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	07/01/2026

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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for one (Resident #1) of eight residents reviewed for dignity.The facility failed to ensure Respiratory Therapist A provided privacy to Resident #1 while providing oral care and tracheostomy (surgically created opening in the windpipe to assist with breathing) suctioning on 6/9/2026. These failures could place the residents at risk of not having the right to a dignified existence maintained.Findings included:Record review of Resident #1's face sheet dated 6/11/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including chronic respiratory failure with hypoxia (condition in which the body or a part of the body is deprived of adequate oxygen at the tissue level) and encounter for attention to tracheostomy (surgically created opening in the windpipe to assist with breathing).Record review of Resident #1's quarterly MDS dated [DATE] revealed, section C (Cognitive Patterns) revealed a BIMS could not be conducted as Resident #1 was rarely or never understood. Section GG (Functional Abilities) revealed Resident #1 was dependent for oral hygiene. Section O (Special Treatments, Procedures, and Programs) revealed Resident #1 received tracheostomy (surgically created opening in the windpipe to assist with breathing) care and suctioning while a resident.Record review of Inservice Training Sheet dated 4/27/26 with topic of HIPAA Compliance - Privacy During Care & Screen Protection with the purpose to reinforce HIPAA requirements by ensuring resident privacy was maintained during care and while accessing electronic health information with staff expectations to close privacy curtains during care.Record review of Resident #1's Order Summary Report dated 6/11/26 revealed physician's order for mouth care every shift with start date of 1/12/26 and provide tracheal suctioning every shift and as needed with start date of 1/12/26.Record review of Resident #1's care plan dated 6/11/26 revealed Resident #1 was care planned as requiring the use of a ventilator with intervention to suction as ordered as needed. Resident #1 was also care planned as being at risk for decline in activities of daily living functions and injury related to impaired mobility and cognition with intervention to provide total care assistance for personal hygiene and grooming. Observation on 6/9/26 at 10:11 a.m. revealed Respiratory Therapist A provided care to Resident #1 of oral care at suctioning to Resident #1's tracheostomy without shutting the door to Resident #1's room or pulling Resident #1's privacy curtain.During interview on 6/9/26 at 10:27 a.m., Respiratory Therapist A said staff normally closed the door or pulled the privacy curtain when providing care to residents. Respiratory Therapist A said some staff shut the door to the room and some staff closed the curtain when providing care. Respiratory Therapist A said he normally pulled the privacy curtain when providing care to residents but because the surveyor was standing in the room, he did not want to hit the surveyor with the privacy curtain. Respiratory Therapist A said staff should not leave the door open or not close the resident's curtain because of their privacy.During interview on 6/11/26 at 11:51 a.m., Respiratory Therapist B said when she was providing care to a resident, she closed the door or closed the curtain to make sure the resident had privacy. Respiratory Therapist B said she would provide privacy for everything including suctioning and oral care. During interview on 6/11/26 (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 2:48 p.m., the surveyor notified the DON regarding Respiratory Therapist A not shutting Resident #1's door or pulling the privacy curtain and the DON said privacy not being given when care was being provided was a dignity issue. Record review of the facility's policy Suctioning the Lower Airway (Endotracheal [ET] or Tracheostomy Tube) dated quarter 3 2018 revealed provide for resident privacy.Record review of the facility's policy Quality of Life - Dignity with revision date of August 2009 revealed Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for 1 (Resident #3) of 8 residents reviewed for pharmaceutical services. The facility failed to ensure Resident #3 received Clonazepam 0.5 mg and Phenobarbital 32.4 mg, both medications ordered for seizures, as ordered as evidenced by gaps in administrations on 11/1/25-11/3/25, 11/10/25 and 11/18/25. This failure could place the residents at risk of not receiving medications as ordered by the physician and risk of seizures (sudden surge of abnormal electrical activity in the brain that can cause changes in behavior, awareness, or muscle control).Findings included:Record review of Resident #3's face sheet dated 6/11/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including acute respiratory failure (when the lungs fail to deliver enough oxygen to the blood or cannot remove carbon dioxide effectively which impairs organ function and potentially cause life-threatening complications) and other seizures (sudden surge of abnormal electrical activity in the brain that can cause changes in behavior, awareness, or muscle control). Record review of Resident #3's admission MDS dated [DATE], section C (Cognitive Patterns) revealed a BIMS could not be conducted as Resident #3 is rarely or never understood. Section I (Active Diagnoses) revealed Resident #3 had an active diagnosis of a seizure disorder or epilepsy. Record review of Resident #3's Order Summary Report dated 6/9/26 revealed physician's order for Clonazepam oral tablet 0.5 mg with instructions to give 1 tablet via peg tube two times a day for anticonvulsant (antiseizure medication) with start date of 10/2/25 and Phenobarbital oral tablet 32.4 mg with instructions to give 1.5 tablets two times a day with start dates of 10/7/25.Record review of Resident #3's care plan dated 6/11/26 revealed focus that Resident #3 was at risk for increased episodes of seizure activity with intervention dated 10/17/25 to give medication per order. Record review of Resident #3's November 2025 MAR revealed Clonazepam 0.5 mg tablet with instructions to give 1 tablet every morning and at bedtime was documented with chart code 9 for 11/2/25 at 8 a.m. and 8 p.m., 11/3/25 at 8 a.m. and 8 p.m. and 11/9/25 at 8 p.m. MAR also revealed Phenobarbital oral tablet 32.4 mg with instructions to give 1.5 tablet every morning and at bedtime was documented as 9 for dates 11/1/25 at 8 p.m., 11/2/25 at 8 a.m. and 8 p.m., 11/3/25 at 8 a.m. and 8 p.m., and 11/18/25 at 8 p.m. Chart codes on the MAR revealed 9 meant other/see progress notes.Record review of Resident #3 progress note dated 11/2/25 at 1:53 a.m. written by LVN D revealed note awaiting delivery from pharmacy- medication has been reordered for phenobarbital oral tablet 32.4 mg with instructions to give 1.5 tablet every morning and at bedtime. Record review of Resident #3's progress note dated 11/2/25 at 9:14 a.m. written by LVN B revealed note on order for clonazepam oral tablet 0.5 mg with instructions to give 1 tablet every morning and at bedtime. Record review of Resident #3's progress note dated 11/2/25 at 9:15 a.m. written by LVN B revealed note on order for phenobarbital oral tablet 32.4 mg with instructions to give 1.5 tablet every morning and at bedtime. Record review of Resident #3's progress note dated 11/2/25 at 10:03 p.m. written by LVN B revealed note on order for clonazepam oral tablet 0.5 mg with instructions to give 1 tablet every morning and at bedtime. Record review of Resident #3's progress note dated 11/2/25 at 10:09 p.m. written by LVN B revealed note on order for phenobarbital oral tablet 32.4 mg with instructions to give 1.5 tablet every morning and at bedtime. Record review of Resident #3's progress note dated 11/3/25 at 7:50 a.m. written by LVN B revealed note on order for clonazepam oral tablet 0.5 mg with instructions to give 1 tablet every morning and at bedtime.Record review of Resident #3's progress note dated 11/3/25 at 7:50 a.m. written by LVN B revealed note on order for phenobarbital oral tablet 32.4 mg with instructions to give 1.5 tablet every morning and at bedtime. Record review of Resident #3's progress note dated 11/3/25 at 9:08 p.m. written by LVN C revealed note on order for clonazepam oral tablet 0.5 mg with instructions to give 1 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tablet every morning and at bedtime. Record review of Resident #3's progress note dated 11/3/25 at 9:09 p.m. written by LVN C revealed note on order for phenobarbital oral tablet 32.4 mg with instructions to give 1.5 tablet every morning and at bedtime. Record review of Resident #3's progress note dated 11/4/25 at 1:14 a.m. written by LVN C revealed Called on-call due to the patient continuously jerking, 2 episodes of vomiting, and needing a script for the patient's Clonazepam and Phenobarbital. The script was placed while on the phone. Order for one time dose of Clonazepam was given but was unable to pull it from the automated medication dispensing system due to the other nurses not having access. Family member was informed and left the facility to go get the patient's medication from home.Record review of Resident #3's progress note dated 11/10/25 at 4:02 a.m. written by LVN D revealed note awaiting delivery from pharmacy. Writer unable to pull medication from automated medication dispensing system for clonazepam oral tablet 0.5 mg with instructions to give 1 tablet every morning and at bedtime.Record review of Resident #3's progress note dated 11/18/25 at 9:28 p.m. written by LVN G revealed note pending pharmacy delivery for phenobarbital oral tablet 32.4 mg with instructions to give 1.5 tablet every morning and at bedtime. Record review of Resident #3's SNF Follow Up dated 11/5/25 written by MD B did not reveal any documentation that Resident #3 had a history of seizure-like movements related to missed doses of clonazepam but did have a past medical history of a seizure disorder. Record review of Resident #3's progress note dated 11/10/25 at 11:08 a.m. by LVN E revealed Called pharmacy regarding resident's Clonazepam. Advised by pharmacy medication partially filled and remaining will be sent on next pharmacy run.Record review of Resident #3's progress note dated 11/10/25 at 6:09 p.m. by LVN E revealed Called pharmacy regarding resident's Clonazepam and Phenobarbital as medication called in by MD. Both medications will arrive on midnight run.Record review of Resident #3's SNF Follow Up dated 11/15/25 written by Nurse Practitioner A revealed Resident #3 had a history of seizure-like movement related to missed doses of clonazepam and past medical history of a seizure disorder. List of medications included clonazepam 0.5 mg tablet with instructions to take 1 tablet every 12 hours. Review of systems revealed no seizures. Record review of Resident #3's SNF Follow Up dated 11/20/25 written by MD B revealed Resident #3 had a history of seizure-like movement related to missed doses of clonazepam and past medical history of a seizure disorder. List of medications included clonazepam 0.5 mg tablet with instructions to take 1 tablet every 12 hours. Review of systems revealed no seizures. Record review of intake investigation worksheet #1058998 dated 12/30/25 revealed concern from Resident #3's family member that Resident #3 had run out of clonazepam for three days which caused her to have an increase in seizures and tremors. During interview on 6/11/26 at 10:29 a.m., the Assistant Administrator said he did not have a phone number for MD B, Nurse Practitioner A, LVN B, LVN C or LVN E. The Assistant Administrator said he obtained MD B and Nurse Practitioner A's phone numbers from the electronic medical record and there was no longer any contact information listed in the electronic medical record and MD B and Nurse Practitioner A no longer worked at the facility.During interview on 6/11/26 at 11:06 a.m., LVN F said if a resident did not have their scheduled medications, she would call the pharmacy right away and call the doctor because they have to put the medication on hold. LVN F said the facility pharmacy could do what was called a hot shot where they have a local pharmacy bring a couple of pills until the medication could be delivered. LVN F said it was not good and would be a major issue if a resident did not have their seizure medication for two days and they should be on top of that. LVN F said they always tell the medication technician to let them know when the resident was down to seven days on their medications. LVN F said the facility had an automated medication dispensing system and more general medications could be obtained but they may not be able to get more specialized medications and they would have to let the pharmacy know to bring out the medication. LVN F said she had not had any problems with residents not receiving their prescription medications. During interview on 6/11/26 at 12:44 a.m., the Assistant Administrator said they keep employee information on a year to year basis and did not have employees' information that no longer worked at the facility.During (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 6/11/26 at 2:20 p.m., LVN A denied any problems with residents' medications not being refilled or not being available and that the facility had had a good supply. Surveyor attempted to contact LVN D on 6/11/26 at 2:33 a.m. via phone but there was no answer. Surveyor left message with request to call surveyor but no response.Surveyor attempted to contact MD B on 6/11/26 at 2:37 a.m. via phone, but there was no answer. Surveyor left message with request to call surveyor but no response.During observation on 6/11/26 at 2:45 p.m. of the facility's automated medication dispensing system revealed an attached list of medications that could be obtained that included Clonazepam 0.5 mg tablet. During interview on 6/11/26 at 1:12 p.m., MA A denied any problems running out of residents' medications as the facility used blister packs, so they did not have problems with the medications running out. MA A said if they did have a challenge, they called the pharmacy and got it worked out. MA A said she did not have access to the pyxis machine and the nurses had access and it was mainly used for as needed medications. During interview on 6/11/26 at 2:20 p.m., LVN A denied any problems with residents' medications not being refilled or not being available and said they had had a good supply. On 6/11/26 at 2:37 p.m., surveyor attempted to contact MD B by leaving a voice message but did not receive a return call.During interview on 6/11/26 at 2:48 p.m., the DON said since she had been at the facility in March 2026 they had educated the nursing staff via in-services the staff about medication availability. The DON said if they needed to use an outside medication they could. The DON said the pharmacy facility had been good since she had been at the facility and had no issues and nothing that they were not able to resolve quickly. The DON said they were able to obtain missing medications or STAT drops from the automated medication dispensing system. The DON said if a seizure medication was not available to a resident it could increase the resident's chances of having a seizure. The DON said if the facility was out of a medication like a seizure medication, she had instructed staff to call the physician and get an order to hold the medication or to get a new order and then they could proceed that way.During interview on 6/11/26 at 3:32 p.m., the DON said they had to get the medications from the pharmacy when the resident gets to the facility. The DON said that they did a run in the morning or a run in the evening, so it depends on what time the resident gets in the facility. The DON said that they did not have a pharmacy onsite and if they had a late admission then they would not have the medications available right away. The DON said regarding a current resident they try not to run out of medications but if they get in a position then they called the pharmacy and asked to STAT a medication or they had to wait until the next drop as well. The DON said they did have the ability to ask the pharmacy for a STAT drop and that took around 4-6 hours. The DON said sometimes there were availability issues with the pharmacy but she had not had any problems since she had been at the facility. The DON said if they were not able to obtain a medication then they call the physician and ask if the resident could be put on something else. The DON said regarding Resident #3 if she was already on two other medications then she would be able to hold over until they got another script. The DON said she could not speak to Resident #3's situation of not getting the Clonazepam on 11/2-11/3/25 except what happened in the notes, and she did not see any kind of seizure activity or anything like that.During interview on 6/18/26 at 2:12 p.m., MD A said Resident #3 was not his patient but was transferred to MD B. Regarding the missing medications for Resident #3, MD A said they did not have at least one of the medications in stock as they were on back order or maybe both of the medications. MD A said Resident #3's family member had a supply at home and the facility needed to approve the medication while the back order was filled and then they could go back to the pharmacy supply. MD A said clonazepam was an antianxiety disorder that was used for a panic disorder but phenobarbital would be the main medication for seizures. MD A said clonazepam would not be used to treat acute seizures and the seizure medication Resident #3 would have been on was the phenobarbital. MD A said Resident #3 did not have any seizure events that he was aware of. MD A said it did happen that residents needed medications that were on back order and there were medications that they could use in their place if residents were having symptoms. MD A said shaking was not necessarily a seizure symptom. MD A said you would (continued on next page)

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