STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675557	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oasis at Pearland	3400 E Walnut Pearland, TX 77581

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41469 Based on interview and record review, the facility failed to ensure 1 of 4 sampled residents (CR #3) were admitted with physician orders for immediate care, in that: The facility failed to have physician's orders that indicated CR #3's need for dressing to healing tracheostomy. This failure places residents with medical needs at risk for a decrease in their quality of care. Findings included: Record review of CR #3's face sheet, dated 08/25/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE] and was diagnosed with anoxic (without oxygen) brain damage and chronic respiratory failure with hypoxia (lack of oxygen). Record review of CR #3's care plan, not dated, revealed no mentioning of resident's trach status or post trach status. Record review of CR #3's MAR, dated 08/25/2024, revealed there were no orders for trach site care. Record review of CR #3's MDS, dated [DATE], reflected resident was not documented to receive tracheostomy care. Record review of CR #3's nurses notes, dated 08/05/2024 - 08/25/2024, revealed no notes regarding trach site care. Record review of CR #3's skin assessment, dated 08/09/2024, revealed there were no notes made regarding a healing trach site. Record review of CR #3's skin assessment, dated 08/16/2024, revealed there were no notes made regarding a healing trach site. (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: 675557	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN A on 08/28/2024 at 2:21 PM, she stated she performed both of CR #3's skin assessments on 08/09/2024 and 08/16/2024 during his stay in the facility. She stated CR #3 admitted with his trach completely out and he had very small penpoint opening at the site. She stated by the next day they did not need to prepare for treatment because it was closed. She stated the trach was closed when he came in and they were even trying to figure out why the resident came with dressing on the trach site in the first place. In an interview with Wound Care Nurse on 08/28/2024 at 1:53PM, he revealed he did not work with CR #3 because he did not have a documented wound. He stated the charge nurses were in charge of documenting skin changes and reporting it verbally to himself. He stated skin assessments were to be done weekly to identify skin changes and address them promptly. In an interview with the LVN B on 08/28/2024 at 3:36 PM, he revealed CR #3's trach site looked fine and he found the resident to have scant pea-size drainage that he felt was not significant enough to report to the physician as it was only part of the healing process. He stated he took initiative on his own to apply dry dressing to it whenever he noticed drainage coming from the site. In an interview with the DON on 08/28/2024 at 3:44PM, she stated LVN B should have reported the drainage from CR #3's trach site even if it was only a pea size amount to give the doctor the opportunity to clarify the need for an order for CR #3's closed trach site. She stated the risk of not addressing the trach site was a lack in continuity of care. Record review of the facility's policy on trach care, not dated, revealed for site and stoma care, document the procedure, condition of the site, and the resident's response.