STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675834	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Galleria	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure assessments accurately reflected the resident's status for 1 of 8 resident (Resident #1) reviewed for accuracy of assessments. - The facility failed to accurately document Resident #1's dysphagia (difficulty swallowing) that required a modified diet and crushed medications in his diagnosis and MDS. This failure could place residents at risk of inaccurate assessments, which could compromise their plan of care . Findings include: Record review of Resident #1's Face Sheet dated 10/30/25 revealed, a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included: kidney failure, difficulty walking, dementia, Parkinson's Disease (a brain disorder that affects movement, balance and coordination), stroke (interrupted blood flow to the brain that causes brain death) and history of stomach cancer. There was no documented diagnosis of dysphagia. Record review of Resident #1's admission Quarterly MDS 09/06/25 revealed, moderately impaired cognition as indicated by a BIMS score of 12 out of 15, independence with eating and substantial/maximal assistance for most functional abilities. Swallowing/Nutritional Status: none of the; nutritional approaches: a mechanically altered diet. There was no diagnosis of dysphagia. Record review of Resident #1's undated care plan revealed, focus: Parkinson's; intervention: allow sufficient time for speech/communication, diet as ordered, encourage daily exercise, mobility as tolerated. Focus: diagnosis of HTN, retention of urine, Parkinson's disease, type two diabetes mellitus without complication, cancer of large intestine textured modified diet with thin liquids. Interventions: Monitor meal intake with each meal, Monitor weights as ordered. There was no care area for dysphagia or crushed medications. Record review of Resident #1's Order Summary Report dated 10/30/25 revealed, no active orders to crush Resident #1's Medications. Record review of Speech Therapy: SLP Evaluation & Plan Treatment dated 09/03/25 revealed, diagnoses: Dysphagia, oropharyngeal phase (the middle part of the throat, located behind the mouth and above the voice box). Dysphagia Medical WorkupPhysician's Signature = The signs/symptoms documented in Dysphagia Medical Work up have been identified through a dysphagia evaluation and I am in agreement with these findings. Precautions / contraindications: Swallow precautions in place, Puree diet and Fall risk. Dry Swallow = Impaired; Overall Abilities Swallowing Abilities = Mild/4. Pills/Meds = Mild; Clinical S/S Dysphagia: Crushed meds. Dysphagia Medical Workup Swallowing Disorder Phase: The above named patient is currently under my care and found to have a swallowing disorder involving the Oral Phase and Pharyngeal Phase. Definite risk for: Aspiration (accidental inhalation of foreign substances, such as food, liquids, or air into the lungs), Choking and Wet or gurgly voice quality after swallowing liquids. Analysis- Behaviors Impacting Safety: Inattention to bolus (ball of chewed food) and Unsafe intake amounts w/decreased self-correction. An observation on 10/30/25 at 12:23 PM revealed, Resident #1 lying in bed reading a newspaper. He said he received crushed medications because of difficulty swallowing but he didn't always have his medications crushed. Resident #1 said he had not had any episodes of choking, or aspiration. In an interview on 10/31/25 at 12:23 PM, the Speech Pathologist said she provided services to Resident #1 for his dysphagia. She said the resident was on swallowing precautions, so he was ordered a soft diet (dietary medication that consists of easily chewed and swallowed food), on thin liquids, alternating bites, crushed medications and sat upright when eating. She said when evaluated, Resident #1 held food and liquids in his mouth making it difficult to swallow, so he required a double swallow. The Speech Pathologist said Resident #1 should not be taking medications whole because there was a risk of swallowing. She said his dysphagia and need for crushed meds should be included in his care plan, and it was nursing's responsibility to ensure he had a plan of care for his dysphagia. In an interview on 10/31/25 at 12:29 PM, the NP said Resident #1 was one of her patients and he had difficulty swallowing. She said she could not say if Resident #1 required crushed medications, that an order for crushed medications would be determined following an evaluation by ST and then she would approve the order. The NP said she would not answer hypotheticals regarding potential risks to residents with dysphagia receiving whole medications. In an interview on 10/31/25 at 12:56 PM, the MDS Nurse said she was responsible for adding a resident's diagnosis to their medical record and she completed MDS(s) and care plans along with her colleague that was currently on leave. She said a resident's diagnosis was retrieved from hospital paperwork, doctors visits, and therapy assessments. The MDS Nurse said the information from a resident's MDS was developed from the diagnosis, the resident interview and other clinical documentation. She said Resident #1 had a modified diet and was managed by speech therapy so

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment describing services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Residents #1) reviewed for comprehensive care plans. - The facility failed to develop a care plan for Resident #1's diagnosis of dysphagia (difficulty swallowing) that required a modified diet and crushed medications in his diagnosis and MDS This failure could place residents at risk of not having their individual, medical, functional, and psychosocial needs identified and cause a physical, mental or psychosocial decline in health. Findings include: Record review of Resident #1's Face Sheet dated 10/30/25 revealed, a [AGE] year-old male who admitted to the facility on [DATE] with diagnosis which included: kidney failure, difficulty walking, dementia, Parkinson's Disease (a brain disorder that affects movement, balance and coordination), stroke (interrupted blood flow to the brain that causes brain death) and history of stomach cancer. There was no documented diagnosis of dysphagia. Record review of Resident #1's admission Quarterly MDS 09/06/25 revealed, moderately impaired cognition as indicated by a BIMS score of 12 out of 15, independence with eating and substantial/maximal assistance for most functional abilities. Swallowing/Nutritional Status: nutritional approaches: a mechanically altered diet. There was no diagnosis of dysphagia. Record review of Resident #1's undated care plan revealed, focus: Parkinson's; intervention: allow sufficient time for speech/communication, diet as ordered, encourage daily exercise, mobility as tolerated. Focus: diagnosis of HTN, retention of urine, Parkinson's disease, type two diabetes mellitus without complication, cancer of large intestine textured modified diet with thin liquids. Interventions: Monitor meal intake with each meal, Monitor weights as ordered. There was no care area for dysphagia or crushed medications. Record review of Resident #1's Order Summary Report dated 10/30/25 revealed, no active orders to crush Resident #1's Medications. All previous orders to crush appropriate medications/open capsule if not contraindicated were discontinued. Record review of Speech Therapy: SLP Evaluation & Plan Treatment dated 09/03/25 revealed, diagnoses: Dysphagia, oropharyngeal phase (the middle part of the throat, located behind the mouth and above the voice box). Dysphagia Medical WorkupPhysician's Signature = The signs/symptoms documented in Dysphagia Medical Work up have been identified through a dysphagia evaluation and I am in agreement with these findings. Precautions / contraindications: Swallow precautions in place, Puree diet and Fall risk. Dry Swallow = Impaired; Overall Abilities Swallowing Abilities = Mild/4. Pills/Meds = Mild; Clinical S/S Dysphagia: Crushed meds. Dysphagia Medical Workup Swallowing Disorder Phase: The above named patient is currently under my care and found to have a swallowing disorder involving the Oral Phase and Pharyngeal Phase. Definite risk for: Aspiration (accidental inhalation of foreign substances, such as food, liquids, or air into the lungs), Choking and Wet or gurgly voice quality after swallowing liquids. Analysis-Behaviors Impacting Safety: Inattention to bolus (ball of chewed food) and Unsafe intake amounts w/decreased self-correction. An observation on 10/30/25 at 12:23 PM revealed, Resident #1 lying in bed reading a newspaper. He said he received crushed medications because of difficulty swallowing but he didn't always have his medications crushed. Resident #1 said he had not had any episodes of choking, or aspiration. In an interview on 10/31/25 at 12:23 PM, the Speech Pathologist said she provided services to Resident #1 for his dysphagia. She said the resident was on swallowing precautions so he was ordered a soft diet (dietary medication that consists of easily chewed and swallowed food), on thin liquids, alternating bites, crushed medications and sat upright when eating. She said when evaluated, Resident #1 held food and liquids in his mouth making it difficult to swallow so he required a double swallow. The Speech Pathologist said Resident #1 should not be taking medications whole because there was a risk of swallowing. She said his dysphagia and need for crushed meds should be included in his care plan, and it was nursing's responsibility to ensure he had a plan of care for his dysphagia. In an interview on 10/31/25 at 12:29 PM, the NP said Resident #1 was one of her patients and he had difficulty swallowing. She said she could not say if Resident #1 required crushed medications, that an order for crushed medications would be determined following an evaluation by ST and then she would approve the order. The NP said she would not answer hypotheticals regarding potential risks to residents with dysphagia receiving whole medications. In an

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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, based on the comprehensive assessment of a resident, residents received treatment and care in accordance with professional standards of practice the comprehensive person-centered care plan and the residents choices 1 of 5 residents (Resident #1) reviewed for quality of care. - The facility failed to ensure Resident #1 received orders for crushed medications as required after a speech therapy evaluation diagnosed him with dysphagia (difficulty swallowing) on 09/03/25 until 10/30/25.- The facility failed to ensure Resident #1 had orders to crush medications before administering crushed medications. This failure could result in resident's not receiving the care necessary, choking, and death. Findings include: Record review of Resident #1's Face Sheet dated 10/30/25 revealed, a [AGE] year-old male who admitted to the facility on [DATE] with diagnosis which included: kidney failure, difficulty walking, dementia, Parkinson's Disease (a brain disorder that affects movement, balance and coordination), stroke (interrupted blood flow to the brain that causes brain death) and history of stomach cancer. There was no documented diagnosis of dysphagia. Record review of Resident #1's undated care plan revealed, focus: Parkinson's; intervention: allow sufficient time for speech/communication, diet as ordered, encourage daily exercise, mobility as tolerated. Focus: diagnosis of HTN, retention of urine, Parkinson's disease, type two diabetes mellitus without complication, cancer of large intestine textured modified diet with thin liquids. Interventions: Monitor meal intake with each meal, Monitor weights as ordered. There was no care area for dysphagia or crushed medications. Record review of Speech Therapy: SLP Evaluation & Plan Treatment dated 09/03/25 revealed, diagnoses: Dysphagia, oropharyngeal phase (the middle part of the throat, located behind the mouth and above the voice box). Dysphagia Medical WorkupPhysician's Signature = The signs/symptoms documented in Dysphagia Medical Work up have been identified through a dysphagia evaluation and I am in agreement with these findings. Precautions / contraindications: Swallow precautions in place, Puree diet and Fall risk. Dry Swallow = Impaired; Overall Abilities Swallowing Abilities = Mild/4. Pills/Meds = Mild; Clinical S/S Dysphagia: Crushed meds. Dysphagia Medical Workup Swallowing Disorder Phase: The above named patient is currently under my care and found to have a swallowing disorder involving the Oral Phase and Pharyngeal Phase. Definite risk for: Aspiration (accidental inhalation of foreign substances, such as food, liquids, or air into the lungs), Choking and Wet or gurgly voice quality after swallowing liquids. Analysis- Behaviors Impacting Safety: Inattention to bolus (ball of chewed food) and Unsafe intake amounts w/decreased self-correction. Record review of Resident #1's admission Quarterly MDS 09/06/25 revealed, moderately impaired cognition as indicated by a BIMS score of 12 out of 15, independence with eating and substantial/maximal assistance for most functional abilities. Swallowing/Nutritional Status:; nutritional approaches: a mechanically altered diet. There was no diagnosis of dysphagia. Record review of Resident #1's Order Summary Report dated 10/30/25 revealed, no active orders to crush Resident #1's Medications. All previous orders to crush appropriate medications/open capsule if not contraindicated were discontinued. An observation on 10/30/25 at 12:23 PM revealed, Resident #1 lying in bed reading a newspaper. He said he received crushed medications because of difficulty swallowing but he didn't always have his medications crushed. Resident #1 said he had not had any episodes of choking, or aspiration. In an interview on 10/30/25 at 02:02 PM, the Administrator said medications should be crushed pursuant to a physician's order. She said crushed medications were normally administered to residents with swallowing issues or due to a resident's preference for crushed medications. The Administrator said failure to have orders for crushed medications could place residents at risk for negative/unintentional consequences and crushing medications without orders was against regulations. In an interview on 10/31/25 at 10:22 AM, the Interim DON said she was not aware of Resident #1 having swallowing issues but failure to have orders to crush medications for those with dysphagia, who required it, could place residents at risk of aspiration and choking. In an interview on 10/31/25 at 10:41 AM, RN B said Resident #1 received medications crushed due to prevent choking or aspiration. She said Resident #1 loved to take his medications with applesauce, and medications require an order to crush medications and failure to receive an order prior to administering could place residents at risk of adverse reactions while failure to have orders to crush medications for resident's with dysphagia could result in aspiration and choking. In an interview on 10/31/25 at 10:58 AM, LVN A said Resident #1 received his medication crushed, but she didn't know the reason why. She said prior to crushing medications there had to be an order in place, and failure to

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preference for 1 of 5 residents (Resident #2) reviewed for respiratory care. - The facility failed to ensure to change the water in Resident #1's oxygen concentrator (a machine that supplies concentrated oxygen) on 10/26/25 which resulted in the bottle being empty while the concentrator was in use and administering oxygen to the resident on 10/30/25. This failure could place residents at risk for dryness, irritation, nosebleeds, sore throats, thickened secretions, discomfort, and infection due to the dry oxygen. Findings include: Record review of Resident #2's Face Sheet dated 10/30/25 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included: respiratory failure with hypoxia (low oxygen) and Hypercapnia (fast breathing), pneumonia (lung infection), COPD (group of breathing disorders that result in difficult breathing), and heart failure. Record review of Resident #2's admission MDS assessment dated [DATE] revealed, intact cognition as indicated by a BIMS score of 14 out of 15, and receipt of oxygen while a resident at the facility. Record review of resident #2's undated care plan revealed, focus- has oxygen therapy r/t CHF; interventions: oxygen settings: the resident has o2 via nasal prongs/mask at 2 L/min PRN. Record review of Resident #2's Order Summary Report dated 10/30/25 revealed,- 10/03/25 Respiratory Orders: Oxygen at 2 liters per nasal cannula every shift for Hypoxia- 10/03/25 Respiratory Orders: Oxygen Tubing Change every night shift every Sun for Oxygen Tubing Change- 10/03/25 Respiratory Orders: Oxygen-with Humidifier Record review of Resident #2's October 2025 TAR revealed,- LVN A signed that she changed Resident #2's oxygen tubing on Sunday 10/26/25.- RN B signed that she checked on Resident #2's Respiratory orders on the night shift on 10/29/25.- LVN C signed that she checked on Resident #2's Respiratory orders on the evening shift on 10/29/25. Record review of Resident #2's Progress Notes from 10/03/25 to 10/30/25 revealed, no documented nasal irritation, or bleeding. An observation and interview on 10/30/25 at 10:17 AM revealed, Resident #2 lying in bed receiving oxygen at 2 L/min via Nasal Canula. The water bottle connected to the oxygen concentrator was empty and with a date of 10/20/25. Resident #2 said she had no problems breathing or dry/irritated/bleeding nostrils. In an interview on 10/30/25 at 10:20 AM, RN A said nursing staff were expected to check a resident's oxygen level frequently, at least per shift, and document it in their MAR. She said the water on the concentrator served to humidify the air being administered to prevent those receiving oxygen from experiencing dry nostrils that could lead to bleeding. RN A said when nurses signed off on O2 monitoring, they were to inspect the volume of oxygen being delivered, the placement of the tubing and the presence of water. She said she did not notice Resident #2 was out of water, and the nurse scheduled for the Sunday evening shift was responsible for changing the water. RN A said the water for the humidifier was changed along with the tubing and both activities are documented under the order to change the tubing. In and interview on 10/30/25 at 02:54 PM, LVN A said she worked with Resident #2 on Sunday 10/26/25. She said when a resident received oxygen, staff are expected to monitor the settings on the concentrator and the resident's o2 levels on each shift. She said the water is used to humidifier the oxygen delivered because oxygen can try out the nostrils. LVN A said if a resident's oxygen was not humidifier due to the bottle being empty they would be at increased risk for dry nostrils and bleeding. She said she changed the water weekly on the 11 PM- 7 AM shift along with the tubing for infection control/prevent contamination of the water and this task was documented under the change tubing task in the TAR. LVN A said she worked with Resident #2 over the weekend, and she thought she changed the oxygen with the tubing. She said if she documented it, she should have done it because she could not remember any issues with Resident #2's oxygen on the weekend of 10/26/25. She said failure to documents accurately, placed residents at risk of missed services or care and adverse reactions. In an interview on 10/31/25 at 10:22 AM, the Interim DON said O2 water and tubing should be changed every 7 days for infection control and to prevent contamination of the tubing and water She said failure to change the water and tubing could place residents at risk of infection and failure to humidify oxygen could result in drying of the nose, cracked and bleeding nostrils which result in discomfort. The Interim DON said when a nurse signed off on the MAR for changing the tubing they were also indicating that the water was changed, and when they signed off every shift they were

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Based on observation, interview, and record review, the facility failed to ensure that the daily staffing was posted and readily accessible for review for 2 of 2 floors (1st floor and 2nd floor) reviewed for required postings. - On 10/30/25, the facility failed to ensure the Daily Associate Posting included the name of the facility and was displayed in a prominent place readily accessible to residents, staff and visitors by hanging it on the corner wall of the nursing station located on one end of the hall on the 1st and 2nd floor.- On 10/31/25, the facility failed to ensure the Daily Associate Posting on the 1st and 2nd floor included the resident census. This failure could affect residents, facility visitors, vendors, and emergency personnel by placing them at risk of not having access to information regarding daily nursing staffing in a timely manner. Findings include: An observation on 10/30/25 at 10:29 AM revealed the facility's Daily Associate Posting hanging on a clip board on the corner of a wall across from the 1st floor nursing station. The name of the facility was not on the posting and the location of the posting was at the end of the left side of a T shaped hallway. An observation on 10/30/25 at 10:48 AM revealed, the facility Daily Associate Posting hanging on a clip board on the corner of a wall across from the 2nd floor nursing station. The name of the facility was not on the posting and the location of the posting was at the end of the left side of a T shaped hallway. In an interview on 10/30/25 at 10:55 AM, the Staffing Coordinator said she was responsible for the staffing schedule and the Daily Associate Posting. She said she did not know the CMS requirements for the Daily Associate Posting and she didn't receive any training prior to gaining the responsibility for creating the posting. She said she didn't know what was supposed to be included and she just completed the template. The Staffing Coordinator said the Daily Associate Postings were located on a clipboard on a corner wall across from the 1st and 2nd floor nursing stations and their purpose was to inform all visitors what staff were in the building. She said the location of the posting across from the nursing station at one end of the T-shaped hall was not in a place where everyone could see it, and it would only be seen by individuals who visited the nursing station located on one side of the hallway. In an interview on 10/30/25 at 02:44 PM, the Administrator said the Staffing Coordinator was responsible for the Daily Associate Posting. She said the posting must be displayed in a location visible to everyone, and it must be posted everyday and include the facility's name, date, census and the staffing for each shift. She said the location of the posting was only visible to anyone that comes in that direction and it was not visible to everyone who entered the facility. The Administrator said the Staffing Coordinator did not receive any training prior to completing the Daily Associate Posting and failure to have the posting in a location visible to all would result in visitors not knowing what the facility staffing was. An observation on 10/30/25 at 01:33 PM revealed the facility's Daily Associate Posting hanging on a clip board in the open sitting area before the hallway leading to 1st floor resident rooms. The facility name was on the posting but the resident census was not on the posting. An observation on 10/30/25 at 01:34 PM revealed, the facility Daily Associate Posting hanging on a clip board in the open sitting area before the hallway leading to 2nd floor resident rooms. The facility name was on the posting but the resident census was not on the posting. In an interview on 10/31/25 at 01:36 PM, the Staffing Coordinator said when she made the schedule on 10/31/25, she forgot to include the census because she forgot to update her premade schedules. She said failure to include the resident census would leave people unaware of the number of residents in the building. Record review of a blank Daily Associate Posting implemented 11/28/17 hanging on the clipboard on the 2nd floor revealed, the document was a photocopy and there was no location name on the form. Record review a SAMPLE Daily Associate Posting implemented 11/28/17, the original document read Location Name at the top left corner of the form. Record review of the facility's policy titled Benefits Improvement Protection ACT (BIPA) Daily Associate Posting revised 10/20/25 revealed, Policy Overview: A daily schedule of licensed and unlicensed nursing associates who are responsible for resident care, should be posted in a prominent location, allowing associates, residents and visitors to view this information. The schedule should include the number and categories of nursing associates scheduled for each shift as well as the total number of hours worked. Staffing is determined by resident population adhering to state and federal regulations. Clinical Services should complete the Clinical Services Sign-in Sheet on every shift. Policy Detail: 1. On a daily basis, a designated associate should post the community-specific number of direct caregivers scheduled for each shift in a 24-hour period by categories of nursing associates employed by the community, as well as the total number of hours worked by both licensed and unlicensed associates directly responsible for resident care. Direct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675834	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Galleria	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records on each resident, in accordance with accepted professional standards and practices, that were complete and accurately documented for 1 of 5 residents (Resident #2) whose records were reviewed for resident identifiable records. - LVN A failed to document accurately when she documented a change of Resident #2's water used for her oxygen concentrator on 10/26/25 when she did not complete it. This failure could place residents at risk of having incomplete or inaccurate records and inadequate care. Findings include Record review of Resident #2's Face Sheet dated 10/30/25 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included: respiratory failure with hypoxia (low oxygen) and Hypercapnia (fast breathing), pneumonia (lung infection), COPD (group of breathing disorders that result in difficult breathing), and heart failure. Record review of Resident #2's admission MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 14 out of 15, and receipt of oxygen while a resident at the facility. Record review of resident #2's undated care plan revealed, focus- has oxygen therapy r/t CHF; interventions: oxygen settings: the resident has o2 via nasal prongs/mask at (2) L/min prn. Record review of Resident #2's Order Summary Report dated 10/30/25 revealed,- 10/03/25 Respiratory Orders: Oxygen Tubing Change every night shift every Sun for Oxygen Tubing Change- 10/03/25 Respiratory Orders: Oxygen-with Humidifier Record review of Resident #2's October 2025 TAR revealed,- LVN A signed that she changed Resident #2's oxygen tubing on Sunday 10/26/25. Record review of Resident #2's Oxygen readings from 10/03/25 to 10/29/25 revealed, no readings under 95%. An observation on 10/30/25 at 10:17 AM revealed, Resident #2 lying in bed receiving oxygen at 2 L/min via Nasal Canula. The water bottle connected to the oxygen concentrator was empty and with a date of 10/20/25. Resident #2 said she had no problems breathing or dry/irritated/bleeding nostrils. In an interview on 10/30/25 at 10:20 AM, RN A said nursing staff are expected to check a resident's oxygen level frequently, at least per shift, and document it in their MAR. She said the water on the concentrator serves to humidify the air being administered to prevent those receiving oxygen from experiencing dry nostrils that could lead to bleeding. RN A said when nurses signed off on O2 monitoring they are to inspect the volume of oxygen being delivered, the placement of the tubing and the presence of water. She said she did not notice Resident #2 was out of water, and the nurse scheduled for the Sunday evening shift was responsible for changing the water. RN A said the water for the humidifier is changed along with the tubing and both activities are documented under the order to change the tubing. In an interview on 10/31/25 at 10:22 AM, the Interim DON said O2 water and tubing should be changed every 7 days for infection control and to prevent contamination of the tubing and water She said failure to change the water and tubing could place residents at risk of infection and failure to humidify oxygen could result in drying of the nose, cracked and bleeding nostrils which result in discomfort. The Interim DON said when a nurse signs off on the MAR for changing the tubing they are also indicating that the water was changed and when they sign off every shift they are signing off on checking that the humidifier has water, the tubing is in good shape, and oxygen being received is as ordered. The Interim DON said failure to document accurately could place residents at risk of inaccurate documentation, missed services/treatment and care opportunities. Record review of the facility policy Routine Clinical Documentation revised 01/2018 revealed, Policy Overview: After admission, all services routinely provided to the resident will be documented in the resident's medical record, regardless of payor source. C. Clinical Nursing Documentation: 1. Daily: Medication administration record as indicated; Treatment administration record as indicated. The policy did not address accuracy of documentation. Record review of the facility policy Oxygen Management Policy revised 09/25 revealed, Policy Overview: This policy provides guidance for the safe storage and use of oxygen. B. Procedure 2. Oxygen Administration a. Verify that there is a physician's order for this procedure. Review the healthcare provider's orders or community protocol for oxygen administration. b. Review the resident's care plan to evaluate for any special needs of the resident. 3. Oxygen Use: b. The nurse should monitor oxygen administration and record the resident's response to oxygen therapy in the medical record. k. When humidifiers are used, they should be changed per the manufacturer's recommendation. Humidifiers should be checked periodically and changed as needed.