

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  04/24/2024
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 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41469</p> <p>Based on interview and record review, the facility failed to ensure for 1 of 12 residents (Resident #4) reviewed for resident assessments was assessed using the quarterly review instrument not less frequently than once every 3 months, in that:</p> <ul style="list-style-type: none"> <li>- Resident #4's EHR showed her quarterly MDS assessment was due for completion by 4/10/2024 but was not done by time of record review on 04/24/2024.</li> </ul> <p>This failure placed residents at risk of not receiving adequate care.</p> <p>Findings included:</p> <p>Record review of Resident #4's face sheet, dated, revealed a [AGE] year-old female who was admitted into the facility on [DATE] and was diagnosed with vascular dementia, Parkinson's disease and protein calorie malnutrition.</p> <p>Record review of Resident #4's last comprehensive MDS, revealed it was dated 01/09/2024.</p> <p>Record review of Resident #4's EHR revealed the resident's quarterly ARD was due by 4/10/2024.</p> <p>In an interview with the MDS Nurse on 04/24/24 at 1:41PM, she stated assessment for admission assessments, quarterly assessments and discharge assessments are all completed within 14 days and the DON then has 7 days to sign off on the assessment and transmit the MDS to CMS . She stated follows the guidance as stated in the RAI manual. She stated she was not aware that she had missed Resident #4's quarterly MDS. She stated she forgot to complete Resident #4's MDS and, as of 04/24/2024, her MDS should have been completed since it was already beyond the 3-month period since her last MDS was completed.</p> <p>In an interview with the DON, on 04/24/24 at 2:52PM, she stated she signed MDS assessments when they were due, but she was not involved in auditing the MDS Nurse's work. She stated she expected the MDS to be completed on time and knew that it could affect billing and updates in resident care plans.</p> <p>Record review of the RAI Manual, dated 2019, revealed a quarterly MDS must be completed within 14 calendar days after ARD and a discharge MDS must be completed within 14 days after discharge date .</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>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41392</p> <p>Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 1 of 6 residents (Resident #42) reviewed for pharmaceutical services.</p> <p>-The facility failed to administer the medication Esomeprazole (used to treat stomach acid related conditions) to Resident #8 on 04/21/2024, 04/22/2024 and 04/23/2024 as physician ordered.</p> <p>This failure could place residents receiving medication at risk of inadequate therapeutic outcomes and discomfort.</p> <p>Findings included:</p> <p>Record review of Resident #8's Diagnosis sheet dated 04/23/2024 revealed, an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included: GERD (gastro-esophageal reflux) and personal history of digestive system disease.</p> <p>Record review of Resident #8's annual MDS dated [DATE] revealed she had a BIMS score of 9 out of 10. She required substantial assistance to partial assistance with all ADLs.</p> <p>Record review of Resident #8's undated Care Plan revealed, focus- Resident #8 has an alteration in gastro-intestinal status r/t cholangitis (inflammation of the bile duct). Interventions included: give medications as ordered. Focus - Resident had GERD. Interventions included: give medications as ordered.</p> <p>Record review of Resident #8's undated order details for Esomeprazole Magnesium delayed release 40 mg, one capsule every morning and at bedtime every day, revealed the order date 3/13/2024.</p> <p>Record review of Resident #8's April 2024 MAR (medication administration records) revealed, on 04/23/2024 the 9:00 AM dose of Esomeprazole Magnesium delayed release 40mg was not given and was put on hold. Resident received Esomeprazole as ordered from 04/01/2024 to 9:00 AM on 4/21/2024.</p> <p>Record review of Resident #8's MD progress note dated 4/14/2024 revealed the date of service was 4/12/2024 and the resident denied acid reflux and heartburn.</p> <p>Record review of Resident #8's nursing progress note dated 04/21/2024 at 9:46 PM, LVN C wrote the Esomeprazole Magnesium 40 mg was pending.</p> <p>Record review of Resident #8's nursing progress note dated 04/22/2024 at 8:37 AM, LVN A wrote the Esomeprazole Magnesium 40 mg was pending.</p> <p>(continued on next page)</p>

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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>Record review of Resident #8's April 2024 MAR (medication administration records) revealed, on 04/23/2024 the 9:00 AM dose of Esomeprazole Magnesium delayed release 40mg was not given but was put on hold.</p> <p>Record review of Resident #8's nursing progress note dated 4/23/2024 at 9:06 AM, written by LVN A revealed that the Omnicell was checked for Esomeprazole 40mg, and the medication was not present. LVN A contacted the pharmacy to check on status of the order and that it was refilled. The NP was notified, no new orders and holding medication until medication arrives.</p> <p>Record review of Resident #8's nursing progress note dated 04/23/24 at 2:32 PM, written by LVN A, revealed the Esomeprazole was refilled in Fort Worth and would be coming from there. LVN A cancelled the request to fill the medication at a Houston location and should be received on the evening delivery run.</p> <p>An observation and interview on 04/23/24 at 08:12 AM revealed, LVN A preparing medication for administration to Resident #8. LVN A administered all ordered 9:00 AM medications by 8:33 AM except for Esomeprazole. LVN A stated she would check the Omnicell for the Esomeprazole 40 mg and that it just may be out of stock. LVN A stated she did not know why it was not available.</p> <p>In an interview on 04/24/2024 at 9:12 AM, Resident #8 stated she had stomach issues for a very long time and had taken medication for it, that always helped her stomach feel better. She stated in the last few days she had been having indigestion.</p> <p>In an interview on 04/24/2024 at 9:19 AM, LVN A stated Resident #8 had a personal history of acid reflux and if she did not receive Esomeprazole, as physician ordered, then heart burn could begin. LVN A stated typically once a medication was down 3-4 doses, she would reorder. LVN A stated she would place a reorder online, or call pharmacy directly, or fax the label. LVN A stated all nurses were responsible to reorder. LVN A stated she would also reorder a medication if it popped up on the PCC during her shift. LVN A stated once a medication was not available, she would notify the physician. LVN A stated when she notified the NP on 04/23/24, the NP did not reorder an alternative medication for the Esomeprazole, the order was to hold.</p> <p>In an interview on 04/24/2024 at 9:40 AM, RN D stated if she would reorder medications when only 3 to 4 days left because she would not want a resident to suffer from not receiving their medications. RN D stated the nurses were responsible to reorder every shift and if a follow up was needed at the end of her shift she would report to the oncoming nurse.</p> <p>In an interview on 04/24/2024 at 10:50 AM, the DON stated the nurses were responsible to reorder medications at least 3 to 4 days before running out. The DON stated she expected the nurses to call the physician right away and ask if the medications can be held and restarted once received from pharmacy then check in with the pharmacy right away. She stated if the medication was OTC, then it can be picked up at local pharmacy. The DON stated the night shift nurses were responsible for auditing the medication rooms and medication carts but not individual medications. The DON stated she would have to trust the nurses to be aware of when medications run low. She stated she reminds the nurses they must reorder when only 3 days left on medications. The DON stated Resident #8's Esomeprazole should have been reordered on 4/19/2024 or 4/20/2024.</p> <p>(continued on next page)</p>		

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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>In an interview on 04/24/2024 at 2:07 PM, the DON stated she checked Resident #8's records and confirmed that the resident received a dose of Esoimeprazole on 04/21/2024 at 11:45 AM, the evening dose was missed and the next dose she received was on 04/24/204 in the morning. The DON states she did not know why the medication was not available the evening of 04/21/2024. She stated the medication could have been picked up at the local pharmacy but d/t the higher dose of 40 mg, it needed to be ordered.</p> <p>Record review of the facility policy titled: Reordering, Changing and Discontinuing Orders, revised on 01/01/2013, read in part: .This policy 4.5 sets forth procedures with respect to Facility's communication of any medication reorders, changes or discontinuations to Pharmacy .2.1 Reorders can be written and submitted on the refill order form .2.2 Verbal refill order can be submitted verbally .2.3 Reorders can be faxed to Pharmacy .2.4 Electronic orders: Authorized Facility staff may use . Further review revealed the policy did not include when to place reorders when medications run low.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41392</p> <p>Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 7 % based on 2 errors out of 28 opportunities, which involved 2 of 6 residents (Resident #8, Resident #42) reviewed for medication errors.</p> <p>1-LVN A failed to administer medications as physician ordered to Resident #8 as by not administering Esomeprazole Magnesium delayed release 40mg on 04/23/2024. The original order for Esomeprazole 40mg twice a day was dated 3/13/2024. The order status was on hold because the medication was out of stock on 04/23/2024.</p> <p>2-LVN B failed to administer medications as ordered to Resident #42 as by administering Vitamin B12 with Folate instead of the physician order for Vitamin B12 without folate on 4/23/2024.</p> <p>These failures could place residents at risk of not receiving the desired therapeutic effect of their medications.</p> <p>Findings included:</p> <p>1. Record review of Resident #8's Diagnoses sheet dated 04/23/2024 revealed, an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included: GERD (gastro-esophageal reflux) and personal history of digestive system disease.</p> <p>Record review of Resident #8's undated Care Plan revealed, focus- Resident #8 has an alteration in gastro-intestinal status r/t cholangitis (inflammation of the bile duct). Interventions included: give medications as ordered. Focus - Resident had GERD. Interventions included: give medications as ordered.</p> <p>Record review of Resident #8's April 2024 MAR (medication administration records) revealed, on 04/23/2024 the 9:00 AM dose of Esomeprazole Magnesium delayed release 40mg was not given but was put on hold.</p> <p>Record review of Resident #8's nursing progress note dated 4/23/2024 at 9:06 AM, LVN A wrote that the Omnicell was checked for Esomeprazole 40mg, and the medication was not present. Contacted the pharmacy to check on status of order and that it was refilled. The NP was notified, no new orders and holding medication until medication arrives.</p> <p>Record review of Resident #8's Order Summary Report received from the DON dated 04/24/2024 at 11:37 AM revealed, Esomeprazole Magnesium oral capsule delayed release 40mg, give every morning and at bedtime, start date 03/13/2024. The order status was on hold.</p> <p>An observation and interview on 04/23/24 at 08:12 AM revealed, LVN A preparing medication for administration to Resident #8. LVN A administered all ordered 9:00 AM medications by 8:33 AM except for Esomeprazole. LVN A stated she would check the Omnicell for the Esomeprazole 40 mg and that it just may be out of stock. LVN A stated she did not know why it was not available.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/24/2024 at 9:19 AM, LVN A stated Resident #8 has a personal history of acid reflux and if she did not receive Eesomeprazole as physician ordered then heart burn could begin.</p> <p>2.Record review of Resident #42's Diagnoses sheet dated 04/04/2024 revealed an [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included a fracture to the right thigh bone, heart disease, and unstageable pressure ulcer to the sacrum.</p> <p>Record review of Resident #42's undated Care Plan revealed, focus- Resident had altered cardiovascular status. Interventions included administer medications as ordered. Focus - Resident had Unstageable pressure ulcer to sacrum. Interventions included: Vitamin C and multivitamins with minerals for wound healing. Further review did not include Vitamin B12 and Folic Acid.</p> <p>Record review of Resident #42's Order Summary Report dated 04/24/2024 revealed an order for Vitamin B12 1000 mcg, give 1 tablet daily for Vitamin insufficiency, order start date was 04/05/2024. Further review revealed an order for Folic acid 1mg, give daily for vitamin insufficiency, order start date 04/05/2024.</p> <p>Record review of Resident #42's April 2024 MAR dated 04/23/2024 at 10:59 AM, revealed LVN B documented she administered Vitamin B12 1000mcg on 04/23/2024 on arising (between 7:00 AM and 10:00 AM).</p> <p>An observation on 04/23/24 at 09:09 AM revealed, LVN B preparing medication for administration to Resident #42. LVN B administered 2 tablets of Vitamin B12 with folate 500 mcg and Folic acid 1 mg tablet.</p> <p>In an interview on 04/23/2024 at 11:30 AM, LVN B stated she gave Resident #42 Vitamin B12 from the bottle with the label Vitamin B12 with folate 500mcg because she did not have Vitamin B12 without folate in her cart. LVN B stated she was not aware that it contained folate (folic acid) and that the resident also received folic acid 1 mg tablet. When asked if she gave the correct medication as physician ordered she stated she would check to see if there was stock Vitamin B12 bottles and would call the NP to ask for the order to be changed.</p> <p>In an interview on 04/24/2024 at 10:50 AM, the DON stated the nurses were responsible for reordering the Eesomeprazole through the online electronic health record system, before they run out for sure at least 3 days prior. The DON stated the night shift nurses were responsible for auditing the medication rooms and medication carts but not individual medications. The DON stated she would have to trust the nurses to be aware of when medications run low.</p> <p>Record review of the facility policy titled General dose Preparation and Medication Administration, dated 12/01/2007 read in part: .4.1 Facility staff should: .Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route .</p>		