

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675834	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/18/2025
NAME OF PROVIDER OR SUPPLIER  Brookdale Galleria		STREET ADDRESS, CITY, STATE, ZIP CODE  2929 Post Oak Blvd Houston, TX 77056	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 of 3 residents (Resident #1) reviewed for pharmaceutical services. LVN C failed to remain in the room and monitor Resident #1's Family Member A administer medications to Resident #1. This failure could place residents at risk of not receiving the therapy needed. Findings included: Record review of Resident #1's admission MDS Assessment, dated 11 /14/25, reflected the resident was a [AGE] year-old male, who admitted to the facility on [DATE]. The resident's diagnoses included spinal stenosis, lumbar region without neurogenic claudication (degenerative condition characterized by the narrowing of the spinal canal in the lower back), hypertension (high blood pressure), diabetes mellitus (disease that occurs when blood sugar are too high), and anxiety disorder (feeling of fear, and uneasiness). Resident #1's BIMS score was not completed. Record review of Resident #1's Care Plan, dated 11/14/25, did not address medication administration. Observation on 11/18/25 at 9:22 AM, LVN C entered Resident #1's room, LVN C had a clear cup with pills inside. Resident #1's family member took the cup with pills and began to give Resident #1 pills 1 by 1. LVN C was observed checking Resident #1's blood pressure then blood sugars, once done checking LVN C was observed leaving the room before ensuring Resident #1 took all his medications. Resident #1's family member was observed still administering two pills after LVN C left the room. LVN C was observed to return to her med cart that was located at end of the hall by the nurse's station. Interview on 11/18/25 at 9:27 AM, Resident #1 was observed sitting in his chair. Resident #1 stated he was doing well, Resident #1's Family Member A stated she had just finished giving resident last 2 pills. Resident #1's Family Member A stated Resident #1 does better and will take all his medications when she gives them to the resident. Resident #1's Family Member A stated she ensures he takes them all. Interview on 11/18/25 at 10:46 AM, LVN C revealed she was the nurse assigned to Resident #1. She stated she provided Resident #1's morning medication. LVN C stated Resident #1's family member gives the pills to Resident #1 because he swallows them better when family member gives them to him. LVN C stated she left the room and returned to the room to ensure that all his medications were taken. She stated she had good communication with Resident #1's Family Member and the Family Member ensured her Resident #1 took all his medications. LVN C stated it was the metformin pill that was still in the cup when she left the room. She stated she should had stayed in the room to ensure all medications was taken. She stated the potential risk of not staying in the room to ensure all medications was given would be someone else taking the medications. Interview on 11/18/25 at 3:47 PM, Unit Manager D revealed nurses should follow the five rights of medication administration which were right patient, right drug, right dose, right route, and right time. She stated nurses should stay with the residents until all medications had been administered. She stated she was made aware of the situation with LVN C leaving the room. She stated it was a failure if the nurse left without ensuring all medications was administered. Unit Manager D stated the potential risk would be resident choking. Interview on 11/18/25 at 4:45 PM, the DON revealed all nurses should follow the five rights of medication administration. She stated all nurses should stay in the room to ensure all medications had been administered. She stated LVN C failed to ensure that the resident swallowed all his medications before leaving the room. The DON stated the potential risk would be anything could happen to the medication if left unattended. Record review of the facility's Medication Administration policy, revised May 2025, reflected the following: A. FOR ORAL MEDICATION ADMINISTRATION: . 7. Observe the client taking the medication.</p>		