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	04/08/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 15976 Based on observations, interviews, and record review, the facility failed to ensure each resident was free from abuse, neglect and exploitation for 2 of 5 (Resident #1 and CR#2) residents reviewed for abuse. The facility failed to ensure Resident #1 was free from sexual abuse when CR #2 told Resident #1 to hold his (CR#2's) penis and touch his body on 3/14/2025. The noncompliance was identified as Past Non-Compliance. The PNC IJ began on 03/14/2025 and ended on 3/17/2025. The facility corrected the noncompliance before the survey began. This failure placed all residents in the facility at risk of abuse and neglect that could result in emotional and mental trauma. Findings included: Record review of Resident #1's admission face sheet dated 4/8/2025 revealed he was a [AGE] year-old male, who admitted to the facility on [DATE] with primary diagnoses of cerebral palsy (disorder of movement and muscle tone), lobar pneumonia (a type of pneumonia that affects and inflames one or more lung lobes), acute respiratory failure with hypoxia (a serious condition where the lungs fail to adequately oxygenate the blood leading to low oxygen levels, epilepsy (nerve activity in the brain causing seizure), muscular atrophy(a condition that causes the muscles to lose mass and strength), asthma (condition where the airways become inflamed), muscle wasting (loss of muscle mass and strength), and intellectual disabilities (significant limitations in both intellectual functioning and adaptive behavior). Record review of Resident #1's Admission MDS assessment dated [DATE] revealed he has a BIMS score of 8 indicating he was moderately impaired for cognition; For behavior he was coded as having no behavior. For ADL activities he was dependent on staff for toileting, shower/bathe, lower body dressing, putting on and taking off shoes and personal hygiene, he was partial/moderate assist for eating, and required substantial/maximal assistance for oral hygiene and upper body dress. The resident was coded as always incontinent of bowel and bladder. Record review of Resident #1's care plan revised 01/21/2025 revealed the following areas of concern: (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 - Few	COGNITIVE IMPAIRMENT: Resident #1's has impaired cognition r/t Congenital Mental Retardation, and is at risk for further decline and injury. o Resident #1's needs will be met and dignity maintained over the next 90 days. o Allow time for tasks and responses o Explain all procedures using terms/gestures the resident can understand o Involve in care to maintain or increase level of independence o Praise for tasks that the resident completes o Repeat information PRN Record review of Resident #1's care plan revised 01/29/2024 revealed the following areas of concern: Record review of nurse's notes 3/15/2025 at 9:30pm COMMUNICATION- with Resident Assistant Administrator was physically in room. Resident In bed comfortably, stated that he feels safe and not upset about situation that occurred earlier in the day. Supportive Care Psychologist will see him 3/16/2025. 3/15/2025 4:06 Incident Note: Resident informed this writer that he had been touched all over his body by another resident. Also states that he was asked to touch the other resident's private parts after the resident came into his room. Resident immediately taken to room and head-to-toe assessment performed without any significant findings. Enhanced supervision began with the alleged perpetrator for resident's safety. Police department, MD and family notified. Observation on 3/17/2025 at 9:25am Resident #1 observed in a low bed. He appeared to have limited ROM. A camera was observed in the room and the resident did not have a roommate. In an interview on 3/17/2025 at 9:25am Resident #1 said CR #2 told him to touch him everywhere. He said he wanted him to touch his crack, his butt, his behind and he did, but he didn't want to touch CR #2's private body parts. He said he told Activity Director A CR #2 wanted him to touch him all over and making him do bad things by touching him. He said Activity Director A told him CR #2 should not have told him to do that, and he (Resident #1) did not do anything wrong. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 3/17/2025 at 1:13pm Resident #1's family member said CR #2 was not Resident #1's roommate. She said she had video evidence on her computer from the camera past Friday. The camera was accidently moved or disconnected on Saturday, and she thought something happened on Saturday but there was no video evidence. She said Resident #1 reported it to Activity Director A. She said she was not aware until she was told on Saturday. She said she felt the facility responded appropriately. I don't think this was an easy thing to deal with and they reacted in a few hours. They called at 4 pm on Saturday and when she got to the facility there was an officer at the facility. In an interview on 3/17/2025 at 2:15pm the Assistant Administrator said on Saturday afternoon, the 15th of March 2025, Activity Director A witnessed CR #2-wheeling Resident #1 back to his room and Resident #1 was calling CR #2 'Daddy. Activity Director A told Resident #1 not to call CR #2 daddy because he was not his father. After the meal, CR #2 wheeled Resident #1 to his room, then came back about an hour later to Bingo. She said she was surprised because Resident #1 did not like Bingo. When Resident #1 got to the table he told Activity Director A that CR #2 (Daddy) made me touch his private parts and I didn't like it. The Administrator said, Resident #1 was usually truthful when he spoke. She called the supervisor over and got statements from the CNA, 2 charge nurses, and Activity Director A. She said both residents were immediately placed on enhanced supervision, she reported the incident to both families, and she called the police. She said Resident #1's family was here when the police arrived. She said no camera footage found on Saturday because the camera was unplugged, the camera footage was from Friday. She said Resident #1 did not have a roommate, both residents were living on separate halls. She said CR #2 was a new admit, he was admitted a few days before the incident. She said he would wander down different halls. She said CR #2 was ambulatory, very friendly, and did not exhibit any behaviors that indicated aggression or sexual behavior. She said CR #2 complained of headache, and CR#2's behaviors of acting drowsy etc. during the interview. She said she called CR #2's family and she was told to send him to the hospital. She said CR #2 was sent to the hospital on Saturday on 3/15/2025 at 9:30 pm. Record review of CR #2's admission face sheet dated 3/20/2025 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE] and was discharged on [DATE] to a local hospital. His diagnoses included chronic kidney disease (inability to filter waste and excess fluid from the blood), type II diabetes (high blood sugar), altered mental status (a state where a person's alertness and awareness are changed), dementia (memory loss), hypertension (high blood pressure), and hyperlipidemia (high fat in blood). Record review of CR#2's care plan dated 3/13/2025 revealed the following: CR#2 was at risk of elopement, risk/wanderer r/t, resident wanders aimlessly. -wanders from hall to hall throughout the day. - safety will be maintained through the review date. - will not leave facility unattended through the review date. - was Assess for fall risk. o Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. o Monitor for fatigue and weight loss. o Monitor location. Document wandering behavior and attempted diversional In an interview on 3/17/2025 at 2:33pm CNA A said she was in-serviced that morning on stopping abuse. She said if she witnessed abuse to report it to the DON and let everyone know. CNA A was able to verbalize understanding of the different forms of abuse. In an interview on 3/17/2025 at 1:35 CNA B said she was in-serviced on the different forms of abuse. If abuse was witnessed between two residents, she was to separate the residents and report to the charge nurse immediately. CNA B was able to verbalize understanding of the different forms of abuse and training. In an interview on 3/17/2025 at 1:45pm CNA C said she was in-serviced on abuse/neglect and if she witnessed any resident-to-resident abuse she would separate the residents, call the charge nurse, and report it to the Administrator. She said she did not know much about the two residents because she normally did not work the halls the residents were on. In an interview on 3/17/2025 at 1:48 pm Resident #4 said he had no problems with any staff or residents. He said if he was abused, he would tell the people at the front desk. He was never abused by any staff or residents. In an interview on 3/17/2025 at 1:48 pm Resident #5 said she had no problems with any staff or residents. She said she was treated well by the staff. She said no resident came to her room. She said if she was abused, she would report it to the charge nurse. In an interview on 3/17/2025 at 1:50 pm Resident #6 said he had no problems with staff or residents. He said the staff treatment was good and he had no problems with other residents. He said if he was abused, he would tell the nurse. In an interview on 3/17/2025 at 1:53pm Resident#7 said he had no problems with other residents. He said if he was abused, he would report it to the charge nurse. In an interview on 3/17/2025 at 1:50pm LVN F said he was recently in-serviced on abuse and neglect, resident rights, and resident to resident abuse. He said if he witnessed resident to resident abuse, he would separate the residents, make sure they were safe, and notify the Administrator. He said no one has reported abuse to him. In an interview on 3/17/2025 at 1:52pm LVN G said she was in-serviced recently on abuse/neglect, resident rights, enhanced supervision, and resident to resident abuse. She said if she witnessed resident to resident abuse she would separate them, monitor them. She said she would interview the staff and residents to find out was going on and she would report to the Administrator or the DON. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/04/2025 at 1:13 pm Activity Director A said CR #2 was pushing Resident #1's wheelchair to the dining room. She said she asked CR #2 if he was going to play bingo and he wheeled Resident #1 back to his room. She said prior to the incident, she heard Resident #1 calling CR #2 daddy when they were in activities. She said she told Resident #1 not to call CR #2 daddy because he was not his daddy. She said after the meal, on 3/15/2025 she noticed CR #2 taking Resident #1 back to Resident #1's room. She said about an hour later they came to bingo, and she was surprised because Resident #1 did not like bingo. Activity Director A said when they got to the table, Resident #1 told her Daddy made me touch his private parts and all over his body and he did not like it. She said she looked for the Weekend Supervisor and told her. She said Resident #1 did not seem afraid, but he looked uncomfortable. In an interview with the Weekend Supervisor on 4/4/2025 at 3:00pm she said she was working the day the incident took place. She said Activity Director A took Resident #1 to her and said Resident #1 told her CR #2 had him touched his private parts and other parts of his body. She said she took Resident #1 to his room and did a head-to-toe evaluation and there were no marks or bruises. She said CR #2 was also evaluated and there were no marks or bruises. She said when she interviewed CR #2, he denied at first that he had Resident #1 touch his private parts but later said Resident #1 only touched his private parts one time. She said they started to monitor both residents in their different rooms. She said CR #2 started complaining of a headache and said he wanted to go to the hospital, and he was later transferred to the hospital. Interview on 4/4/2025 at 3:20pm with the Administrator revealed Activity Director A told her Resident #1 told her CR #2 had him to do something he did not want to do. She said Activity Director A told her that Resident#1 came to her and told CR #2 (Daddy) let him touch his private part, and he did not like it. She said Resident #1 was brought back to his room, head to toe assessment done and enhanced supervision and monitoring started. CR #2 was brought to his room and a head to toe assessment done and enhanced supervision and monitoring put in place. She said she immediately launched an investigation. She said after the assessment CR#2 started complaining of a headache and said he wanted to go to the hospital. She said Resident#1 and CR #2 were not roommates but were meeting at lunch. She said CR #2 would push Resident #1's wheelchair to his room and he never displayed any inappropriate behaviors. She said they were thinking of elopement as CR #2, wandered in the facility, so being inappropriate was a surprise for them. He said they were always redirecting him because he at times was confused and walked up and down the hallway. She said there was no witness to the inappropriate touching but Resident #1 said CR #2 let him touch his body part. The Administrator said during the interview CR #2 first said Resident #1 fell and he picked him up and might have touched his bottom in the process. She said at that point she knew CR #2 was not telling the truth. She said if Resident #1 fell CR #2 could not pick him up by himself. She continued to ask him questions and he finally said that he let him touch his private part, but he only did it once. She said CR #2's family was notified, and permission given for the resident to be sent to the hospital. She said he was discharged to the hospital and would not be readmitted to the facility. She said in-services were done on abuse/neglect, enhanced supervision, and resident rights. Observation on 4/4/2025 at 12:20pm Resident #1 was observed in bed, he was alert and oriented with some confusion. He was clean and groomed with no offensive odor. The call light was observed to be within reached. No visible marks or bruises noted. CR #2 was not interviewed on 4/4/2025 because he was not at the facility. He was sent to the hospital and did not return. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with Resident #1 on 4/4/2025 at 12:20pm, Resident #1 said he was treated well at the facility. He stated CR #2 abused him. He was asked at that time, what CR #2 did. He said CR #2 made him touch his private body parts all over and he did not like it. He said the man who touched him was living in another room. He stated he did not have a roommate. In a telephone interview with Resident #1's family on 04/04/2025 at 2:00pm she said the family was notified of the abuse regarding Resident #1 and CR #2. She said she was satisfied with the fact it was addressed in a timely manner. She said by the time she arrived, the police was in the building and the investigation was in progress. In an interview on 04/04/2025 at 12:17pm Medication Aide H said she had been working at the facility for about a year and she said she was trained on abuse, neglect, resident to resident abuse, and resident rights. She said if she witnessed two residents fighting, she would separate them and call the nurse. She said she would report any abuse or neglect to the DON, and the Administrator. In an interview on 04/04/2025 at 3:15pm Medication Aide L said she had been working at the facility for the last [AGE] years. She said she was trained on abuse, neglect, resident to resident abuse, and resident rights. She said if she witnessed two residents in a fight or any other altercation, she would separate them and call the nurse. She said she would report any abuse to the nurses, the DON, and the Administrator. In an interview on 04/04/2025 at 2:17pm CNA K said she was trained on abuse and neglect. She said she had never seen anyone being abusive to Resident#1. She said they were trained on not having residents pushing residents, resident to resident abuse, and resident rights. In an interview on 04/04/2025 at 3:40 pm RN E said she had been working at the facility for almost one year and she was recently trained on abuse, neglect, resident to resident abuse, and resident rights. She said if she witnessed two residents in a fight or other altercation, she would separate them, call the nurse, and notify the family. She said she would report any form of abuse to the nurses, the DON, and the Administrator. On 04/08/2025 at 2:50pm, the facility's Administrator, DON, and Regional Nurse were notified of the past noncompliance IJ. A plan of removal was not requested. An IJ template was provided to the Administrator on 04/08/2025 at 2:58 p.m. In an interview on 04/08/2025 at 3:50pm CNA I said she had been working at the facility for the last three weeks. She said she was trained on abuse, neglect, resident to resident abuse, resident rights, and residents who wandered in other resident's room. She said if she witnessed two residents in a fight, she would separate them and call the nurse. She said she would report any abuse to the nurses, the DON, and the Administrator. In an interview on 04/08/2025 at 4:04pm Medication Aide H said she was in-serviced on abuse and neglect, resident to resident abuse, and resident rights. She said if she witnessed resident to resident abuse, she would separate them and call the nurse. She said if she witnessed abuse, she would report it to the nurse and the administrator. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 4/08/2025 at 4:10pm CNA J said he was in-serviced recently on abuse and neglect, resident rights, and resident to resident abuse. He said if he witnessed resident to resident abuse he would separate them, call the nurse, and report the incident to the charge nurse and administrator. Record review of Resident #1's clinical records revealed that the resident was seen by psychiatric services on 3/18/2025 and they would be following the resident. Further review revealed Resident #1 said he felt safe at the facility. Record review of the in-service dated 3/15/2025 revealed all staff were in-serviced on abuse and neglect, reporting of abuse and neglect, signs of abuse and neglect, exploitation , enhanced supervision, resident rights safety, and supervision to prevent abuse and neglect of resident. Staff sign in sheets were also reviewed. Record review revealed safe survey was done with residents on 3/15/2025 and residents verbalized that they felt safe at the facility. Interviews were conducted with facility staff, and they confirmed they were in-serviced. Staff were able to recall the incident that triggered the in-serviced. Record review of the facility's document date 07/17/2021 titled, Abuse read in part . POLICY It is the policy of this center to prohibit resident abuse or neglect in any form, and to report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse or neglect caused by another person. DEFINITIONS Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled using technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The noncompliance was identified as Past Non-Compliance. The IJ began on 03/14/2025 and ended on 04/08/2025. The facility corrected the noncompliance before the survey began.