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	12/09/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 4 of 93 resident rooms (room [ROOM NUMBER], 107, 140, and 146) reviewed for environment.- The facility failed to have clean water, and the water was brown when the faucet was turned on, in rooms [ROOM NUMBERS].- The facility failed to have water pressure, and the water barely came out of the faucet, in Rooms 106, 107, 140 and 146.These failures could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life.The findings included:In an observation on 9/21/25 at 12:24pm, the faucet in room [ROOM NUMBER] was turned on and brown water came out for several minutes. The water pressure was also very low, and the water barely trickled out of the faucet.In an observation on 9/21/25 at 12:29pm, the faucet in room [ROOM NUMBER] was turned on and brown water came out for approximately 10-20 seconds. In an observation on 9/21/25 at 12:31pm, the faucet in room [ROOM NUMBER] was turned on and the water pressure was very low. The water barely trickled out of the faucet.In an observation on 9/21/25 at 12:34pm, the faucet in room [ROOM NUMBER] was turned on and the water pressure was very low. The water barely trickled out of the faucet.In an interview with the ADM on 9/21/25 at 12:40pm, after he was shown the pictures/videos of the brown water, he said they were having a lot of plumbing issues, and he would contact maintenance.In an interview with the ADM on 9/21/25 at 1:34pm, the ADM said he had just sent the Nurse Supervisor around to all the faucets in the resident rooms to test them, and she identified 7 rooms that had brown water coming out of the faucet. He said they put hand sanitizer by those sinks, would keep those sinks running until the water ran clear, and the Nurse Supervisor would keep monitoring them. He said staff had not notified him of any brown water, but maintenance had changed out some pipes on Friday, 9/19/25, and the Maintenance Assistant said there would be some brown water but only for that day. In an interview and observation on 9/21/25 at 2:32pm, the ADM and the Staffing Coordinator said the water was running clear in all 7 faucets and produced a cup with clear water in it showing the water that came out of the faucet.In an interview on 9/21/25 at 2:32pm, the Maintenance Assistant said plumbers shut off the water on Friday, 9/19/25, for a couple hours and then turned them back on. He said he was not sure why the plumbers had to turn off the water, but he thought they were working with the pipes in the ditch behind the facility. The Maintenance Assistant said he had not heard about any issues of brown water until today, and if staff had used the sinks on Friday, the water would have already cleared out the lines. He said the slow water from the faucet was because the sediment from the line got stuck in the tip of the faucet. He said he had to go to those sinks and empty the filter on the tip of the faucet to get the sediment out.In an interview on 9/21/25 at 3:35pm, Med Aide T said she did notice brown water in the sinks in the resident's rooms, and she waited and let the water turn clear before she washed her hands. In an interview on 9/21/25 at 3:38pm, LVN C said he did notice brown water from some of the sinks in the resident's rooms and he let the water run clear before washing his hands. In an interview on 9/21/25 at 4:30pm, the ADM said he did not think to check the water in the sinks on Friday after the pipes were worked on. He said he should have checked them before he left to ensure the water was clear.Record review of the facility's policy and procedure on Maintenance Service with no dates, read in part: Maintenance service shall be provided to all areas of the building, grounds, and equipment. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel include, but are not limited to: Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. Maintaining the building in good repair and free from hazards.Establishing priorities in providing repair service.Providing routinely scheduled maintenance service to all areas. Others that may become necessary or appropriate. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. A copy of the maintenance schedule shall be provided to each department director so that appropriate scheduling can be made without interruption of services to residents. Maintenance personnel shall follow established infection control precautions in the performance of their daily work assignments.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain grooming and personal hygiene for 1 out of 5 residents (Resident #1) reviewed for ADLs.- The facility failed to provide scheduled showers, three times a week to Resident #1 for the weeks of 8/25/25-8/30/25, 9/1/25-9/6/25, and 9/15/25-9/20/25.This failure could place residents at risk of skin breakdown, infection, and reduced feelings of self-worth.Findings included:Record review of Resident #1's undated face sheet revealed he was a [AGE] year-old male admitted [DATE], with diagnoses of complete paraplegia (unable to move arms or legs), type 2 diabetes (body does not produce insulin or resists it), heart failure (heart does not pump effectively), stage 4 pressure ulcer of the sacrum (pressure ulcer of the tailbone that exposes bone, tendon, or muscle), neurogenic bowel (nerve damage disrupts normal bowel function), and neuromuscular dysfunction of bladder (problems with storing and emptying urine).Record review of Resident #1's admission MDS assessment dated [DATE], revealed a BIMS score of 15 out of 15 which indicated normal cognition. According to the MDS, the resident had impairment on both sides of his upper and lower extremities and was dependent (helper does all of the effort and Resident does none of the effort) for all mobility and selfcare. The resident had an indwelling catheter (tube into bladder to drain urine). The Resident was admitted with 3 Stage 3 (fat is exposed but bone, tendon, or muscle is not) pressure ulcers.Record review of Resident #1's Care Plan dated 7/31/25, revealed a Focus: Resident is at risk for decline in ADL functions and injury r/t paraplegia and weakness (Initiated: 8/18/25). The goal was to be well dressed, groomed, clean, odor free, and have no decline in ADL functioning over the next 90 days (Initiated: 8/18/25, Target: 11/13/25). The interventions included providing total care assistance for bathing, providing total care assistance for personal hygiene/grooming, and providing oral care daily and as needed.Record review of Resident #1's H&P dated 8/14/25 at 9:17pm from MD P revealed, .History of Present Illness.Otherwise, the patient's only other complaint is that he has not had a bath or shower since he has been here. I told him we would address that to get that taken care of and resolved.Review of Systems.PSYCHIATRIC- No depression, No anxiety, No mood swings, No sleep disturbances, No changes in memory or concentration.SKIN- No rashes, No itching, No skin discoloration, No bruising, Has stage 4 sacral wound, Reports not having bath or shower since admission.Assessment and Plan.Patient is bedbound and requires assistance with feeding and activities of daily living.Patient reports not having had a bath or shower since admission; will address this with nursing staff to ensure proper hygiene care is provided.Record review of Resident #1's Progress Notes from 7/31/25-9/11/25 revealed no refusals of baths and/or showers.Record review of Resident #1's Shower Logs revealed the following:- 8/25/25-8/30/25: He received 1 bath on 8/25- 9/1/25-9/6/25: He received no baths.- 9/15/25-9/20/25: He received 1 bath on 9/17/25.Record review of Resident #1's Skin Monitoring Comprehensive CNA Shower Review revealed the following:- He had a bath on 9/8/25- He had a bath on 9/10/25- He had a bath on 9/12/25- He had a bath on 9/17/25In an interview and observation on 9/21/25 at 12:08pm, Resident #1 was lying on his back in bed with a gown on. He had bilateral hand contractures, long yellow nails, and a big, bushy beard. He said he had 2 bed baths since he had been at the facility. He said he would like to have his beard trimmed but no one had ever asked him, so he thought there was no way to trim it.In an interview on 9/21/25 at 3:25pm, the Nurse Supervisor said they had a Shower Tech during the week and the Nurse Aide's did them on Saturday. She said they did not perform showers/baths on Sunday.In an interview on 9/21/25 at 3:35pm, Med Aide T said they had a Shower Tech during the week and on the weekends. She said if a Resident did not receive showers/baths they could smell bad or itch.In an interview on 9/21/25 at 3:38pm, LVN C said they had a Shower Tech, or the Aides gave them. He said they usually had several aides at one time giving showers/baths. He said he had Residents complain before about not getting showers, but it was usually because they initially refused it and then wanted it later in the shift when they did not have time. He said if a Resident did not receive a shower, it could cause skin breakdown.In an interview on 9/21/25 at 4:06pm, the ADON said the CNAs gave the showers on Saturday, and there were 4. She said there was 1 Shower Tech during the week who gave showers and bed baths to problem Residents needing baths. She said the CNAs did the other bed baths during the week. The ADON said Resident #1 was one of the problem Residents that the Shower Tech would do during the week because he refused to get a bath sometimes.In an interview on 9/21/25 at 4:18pm, the ADON said the talk about Resident #1 during morning rounds