist bar and then kicked the bar with her right leg. She said CNA B also said Resident #24's leg was close to the assist bar before she kicked it. LVN A said Resident #24 reported pain in that area. LVN A said there was 1 person assisting Resident #24. Resident #24 was a 1-2 person assist but needed 2 people if she was unable to help with completing the transfer such as due to weakness, at which time the aide assisting her would get another staff to help with the transfer. LVN A did not know what Resident #24's strength really was because Resident #24 only got up twice for therapy while LVN A was her nurse. LVN A said she put a nurse's note in Resident #24's record that she was a two person assist due to the incident. LVN A said the second time she saw Resident #24 get up was on 3/3/2026. LVN A said the number of people required to assist her would be based on what therapy told nursing. LVN A said the cap underneath the assist bar handle was not covered. LVN A said she went to the DON after the incident and the DON came into the room and interviewed LVN A and CNA B. LVN A said there was usually a cover or cap under the bar but she was not sure if that was something that should be there. During an interview on 3/12/2026 at 9:33 a.m., LVN A said therapy told her they were able to get (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER West Oaks Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 Green Crest Dr Houston, TX 77082	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #24 out of bed with one person and that Resident #24 was a one person transfer now. Later in the day on 03/03/2026, CNA B asked LVN A and that's what LVN A reported to CNA B. LVN A said she did not tell the DON about therapy making Resident #24 a 1-person transfer. LVN A said after the incident, the DON and Administrator came into the room to examine Resident #24's bed and said they put a cap on the grab bar. During an interview on 03/11/2026 at 8:40 a.m., MDS A said he got information about a resident's functional abilities through initial assessments upon admission, hospital discharge documentation, their previous nursing facility and family member interviews. MDS A said Resident #24 needed 1-2-person assistance for transfers. MDS A said he did not know if she could get up on her own. MDS A said Resident #24 had a laceration and did not know how she sustained the injury. MDS A said, according to Resident #24's most updated MDS, she required substantial to maximal assistance which translated to needing 1 to 2 people for transfers. MDS A said Resident #24 had generalized weakness and could not stand on her own so she was care-planned for two-person assist for her safety when he completed the baseline care plan on 02/24/2026. MDS A said he did not observe Resident #24's mobility assessments and that he interviewed her and could tell she had generalized weakness and would be unable to transfer safely on her own and would require maximal assistance of 1 to 2 persons. During an interview on 03/11/2026 at 10:17 a.m., the DON said substantial to maximal assistance would be 1-2-person assistance, depending on the resident's functional abilities that day. PTA G told LVN A that Resident #24 could be a one-person transfer and was a minimal assist. The DON said she updated the care plan the morning of 03/03/2026 based off of PTA G's notes. The DON said that the notes would be enough to change Resident #24's care plan and did not need to wait for the morning meeting or other consultation with the therapy department. The DON said that care plans could change based on assessments, talking to nursing and staff who would provide observations. During an interview on 03/11/2026 at 10:45 a.m., PTA G said she saw Resident #24 one time and assisted Resident #24 out of bed, where she took a few steps and was able to pivot to get into the wheelchair. PTA G said Resident #24 did not take any steps. PTA G said Resident #24 worked on exercises with PTA G, including reaching for items, and working on wheelchair mobility. PTA G said she assisted Resident #24 back to her room where Resident #24 stayed up in her wheelchair. PTA G said she took a table to her, gave her the call light, and told her to press it when she wanted to get back in bed. PTA G said she did not see her get into bed nor did she assist her with chair-to-bed transfer on 03/03/2026. PTA G said Resident #24 could not have gotten back into bed on her own. She said the level of assistance she needed depended on how long she was sitting up and on her energy level. She said Resident #24 required 1 to 2 people to get back into bed. PTA G said a nurse asked her after therapy was completed if Resident #24 was able to get up by herself and PTA G replied that PTA G got Resident #24 out of bed. PTA G said she never told LVN A that Resident #24 was a one-person assist going forward. PTA G said it was easier to get out of bed since at that time someone would be at a higher level and getting back into bed would be more difficult. During an interview on 03/11/2026 at 10:53 a.m., ADON C, said his responsibilities included re-checking admission orders and assessments. He said he did not remember which nurse admitted Resident #24. ADON C said he had Resident #24 as a two-person assist upon admission in her care plan because he assessed her on the first day and she did not get out of bed so they did not know how much help Resident #24 needed. He also said since Resident #24 was not the smallest person and arrived to the facility on a stretcher, he put her as a two-person assist. ADON C said care plans could change daily, but the plan remained at a two-person assist before therapy assessed her. ADON C said he expected that if the resident needed help, then he would make sure they were documented as a two-person assist before clearance from therapy. ADON C said that the facility received updates about residents from morning meetings and that any changes to the resident's MDS could update the Kardex which could be accessed by nurses and aides in providing resident care. During an interview on 03/11/2025 at 11:22 a.m., the Administrator said when a resident was admitted, the facility might have them as a two-person assist and when therapy (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER West Oaks Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 Green Crest Dr Houston, TX 77082	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	assessed them, therapy could communicate with nursing and there would be a change in the care plan. The Administrator said management might talk about a resident's functional abilities after a treatment and then communicate further during morning meetings. She said therapy communicated with nursing that Resident #24 was a one-person assist. She said things could change throughout the day and any changes would not necessarily need to wait until the morning meeting. During an interview with the Administrator and DON on 03/12/2026 at 2:58 p.m., the DON said Resident #24 had her hand on the assist bar when she kicked up, and that Resident #24 shifted or leaned to the left to try to catch herself from falling over. The DON said Resident #24's care plan was updated to 1 to 2 people because therapy said so on 03/03/2026. The DON said the therapist was able to transfer Resident #24 with one person, so the therapist told the nurse who told the aide. The DON said she made changes to the care plan based on therapy notes and changed Resident #24's assistance. The DON said Resident #24 only required one person, but she could have requested another person if she wanted and that was within her rights to do so. During an interview with PTA M on 03/12/2026 at 3:25 p.m. by telephone, he said he was a physical therapist and conducted resident evaluations, recertifications, and treatments. PTA M said he did an assessment for Resident #24 on the morning of 03/12/2026. PTA M said Resident #24 required moderate assistance with bed mobility and refused transfers so he could not conduct gait or wheelchair mobility assessments. PTA M said Resident #24 required a mechanical lift to get out of bed before she refused transfers. PTA M did not know how Resident #24 sustained her injury. PTA M said that transfers would mean going from one place to a different place, so going from wheelchair to the bed and vice versa. PTA M said that Resident #24 required maximum assistance during her first assessment on 03/01/2026, which still could mean needing one person to help her. PTA M said he could not speak on the care plan changes in assistance for transfers. During an interview with the DON and CNA B on 03/12/2025 at 3:54 p.m., the DON said she just talked to Resident #24 who said she was sitting in bed trying to readjust her pillows when she leaned back and injured herself. The DON said Resident #24 was already in bed when the injury happened. During an interview with the DON on 03/13/2026 at 9:12 a.m., she said she interviewed Resident #24 on 03/13/2026 and Resident #24 said she was holding on to the rail with her right hand and felt a sharp pain in her right leg. The DON said CNA B got Resident #24 in bed and went to get someone immediately. The DON said she thought the assist bar got caught on Resident #24's leg. The DON said when she went to inspect the bed, the bed was capped and she did not change anything with the bed. During an interview on 03/13/2026 at 9:49a.m., the wound care nurse said she waited for therapy to assess residents for transfer assistance and bed mobility. The wound care nurse said she would then be able to help residents with repositioning and sitting up in bed during wound care. She said she did not assist with transfers. Record review of the facility's policy titled Safe Resident Handling/Transfers last revised January 2023, it read in part, It is the policy of this community to ensure that patients/residents are handled and transferred safely to prevent or minimize risks for injury and promote a safe, secure and comfortable experience for the patient/resident while keeping the team members safe in accordance with current standards and guidelines. Compliance Guidelines: 1. The interdisciplinary team or designee will evaluate and assess individual mobility needs, considering other factors as well, such as weight and cognitive status. 2. The mobility needs will be addressed on admission and reviewed quarterly, after a significant change in condition or based on direct care staff observations or recommendations. 3. Mechanical lifting equipment or other approved transferring aids will be used based on individualized needs and per the care plan to prevent manual lifting except in medical or other emergencies. 13. Lifting and transferring will be performed according to the individualized plan of care. Record review of the facility's policy titled, Statement of Resident Rights last revised January 2023, it read in part, Resident/Patient Rights include: 1. To all care necessary for them to have the highest possible level of health; 2. To safe, decent and clean conditions. 10. To participate in developing a plan of care, to refuse treatment. The community will continue to care for the resident in a manner that allows the resident to attain or maintain his/her (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER West Oaks Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 Green Crest Dr Houston, TX 77082	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	highest practicable physical, mental, and psychosocial well-being to the extent possible given the refusal of recommended medical care and treatment. Treatment is defined as care provided for purposes of maintaining/restoring health, improving functional level, or relieving symptoms. Record review of the facility's policy on Care Plan Development, Review, and Update Policy dated February 2017, it read in part, The community develops a comprehensive care plan for each resident that includes measurable objectives designed to meet the resident's medical, nursing, mental, and psychosocial needs as identified in the comprehensive assessment. The care plan should reflect the identified problem or risk, the measurable outcome objective, and the appropriate interventions based on the resident's abilities, needs, medical condition, and preventative measures. The care plan may also include the resident's expressed preferences. The care plan should be written in a manner that is understandable, and actionable for staff, ensuring that the interventions can be implemented as intended. The care plan should also allow for appropriate variability in care approaches when the resident's needs fluctuate, and within the scope of the resident's assessed needs and abilities. The care plan, in conjunction with the broader plan of care documented throughout the medical record, is developed to help the resident attain or maintain their highest practicable physical, mental, and psychosocial well being, in accordance with federal regulations and RAI guidance. 'Interdisciplinary' means that professional disciplines work together to provide the greatest benefit to the resident. The IDT should include within the care plan the right to refuse any recommended care, treatment or services identified but, that is not provided due to the resident exercising his or her right to refuse care, service, or treatment, as well as the resident's legal representative acting on behalf of the resident. The care plan should be prepared by an interdisciplinary team, including the attending physician, a registered nurse with responsibility for the resident, and other appropriate team members in disciplines as determined by the resident's needs. During an interview on 03/13/2026 at 5:45 p.m., the DON and VP of Operations said they did not have a policy on maintaining resident beds.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER West Oaks Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 Green Crest Dr Houston, TX 77082	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement.1. The facility failed to ensure leftover food to be used later with a temperature in the danger zone was discarded. 2. The facility failed to ensure leftover food past the due date was discarded.3. The facility failed to ensure that food past the use date was discarded. 4. The facility failed to ensure food was stored 6 inches off the floor.5. The facility failed to store in a separate container a scoop used for food bins in the kitchen storeroom.6. The facility failed to fix broken tiles in the kitchen These failures could place residents at risk of food borne illness and disease.During an observation of the facility kitchen on 03/10/26 at 8:00 a.m., it revealed the following: 1. Can opener blade with food debris.2. An open package of deli ham with no used by date in the fridge.3. A package of sliced swiss cheese not dated, no used by date in the fridge.4 A package of sliced cheddar cheese with no used by date in the fridge.5. A tray full of milk in glass was measured at 45 degrees Fahrenheit on the serving lunch table.6. A food rack where food is stored in the storeroom was 2 1/2 inches off the floor.7. Scoop dispenser left in flour bin. During an interview on 03/10/2026 at 8:00 a.m., the Dietary Food Service Manager stated that the following foods (deli ham, Swiss cheese, sliced cheddar cheese) stored in the refrigerator to be used for a later date should be discarded prior to the use by date. She stated the leftover food with danger food temperature 40 degrees Fahrenheit to 140 degrees Fahrenheit should have been discarded. She stated that she was responsible for meeting the requirements and she would in-service dietary staff on proper handling, storing, and dating leftover food for compliance.Record review of the facility's policies and procedures for Food Safety, not dated, read, .potentially hazardous leftover foods are properly covered, labeled, dated, and refrigerated immediately. They are discarded on the used by date unless otherwise indicated. For food storage keep off floor and food racks off the floor at least 6 inches off the floor.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER West Oaks Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 Green Crest Dr Houston, TX 77082	
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with incontinent bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 18 resident (Resident #8) reviewed for incontinent care. The facility failed to ensure CNA A put on a gown and changed gloves and cleaned Resident #8's indwelling catheter and penis foreskin before putting on a clean brief during foley catheter and incontinent care on 3/12/26. This failure could place residents at risk for pain, infection, injury, and hospitalization. Record review of Resident #8's face sheet, dated 3/10/2025, revealed an [AGE] year-old male admitted [DATE] and re-admitted [DATE]. His medical diagnoses included muscle wasting and atrophy (loss of muscle tissue, causing muscles to become small, thinner and weaker) not elsewhere classified, unspecified shoulder, dysphagia (difficulty swallowing), oropharyngeal phase(difficulty initiating a swallow or moving food from the esophagus), cognitive communication deficit, unsteadiness on feet, muscle weakness (generalized), obstructive and reflux uropathy,(blockage in the urinary tract that prevent urine from draining properly , causing backup and potential kidney damage) unspecified, nasal congestion, sepsis (a life -threatening medical emergency that occurs when the body's immune system has an infection, causing it to damage its own tissue and organs) essential primary hypertension(high blood pressure) and urinary tract infection. Record review of Resident #8's quarterly MDS assessment, dated 1/20/26, reflected a BIMS score of 13 out of 15, which indicated intact cognition. He required assistance from staff with ADL care. Record review of Resident #8 's care plan, dated 1/27/26, reflected, . The resident had an ADL self-care deficit .Interventions.Personal Hygiene and Toilet use- Resident is totally dependent . Resident #8 was also care-planned for a Foley catheter (a sterile tube that is inserted into your bladder to drain urine) and incontinent care, with interventions including following physician orders for catheter insertion, changes and maintenance. Review of Resident #8's Physician's orders, dated 1/25/2026 through 3/1/2026, reflected orders for the following: Foley Catheter cleansing and perineal hygiene daily and as needed if soiled, using a catheter securing device with a start date of 1/25/2026. During an observation on 3/12/26 at 5:20 p.m., during Foley Catheter and incontinent care with Resident #8, revealed CNA A did not don (wear) PPE (gown), did not wash hands, wore clean gloves, picked up a cleaned brief, wet wipes from Resident #8's dresser and placed it on the bed. CNA A was observed using wet wipes and cleaned Resident #8's groin and the front part of the scrotum. Resident #8 was repositioned to his left, CNA A using the clean wet wipes cleaned in-between buttocks and around the buttocks. CNA A did not clean the back side of the scrotum, she then picked up the cleaned brief that was on the bed, placed it under Resident #8 without changing gloves. CNA A did not clean back part of the scrotum, penis fore skin, penis head and indwelling catheter before fastening the brief. During an interview with CNA A on 3/12/26 at 5:41 p.m., she said she did not clean the back part of the scrotum, penis fore skin, penis head and indwelling catheter because she forgot. She said she knew not cleaning the back part of the scrotum, penis fore skin, penis head and indwelling catheter could cause infection, skin break and odors. During an interview with CNA A on 3/12/26 at 5:41 p.m., she said she forgot to wear PPE while performing incontinent care, she knew not wearing PPE could cause infection to her and the residents.Review of the facility's policy titled Subject: Incontinent Care- With or Without Catheter, not dated, indicated: POLICYIt is the policy of this center to provide incontinent care to residents in a manner which provides privacy, promotes dignity and ensures no cross contamination.MALE1. Follow steps below: . Cleanse the penis shaft with wipe from the top of the shaft towards the rectum, including the scrotum. Using a new wipe with each stroke clean from the upper part of the leg to the hip. Repeat on the other side and then once from hip bone to hip bone Turn the resident over and repeat on the back side.2. Take off gloves, put them into the trash bag with the soiled brief and wipes.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER West Oaks Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 Green Crest Dr Houston, TX 77082	
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 a resident who was fed by enteral means received the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feedings including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal-pharyngeal ulcers for 1 of 5 residents (Resident #108) reviewed for feeding tubes. The facility staff failed to check Resident #108's g-tube placement before administering medication on 3/10/26. This failure could place residents at risk for complications such as aspiration pneumonia (occurs when food or liquid is breathed into the airway or lungs, instead of being swallowed), pneumothorax (a condition that occurs when air leaks into the space between the lungs and chest wall), perforations, empyema (one of the diseases that compromises chronic obstructive pulmonary disease), bronchopleural fistula (a sinus tract between the main stem, lobar, or segmental bronchus and the pleural space), and/or hospitalization. Record review of Resident #108's face sheet, dated 3/10/26, revealed a [AGE] year-old male was admitted on [DATE] and re-admitted on [DATE]. Resident #108 had a diagnoses of gastrostomy (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach), gastro-esophageal reflux (Gastric reflux) disease without esophagitis, aphasia (not enable to speak) following unspecified cerebrovascular disease (stroke), functional quadriplegia (medical condition involving paralysis of all four limbs (both arms and both legs) and torso, unspecified severe protein-calorie malnutrition, tracheostomy status (surgically created hole in the front of the neck that leads directly into the windpipe, or trachea). Record review of Resident #108's admission MDS, dated [DATE], reflected the BIMS score was 0 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was totally dependent on staff for bed repositioning and personal hygiene. Further record review of the MDS indicated Resident #108 was incontinent of bladder and bowel. Record review of Resident #108's care plan, dated 1/24/26, reflected Resident #108 had an ADL self-care performance deficit and the goal was the resident would improve current level of function. Record review of Resident #108's Physician's Orders, dated 2/17/26, reflected the following orders: Had NPO (nothing per oral/nothing by mouth) check gastric tube placement by auscultation (using stethoscope to listen to bowel sound) prior to meds, formula, and H2O flushes every shift. Check for residual every shift if > 60ccs, stop feeding and notify MD every shift. Feeding of Nova source Renal @ 45 cc/hr via pump, Flush GT with 30 ml water before and after administration of meds, flush with 10 cc between each medication every shift. During an observation of medication administration on 3/10/26 at 9:02 a.m., for Resident #108, RN H opened the medication cart, removed iron supplement liquid, poured 6cc in a medication cup from a 16 fl. oz. iron supplement liquid bottle. RN H said he needed to check Resident 108's blood pressure, then poured the 6 cc liquid iron back into the bottle. RN H was observed checking Resident #108's blood pressure (BP127/75, P81), RN H then went back to the medication cart, opened and poured out 5cc of iron supplement liquid in the medication cup and then punched three other medications, crushed it individually and then diluted with 20cc of water, then went back to the resident's room. RN H unplugged Resident #108's g-tube feeding of Nova source without checking for placement. During an interview with RN H on 3/10/26 at 9:25 a.m., regarding not checking for placement for Resident #108 before medications administration, RN H said he forgot and he knew not checking for placement could cause aspiration pneumonia, bloating, being too full and death. RN H said he had medication training upon hire by the DON. During an interview on 3/12/26 at 2:50 p.m., the DON said nurses should check the g-tube for proper placement by visual inspection and for aspirated stomach content prior to administering medication and water. The DON said not checking g-tube placement before administration of medication could (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER West Oaks Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 Green Crest Dr Houston, TX 77082	
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	result in infection, bloating, discomfort and death. Record review of the facility provided policy titled, Medication Administration Via Enteral Tube Care, dated 3/15/19, reflected the following . Policy Explanation and compliance Guidelines . To administer medications through a enteral tube in an accurate, safe, timely and sanitary manner. RESPONSIBLE DISCIPLINES Licensed Nurses EQUIPMENT: Prescribed medication Towel or incontinent pad 50 to 60 ml. Piston type catheter-tip syringe Stethoscope Cup for mixing medication and fluid 30-50 ml. of water Gloves GUIDELINES: 1. Verify correct medication to be administered. 2. Prepare medication 3. Verify resident identity & provide privacy 4. Explain procedure 5. Drape chest with towel or incontinent pad 6. Elevate head of bed to Fowler's position 7. Stop enteral pump, if applicable 8. Put on gloves 9. Auscultate for placement 10. Remove plug at the tip of the tube; check for residual; attach syringe to tip. 11. Instill 10-30 ml. of water into tube through syringe to check for patency. If water flows in easily, tube is patent. If it flows in slowly, raise funnel to increase pressure. If water does not flow properly, stop, notify physician, and follow orders.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER West Oaks Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 Green Crest Dr Houston, TX 77082	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain 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 for 2 of 11 residents (Resident #8 and Resident #108) reviewed for infection control. 1.The facility failed to ensure CNA A used the required PPE (gown) for Resident #8, who was on enhanced barrier precautions while performing incontinent/indwelling foley catheter care on 3/10/26. 2. CNA A failed to perform hand hygiene with glove changes during perineal care on Resident #8 3, RN H poured iron supplement liquid into a medication cup and then poured it back into the original 6 fl oz bottle, which could cause contamination, on 3/10/26. These failures could place the residents at risk of cross-contamination and development of infection. Record review of Resident #108's face sheet, dated 3/10/26, revealed a [AGE] year-old male was admitted on [DATE] and re-admitted on [DATE]. Resident #108 had a diagnoses of gastrostomy (a small opening into the abdomen and inserted a tube directly into the stomach allowing for food and liquids to be delivered directly into the stomach), gastro-esophageal reflux(Gastric reflux) disease without esophagitis, aphasia (not able to talk) following unspecified cerebrovascular disease (stroke), functional quadriplegia (medical condition involving paralysis of all four limbs (both arms and both legs) and torso, unspecified severe protein-calorie malnutrition, tracheostomy status (surgically created hole in the front of the neck that leads directly into the windpipe, or trachea). Record review of Resident #108's admission MDS, dated [DATE], reflected the BIMS score was 0 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was totally dependent on staff for bed repositioning and personal hygiene. Further record review of the MDS indicated Resident #108 was incontinent of bladder and bowel. Record review of Resident #108's care plan, dated 1/24/26, reflected Resident #108 had an ADL self-care performance deficit and the goal was the resident would improve current level of function. Record review of Resident #108's Physician's Orders, dated 2/17/26, reflected the following orders: Had NPO (nothing per oral/nothing by mouth) check gastric tube placement by auscultation (using stethoscope to listen to bowel sound) prior to meds, formula, and H2O flushes every shift. Check for residual every shift if > 60ccs, stop feeding and notify MD every shift. Feeding of Nova source Renal @ 45 cc/hr via pump, Flush GT with 30 ml water before and after administration of meds, flush with 10 cc between each medication every shift. During an observation of medication administration on 3/10/26 at 9:02 a.m., for Resident #108, RN H opened the medication cart, removed iron supplement liquid, poured 6cc in a medication cup from a 16 fl. oz. iron supplement liquid bottle. RN H said he needed to check Resident 108's blood pressure, then poured the 6 cc liquid iron back into the bottle. RN H was observed checking Resident #108's blood pressure (BP127/75, P81), RN H then went back to the medication cart, opened and poured out 5cc of iron supplement liquid in the medication cup During an interview via telephone on 3/12/26 at 4:43 p.m., RN H, said, regarding pouring Iron supplement back to bottle after pouring it in the medication cup, it was hygienic because the medication was clean. During an interview on 3/12/26 at 5:38 p.m., the DON when asked if iron supplement poured from the medication cup into bottle was hygienic, said, I am old school, I would have wasted the iron but I am not sure what the policy says, I have to look into it. Record review of Resident #8's face sheet, dated 3/10/2025, revealed an [AGE] year-old male admitted [DATE] and re-admitted [DATE]. His medical diagnoses included muscle wasting and atrophy (loss of muscle tissue, causing muscles to become small, thinner and weaker) not elsewhere classified, unspecified shoulder, dysphagia (difficulty swallowing), oropharyngeal phase(difficulty initiating a swallow or moving food from the esophagus), cognitive communication deficit, unsteadiness on feet, muscle weakness (generalized), obstructive and reflux uropathy,(blockage in the urinary tract that prevent urine from draining properly , causing backup and potential kidney (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER West Oaks Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3625 Green Crest Dr Houston, TX 77082	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	damage) unspecified, nasal congestion, sepsis (a life -threatening medical emergency that occurs when the body's immune system has an infection, causing it to damage its own tissue and organs) essential primary hypertension(high blood pressure) and urinary tract infection. Record review of Resident #8's quarterly MDS assessment, dated 1/20/26, reflected a BIMS score of 13 out of 15, which indicated intact cognition. He required assistance from staff with ADL care. Record review of Resident #8 's care plan, dated 1/27/26, reflected, . The resident had an ADL self-care deficit .Interventions.Personal Hygiene and Toilet use- Resident is totally dependent . Resident #8 was also care-planned for a Foley catheter (a sterile tube that is inserted into your bladder to drain urine) and incontinent care, with interventions including following physician orders for catheter insertion, changes and maintenance. Review of Resident #8's Physician's orders, dated 1/25/2026 through 3/1/2026, reflected orders for the following: Foley Catheter cleansing and perineal hygiene daily and as needed if soiled, using a catheter securing device with a start date of 1/25/2026. During an observation on 3/12/26 at 5:20 p.m., during foley Catheter and incontinent care with Resident #8, revealed CNA A don (worn) PPE (gown), did not wash hands, wore a clean glove, picked up cleaned brief, wet wipes from Resident #8's dresser and placed it on the bed. CNA A then picked up the clean brief from the bed and placed it under Resident #8 without changing gloves. During an interview with CNA A on 3/12/26 at 5:41 p.m., she said she forgot to change gloves and wear PPE (gown) while performing incontinent care. She said she knew not wearing PPE could cause infection to her and the residents. During an interview on 3/12/26 at 4:35 p.m., the DON stated any resident who had a foley catheter was placed on Enhanced Barrier precautions (an infection control intervention designed to reduce the transmission of multidrug-resistant organisms and employs targeted gown and glove use during high-contact resident care activities for targeted residents) to help reduce the spread of MDRO's. She stated signage was posted outside to the door, which explained what PPE was to be worn and for what task. She stated any contact with a resident with a urinary catheter required the use of gown and gloves. She stated the staff had received training on the use of Enhanced Barrier Precautions and hand washing. Guidance/ProcedureEnhanced Barrier Precautions (EBP) are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.EBP are indicated for residents with any of the following: Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; orWounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO. ^ Wounds generally include chronic wounds, not shorter-lasting wounds: skin breaks/skin tears/or similar areas.^ Examples of chronic wounds: pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers.^ Examples of indwelling medical devices: central lines, urinary catheters, feeding tubes, and tracheostomies.When EBP are indicated, EBP should be employed for the following high-contact resident care activities: Dressing, bathing/showering, transferring, providing hygiene, changing briefs, assisting with toileting, device care, and wound care. In general, gowns and gloves would not be recommended when performing transfers in common areas such as dining or activity rooms, where contact is anticipated to be shorter in duration.Therapy consideration: if close contact is required to perform therapy functions, gown and gloves are recommended.Residents are not restricted to their rooms or limited from participation in activities.The facility has discretion in how they choose to communicate these precautions to the staff.PPE for EBP is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room.The facility has discretion in using EBP for residents who do not have wounds or indwelling medical devices and are infected or colonized with an MDRO that is not currently targeted by CDC. Review of the facility's policy titled, Subject: Incontinent Care- With or Without Catheter, not dated, indicated, POLICY: It is the policy of this center to provide incontinent care to residents in a manner which provides privacy, promotes dignity and ensures no cross contamination.		