

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676122	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Oak Grove Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 6230 Warren St Groves, TX 77619	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 (Resident #4, Resident #74, and Resident #71) of 20 residents reviewed for infection control. 1. The facility failed to ensure LVN A sanitized the bottle of wound cleanser after using it in Resident #4 room and before it was placed in the medication cart. 2. The facility failed to ensure CNA C sanitized her hands and changed gloves before performing incontinent and catheter care for Resident #74. 3. The facility failed to ensure MA A sanitized her hands before placing Resident #71 pills into medication cup without using any hand hygiene. 4. The facility failed to ensure MA A sanitized her hands after touching a dirty medication cup and before administering eyedrops into Resident #71 eyes. These failures placed residents at risk for healthcare associated cross contamination and infections. Findings included: 1. Record review of Resident #4's admission record dated 09/10/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included a stage 4 pressure ulcer. Record review of Resident #4's physician orders dated September 2025 indicated she had treatment orders for Stage IV to the sacrum (region of the body at the base of the spine): clean with wound cleanser, pat dry, apply medi-honey (medical grade honey for wounds), alginate (dressing which absorbs wound fluid) and cover with dry dressing daily and prn with a start date of 08/20/25. Record review of Resident #4's admission MDS assessment dated [DATE] indicated she was rarely/never understood. She had one stage 4 pressure ulcer. Record review of Resident #4's care plan dated 07/29/25 indicated Resident #4 had a stage 4 pressure ulcer wound to her sacral area, and was at risk for further breakdown and at risk for infection. During an observation and interview on 09/09/25 at 9:02 a.m., LVN A donned gown and gloves and said Resident #4 was in EBP. LVN A removed the soiled dressing then removed her gloves and sanitized her hands. She donned new gloves then sprayed 4 by 4 gauze with NS/ wound cleanser. Then she placed the bottle on the table next to the bed. She cleaned the pressure ulcer, removed soiled gloves, washed her hands and donned new gloves. She applied new dressing, removed gloves and washed her hands and walked to the medication cart placed the bottle of NS / wound cleanser in the bottom drawer without sanitizing it. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 676122	Facility ID: 676122
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/09/25 at 9:30 a.m., LVN A said she should have cleaned the bottle before placing it back on her cart to prevent spreading any germs. She said she had been trained and just forgot. During an interview on 09/09/25 at 10:30 a.m., the DON said her expectation was for the staff to sanitize the bottles prior to placing them back on the cart and it should have been wiped with sanitizer to prevent the spread of germs. 2. Record review of a face sheet dated 09/10/25 indicated Resident #74 was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) with diabetic amyotrophy (a complication of diabetes that affects the nerves that supply the thighs, hips, buttocks, and/or lower legs) and neuromuscular dysfunction of bladder (a condition where the nerves and muscles that control bladder function are impaired, leading to abnormal urinary control). Record review of a quarterly MDS dated [DATE] indicated Resident #74 had a BIMS score of 13 indicating she had intact cognition, was dependent for most ADLs, and had an indwelling urinary catheter (a thin, flexible tube inserted into the bladder through the urethra to drain urine). Record review of a care plan last revised 05/07/25 indicated Resident #74 was at risk for infection related to her indwelling catheter. Record review of a physician's order dated September 2025 indicated urinary catheter care every shift. During an observation of incontinent care and catheter care on 09/10/25 at 9:57 a.m., CNA C and CNA D washed their hands and gowned and gloved. CNA C explained the care they would perform and positioned Resident #74 in bed using the hand control of the bed. CNA C then uncovered the resident, opened her brief and tucked the brief under Resident #74 for care. Without performing hand hygiene and changing gloves CNA C then picked up wipes from her prepared table and began incontinent and catheter care using wipes to wipe outer folds of the resident's vagina and labia using a front to back motion. She performed catheter care wiping around the insertion site and then out from the resident's body along the tubing. She rolled the resident to her left side with assistance of the other CNA. She performed hand hygiene and changed gloves and continued incontinent care wiping front to back. She performed hand hygiene and changed gloves. She applied barrier cream and changed Resident #74's under pad and assisted resident into a new brief. During an interview on 09/10/25 at 10:15 a.m., CNA C said she should have performed hand hygiene and applied new gloves after touching the resident and her brief before she began incontinent and catheter care. She said by not changing her gloves she risked cross contamination and infection to the resident. She said she had worked at the facility for 1 year and had received numerous trainings concerning infection control, hand hygiene and changing gloves. She said she was nervous with the surveyor watching her and missed sanitizing her hands and glove change. During an interview on 09/10/25 at 10:20 a.m., the DON said she expected all nursing staff to perform hand hygiene and change gloves between touching the resident and beginning care. She said the possible negative outcome of not performing hand hygiene and glove changes could be the spread of infection to the resident. She said that infection control in-services and hand hygiene/glove changing in-services were presented to staff by the Infection Control Nurse. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/10/25 at 1:04 p.m., the Infection Control Nurse said she presented infection control in-services to staff at least quarterly. She said she also observed staff doing incontinent care and other tasks. She said she was surprised that CNA C had forgotten a hand hygiene and glove change because she had watched her perform incontinent care and catheter care many times without any lapses in infection control. She said hand hygiene and glove changes protected residents from cross contamination and infections. 3. Record review of Resident #71's clinical record revealed a [AGE] year-old female, admitted to the facility initially on 12/10/2023 with re-admit 08/31/2024, with pertinent diagnosis: other seasonal allergic rhinitis (a condition that causes inflammation of the nasal passages in response to airborne allergens, such as pollen from trees, grasses, and weeds.), cognitive communication deficit (a difficulty with effective verbal and nonverbal communication), unspecified dementia (a condition where cognitive decline is present, but the specific underlying cause cannot be identified), unspecified severity with agitation, unspecified glaucoma (Glaucoma is a group of eye diseases that damage the optic nerve, which connects the eye to the brain- cause is unknown). Record review of Resident #71's Physician Orders dated September 2025 indicated Timolol Maleate ophthalmic solutions 0.25% Instill 1 drop in both eyes two times a day related to Unspecified glaucoma to be administered twice a day at 9:00 AM & 9:00 PM. Record review of Resident #71's quarterly MDS dated [DATE] indicated Resident #71 has impaired vision related to Glaucoma. Record review of Resident #71's care-plan dated 08/28/2025 indicated Resident #71 has impaired vision related to Glaucoma; Interventions needed: administer Timolol maleate to both eyes as ordered. Observe for a decrease /change in vision and notify MD. During observation on 09/09/2025 at 8:46 am, MA A pulled Resident #71's pill cards out of the hall C & hall D medication cart and started placing pills into the medication cup without using any hand hygiene. During observation on 09/09/2025 at 8:47 am, MA A handed Resident #71 her medicine cup. Once Resident #71 took her medication MA A grabbed the medication cup and threw it away, failing to perform hand hygiene after touching the dirty medication cup and before administering eyedrops into Resident #71 eyes. During interview on 09/09/2025 at 8:55 am, MA A said she should have slowed down while passing medications. She said she should have sanitized her hands prior to administering the eyedrops as she had been trained to do. During interview on 09/09/2025 at 9:08 am, the Infection Control Nurse said she has trained and demonstrated to all staff the importance of using proper hand hygiene. During interview on 09/09/2025 at 10:05 am, the DON said she expected all staff to perform hand hygiene to prevent the spread of infection. She stated all staff have been trained to perform hand hygiene. Record review of an undated facility policy titled Handwashing/Hand Hygiene indicated &hellip; &ldquo;This facility considers hand hygiene the primary means to prevent the spread of (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	healthcare-associated infections." … "1. Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task (for example, placing an indwelling device or handling invasive medical device); c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; e. before moving from work on a soiled body site to a clean body site on the same resident; g. immediately after glove removal."		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care for 1 of 20 residents reviewed for new admissions. (Resident #51)The facility failed to develop and accurately complete a baseline care plan within 48 hours of admission for Resident #51.This failure could lead to residents not receiving necessary care and decreased quality of life.Findings include:Record review of Resident #51's face sheet, dated 09/10/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included displaced fracture of right tibial tuberosity (shinbone), cellulitis (bacterial infection of skin and underlying tissues), diabetes, and chronic kidney disease. Resident #51 had a history of a kidney transplant and was prescribed immunosuppression therapy (a medical treatment that aims to weaken or suppress the immune system).Record review of the admission MDS dated [DATE] indicated Resident #51 had a BIMS score of 09 indicating moderately impaired cognitive skills. Resident #51 had a surgical wound requiring application of nonsurgical dressings. Medication regime included antianxiety medications, hypnotics, anticoagulant, and opioid pain medications. Resident #51 required hemodialysis, had intravenous access on admission and while a resident. Record review of Resident #51's Order Summary Report indicated admission date of 08/28/2025 with prescribed orders as follows:- Eliquis 2.5 mg twice daily (an anticoagulant)- Escitalopram Oxalate 5 mg daily (antidepressant)- Hydrocodone-Acetaminophen 10-325 mg every 6 hours as needed for pain- Tacrolimus 1 mg for history of immunosuppression therapy- Temazepam 15 mg at bedtime related to insomnia- Dialysis appointment every Monday, Wednesday and Friday- Dialysis port to right chest and fistula (an abnormal connection between an artery and vein) to left arm - No blood pressure [check] to affected dialysis site- Hemodialysis access site checks every shift- Enhanced barrier precautions- Occupational therapy 5x weeks x 30 days- Skilled physical therapy services 5x week x 30 days Record review of Resident #51's September 2025 MAR and TAR indicated he was administered Eliquis 2.5 mg twice daily, Escitalopram Oxalate 5 mg daily, Tacrolimus 1 mg (2 capsules) twice daily, Hydrocodone-Acetaminophen 10-325 mg on 11 occasions from 09/01/2025 through 09/08/2025 with pain rated 3- 10 on a scale of 1-10, and had received dressing changes to surgical site of right lower leg every Monday, Wednesday and Friday. Review of the baseline care plan dated 08/28/2025 for Resident #51 did not address the following instructions needed to provide effective and person-centered care of the resident:- Communication - indicated Resident #51 can communicate easily with staff and understand the staff. Indicated unable to determine in answer to if needed or wanted an interpreter to communicate with physician or health care staff. Primary language was Spanish;- Active diagnosis contributing to admission was left blank. (Resident admitted for post-surgical repair of fractured tibia);- Prescribed PRN (as needed) opioid pain medications;- Prescribed routine medications; - Enhance Barrier Precautions were not included;- history of kidney transplant and immunosuppression therapy medications;- dietary preferences; and- Prescribed therapy services frequency. During a record review and interview on 09/10/2025 at 11:45 a.m., after review of Resident #51's baseline care plan, MDS nurse B said she had 26 years' experience with MDS and care plans. She acknowledged Resident #51's baseline care plan was not complete in that the medication list, therapy services including frequency, enhanced barrier precautions, and admitting diagnosis was omitted. MDS nurse B said the medication list, including routine and PRN medications, should have been listed completely. She added the enhanced barrier precautions should have been listed since Resident #51 was a dialysis resident and was admitted to facility for post-surgical wound care and therapy services. During a record review and interview on 09/10/2025 at 12:10 p.m., after reviewing Resident #51's baseline care plan together, the DON said (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the document should have contained instructions regarding language barrier, post-surgical treatment of wound, pain medications as well as dietary preferences, physician treatment orders, prescribed therapy services, enhanced barrier precautions, etc. The DON said her expectations were for all fields of the baseline care plan to be completed accurately. The DON said inaccuracies on baseline care plans could affect newly admitted residents by potential delay of care and services, medication errors, or the potential to miss needed services. She said the MDS nurses were responsible for the accuracy and completion of the baseline care plans for which she would sign-off on. Record review of a policy titled Care Plans - Baseline dated 2001, indicated the following. A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation.1. The baseline care plan includes instructions needed to provide effective person-centered care of the resident that meet professional standards of quality care and must include the minimum health care information necessary to properly care for the resident including but not limited to the following:initial goals based on admission orders in discussion with the representative, physician's orders, dietary orders, therapy services.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that assure the accurate administering of all drugs and biologicals to meet the needs of each resident for 2 of 5 residents (Residents #71 and #77) reviewed for Pharmacy Services. MA A failed to shake the bottle of Flonase [Fluticasone Propionate Suspension] Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) before administering it to Resident #71. MA B failed to shake the bottle of Flonase [Fluticasone Propionate Suspension] Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) before administering it to Resident #77. This failure could cause residents to experience cough, congestion, sneezing or shortness of breath. Findings Include: Resident #71 Record review of Resident #71's clinical record revealed a [AGE] year-old female, admitted to the facility initially on 12/10/2023 with re-admit 08/31/2024, with pertinent diagnoses: other seasonal allergic rhinitis (a condition that causes inflammation of the nasal passages in response to airborne allergens, such as pollen from trees, grasses, and weeds), cognitive communication deficit (a difficulty with effective verbal and nonverbal communication), unspecified dementia (a condition where cognitive decline is present, but the specific underlying cause cannot be identified), unspecified severity with agitation, unspecified glaucoma (Glaucoma is a group of eye diseases that damage the optic nerve, which connects the eye to the brain- cause is unknown). Record review of Resident #71's active Physician Orders for August 2025 indicated: Flonase [Fluticasone Propionate Suspension] Nasal suspension 50 MCG/ACT 2 spray in each nostril one time a day related to seasonal allergic rhinitis due to cough and congestion. Record review of Resident #71's Care Plan revised on 08/28/2025 indicated Resident #71 has Diagnosis of seasonal allergies and Tx R/T Dx-Flonase nose spray. Interventions: administer Flonase as ordered by attending physician. Record review of Resident #71's MAR for August 2025 indicated the Flonase nasal spray was scheduled for 9:00 am. During observation and interview of medication pass on 09/09/2025 at 8:05 am, MA A removed Resident #71's Flonase nasal spray from the manufacturers box that was located inside the medication cart. MA A then walked into Resident #71 room, explained the procedure to Resident #71, and administered 2 sprays of Flonase in each nostril without gently shaking the bottle (as directed by the manufacturer prior to medication administration). During Interview on 09/09/2025 at 8:20 am, MA A said before administration of the nasal spray, she needed to check the expiration date. MA A said there was nothing else she needed to do before administering it. MA A said if Flonase was not administered per physician and manufacturer's instructions, the resident would not get the full effective dose. MA A said she has been trained on administering nasal sprays/ medications and knows nasal sprays need to be shaken. Resident #77 Record review of Resident #77's clinical record indicated a [AGE] year-old male admitted to the facility initially on 12/16/2021 with re-admit 09/28/2023, with pertinent diagnoses: other seasonal allergic rhinitis (a condition that causes inflammation of the nasal passages in response to airborne allergens, such as pollen from trees, grasses, and weeds), low back pain, muscle weakness (generalized), other lack of coordination. Record review of Resident #77's active Physician Orders for August 2025 indicated: Flonase [Fluticasone Propionate Suspension] Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) 1 spray in both nostrils two times a day related to seasonal allergic rhinitis due to cough and congestion. Record review of Resident #77 care plan dated 07/18/2025 Indicated was at risk for Shortness breath with Tx R/T Dx-Flonase nose spray. Interventions: administer Flonase as ordered by attending physician. Record review of Resident #77's MAR for August 2025 indicated the Flonase nasal spray was scheduled for 9:00 am. During observation and interview of medication pass on 09/09/2025 at 8:28 am, MA B removed Resident #77's Flonase nasal spray from the manufacturers box that was located inside the medication cart. MA B then walked into Resident #77 room, explained (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the procedure to Resident #77, then administered 1 spray of Flonase in each nostril without gently shaking the bottle (as directed by the manufacturer prior to medication administration). During Interview on 09/09/2025 at 9:20 am, LVN B said he expected MAs to follow MD's orders and manufacturer's instructions when administering medications to residents to avoid potential medication errors. During Interview on 09/09/2025 at 8:40 am, MA B said before administration of the nasal spray, she needed to check the expiration date. MA B said if Flonase was not administered per physician and manufacturer's instructions, the resident would not get the full effective dose. MA B said she has been trained on administering nasal sprays/ medications and knows nasal sprays need to be shaken. During interview on 09/10/2025 at 8:12 am, Resident #77 said the MAs mostly shake the Flonase but not always. During interview on 09/09/2025 at 2:05 pm, the DON said she expected Nursing staff who passed medications to do so only by Doctor's Order and if the manufacturer states to shake then they would need to shake the medication gently. The DON stated turning the bottle upside down can be considered shaking gently. The DON stated if staff do not follow Doctor's Order and the manufacturer it could lead to the potential of the resident not getting the full dose of the medication. During interview on 09/10/2025 at 10:30 am, the ADON said he expected nursing staff who administer medications to follow MD orders, facility policy, and manufacturer instructions related to medication administration to reduce the potential for cough, and congestion. During interview on 09/10/2025 at 11:05 am, LVN C said she expected MAs to clarify any manufacturer's instructions they may not understand with their charge nurse before administering any medications. LVN C stated if a nurse or MA doesn't shake a medication bottle that says it needs to be shaken; it can result in a resident not getting all their medication as ordered. Record review of MA A and MA B Nurse and Certified Medical Aide Medication Pass Worksheet (skills check-off) dates 07/01/2025 conducted at 9:00 am indicated both MA A and MA B had demonstrated proper techniques with no errors related to nasal spray administration. Record review of the manufacturer's box of Flonase nasal spray indicated the bottle of Flonase should be shaken gently before each use. Record review of the facility's policy entitled, Administering Medications revision date: April 2019 indicated (in part) the following:Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed.4. Medications must be administered in accordance with the orders, including any required time frame. 10. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 7.41%, based on two errors out of 27 opportunities, which involved 2 of 5 residents (Resident #71, and #77) and 2 of 3 staff (MA A, and MA B) reviewed for medication error, in that: MA A failed to shake the bottle of Flonase [Fluticasone Propionate Suspension] Nasal Suspension 50 MCG/ACT before administering it to Resident #71. MA B failed to shake the bottle of Flonase [Fluticasone Propionate Suspension] Nasal Suspension 50 MCG/ACT before administering it to Resident #77. This failure could affect the Residents health, safety and quality of life. Findings Include: Resident #71 Record review of Resident #71's clinical record revealed a [AGE] year-old female, admitted to the facility initially on 12/10/2023 with re-admit 08/31/2024, with pertinent diagnoses: other seasonal allergic rhinitis (a condition that causes inflammation of the nasal passages in response to airborne allergens, such as pollen from trees, grasses, and weeds), cognitive communication deficit (a difficulty with effective verbal and nonverbal communication), unspecified dementia (a condition where cognitive decline is present, but the specific underlying cause cannot be identified), unspecified severity with agitation, unspecified glaucoma (Glaucoma is a group of eye diseases that damage the optic nerve, which connects the eye to the brain- cause is unknown). Record review of Resident #71's active Physician Orders for August 2025 indicated: Flonase [Fluticasone Propionate Suspension] Nasal Suspension 50 MCG/ACT 2 spray in each nostril one time a day related to seasonal allergic rhinitis due to cough and congestion. Record review of Resident #71's Care Plan revised on 08/28/2025 indicated Resident #71 has Diagnosis of seasonal allergies and Tx R/T Diagnosis -Flonase nose spray. Interventions: administer Flonase as ordered by attending physician. Record review of Resident #71's MAR for August 2025 indicated the Flonase nasal spray was scheduled for 9:00 am. During observation and interview of medication pass on 09/09/2025 at 8:05 am, MA A removed Resident #71 Flonase nasal spray from the manufacturers box that was located inside the medication cart. MA A then walked into Resident #71 room, explained the procedure to Resident #71, and administered 2 sprays of Flonase in each nostril without gently shaking the bottle (as directed by the manufacturer prior to medication administration). During interview on 09/09/2025 at 8:23 am, MA A said she made a medication error by not shaking the bottle of Flonase. MA A said if Flonase was not administered per physician and manufacturer's instructions, the resident would not get the full effective dose. MA A said she has been trained on administering nasal sprays/ medications and knows nasal sprays need to be shaken. Resident #77 Record review of Resident #77's clinical record indicated a [AGE] year-old male admitted to the facility initially on 12/16/2021 with re-admit 09/28/2023, with pertinent diagnoses: other seasonal allergic rhinitis (a condition that causes inflammation of the nasal passages in response to airborne allergens, such as pollen from trees, grasses, and weeds), low back pain, muscle weakness (generalized), other lack of coordination. Record review of Resident #77's active Physician Orders for August 2025 indicated: Flonase [Fluticasone Propionate Suspension] Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal) 1 spray in both nostrils two times a day related to seasonal allergic rhinitis due to cough and congestion. Record review of Resident #77 care plan dated 07/18/2025 Indicated was at risk for shortness of breath with Tx R/T Diagnosis-Flonase nose spray. Interventions: administer Flonase as ordered by attending physician. Record review of Resident #77's MAR for August 2025 indicated the Flonase nasal spray was scheduled for 9:00 am. During observation and interview of medication pass on 09/09/2025 at 8:28 am, MA B removed Resident #77 Flonase nasal spray from the manufacturers box that was located inside the medication cart. MA B then walked into Resident #77 room, explained the procedure to Resident #77, then administered 1 spray of Flonase in each nostril without gently shaking the bottle (as directed by the manufacturer prior to medication administration). During Interview with LVN B on 09/09/2025 at 9:20 am indicated he expects MAs to (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676122	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Oak Grove Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 6230 Warren St Groves, TX 77619	
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow MDs orders and manufacturer's instructions when administering medications to residents to avoid potential medication errors. During interview on 09/09/2025 at 8:45 am, MA B said if Flonase was not administered per manufacturer's instructions, the resident would not get the proper dose. MA B said she should have shaken the bottle of Flonase prior to giving it to Resident #77. MA B said she made a medication error by not shaking the bottle. MA B said she has been trained in administering nasal sprays/ medications and knows nasal sprays need to be shaken. During interview on 09/10/2025 at 8:12 am, Resident #77 said the MAs mostly shake the Flonase but not always. During interview on 09/09/2025 at 2:05 pm, the DON said she expected Nursing staff who passed medications to do so only by Doctor's Order and if the manufacturer stated to shake then they would need to shake the medication gently. The DON stated turning the bottle upside down can be considered shaking gently. The DON stated if staff do not follow Doctor's Order and the manufacturer it could lead to the potential of the resident not getting the full dose of the medication would be considered a medication error. During interview on 09/10/2025 at 10:35 am, the ADON said he expected nursing staff who administered medications to follow MD orders, facility policy, and manufacturer instructions related to medication administration to avoid medication errors. During interview on 09/10/2025 at 11:15 am, LVN C said she expected MAs to clarify any manufacturer's instructions they may not understand with their charge nurse before administering any medications to avoid medication errors. LVN C stated if a nurse or MA doesn't shake a medication bottle that says it needs to be shaken it can result in a resident not getting all their medication as ordered. Record review of MA A and MA B's Nurse and Certified Medical Aide Medication Pass Worksheet (skills check-off) dates 07/01/2025 conducted at 9:00 am indicated both MA A and MA B had demonstrated proper techniques with no errors related to nasal spray administration. Record review of the manufacturer's box of Flonase nasal spray indicated the bottle of Flonase should be shaken gently before each use. Record review of the facility's policy entitled, Administering Medications revision date: April 2019 indicated (in part) the following:Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed.4. Medications must be administered in accordance with the orders, including any required time frame. 10. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.		

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure all drugs and biologicals were stored in locked compartments and permit only authorized personnel to have access to the keys for 1 of 4 residents (Resident #71) reviewed for storage of medications. -Resident #71 had 13 liquid plastic single vials of Systane Ultra PF 0.7 ml (Artificial tears- eyedrops) with an expiration date of [DATE] inside her bed side drawer unsupervised. This failure could cause harm to Resident #71 eyes by causing infection, increasing her eye pressure, thus leading to blindness. The findings include: Record review of Resident #71's face sheet dated [DATE] indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with other seasonal allergic rhinitis (a condition that causes inflammation of the nasal passages in response to airborne allergens, such as pollen from trees, grasses, and weeds), cognitive communication deficit (a difficulty with effective verbal and nonverbal communication), active dx of unspecified dementia (a condition where cognitive decline is present, but the specific underlying cause cannot be identified), unspecified severity with agitation, unspecified glaucoma (Glaucoma is a group of eye diseases that damage the optic nerve, which connects the eye to the brain- cause is unknown). Record review of Resident #71's quarterly MDS dated [DATE] indicated she usually understood others and was usually understood by others. The MDS also indicated she had a BIMS score of 11 which meant she had moderate cognitive impairment and had short-term and long-term memory problems. Resident #71 usually understood or understands others but has difficulty communicating some words or finishing thoughts but is able if prompted or given time. Record review of Resident #71's physician orders indicated there is no order for Systane Ultra PF 0.7 ml (Artificial tears- eyedrops). Record review of Resident #71's care-plan indicated - dated [DATE] indicated Resident #71 is at risk for decline in cognition, at risk for decline in cognitive impairment. Interventions needed: administer medication as ordered. - dated [DATE] Resident #71 has impaired vision related to Glaucoma; Interventions needed: administer Timolol maleate to both eyes as ordered. Observe for a decrease /change in vision and notify MD. Place frequently used items in reach. There was no Care Plan for Resident #71 to self-administer medications. During observation and interview on [DATE] at 9:12 am, Resident #71 said she has drops she uses sometimes. Resident #71 pointed to her bedside drawer and requested surveyor to open drawer. Surveyor did not touch or open bedside drawer but requested LVN B to assist with Resident #71 request. LVN B asked Resident # 71 for permission to open bedside drawer. Resident #71 stated yes. LVN C (assigned LVN to Resident #71) entered the room. During interview on [DATE] at 9:15 am, LVN B opened bedside drawer, locating 13 plastic single vials of Systane Ultra PF 0.7 ml (Artificial tears- eyedrops) with an expiration date of [DATE]. LVN B & LVN C asked Resident #71 where she got the eyedrops from, and Resident #71 said she had the eyedrops for a while. During interview on [DATE] at 9:30 am, LVN B said they didn't know Resident #71 had the expired eyedrops. LVN B said Resident #71 should not have the eyedrops in her possession. LVN B said Resident #71 having the expired Artificial tears- eyedrops in her possession is a potential risk for her putting the eyedrops in her eyes. During interview on [DATE] at 9:33 am, LVN C said Resident #71 did not have an order for the eyedrops. LVN C said Resident #71 should not have had the Artificial tears- eyedrops because she does not have an order for them. LVN C the eyedrops are expired, and it could cause harm to Resident #71 eyes if she applies them to her eyes by increasing her eye pressure related to her Dx of Glaucoma. During an interview on [DATE] at 10:07 am, the DON said her expectation is for residents not to have any type of medications whether prescription or over the counter in their possession. DON said no one knew Resident #71 had the eyedrops until surveyor interviewed Resident #71 about the effectiveness of her medications. DON said potential harm could come to Resident #71 if she orally ingested the (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Oak Grove Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 6230 Warren St Groves, TX 77619	
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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expired eyedrops or used them in her eyes. During interview on [DATE] at 2:26 pm, Resident #71 RP said Resident #71 is very confused because she has dementia and has Glaucoma. She doesn't know how Resident #71 got the eyedrops. RP said she's glad the eyedrops were found and removed. Her biggest concern was the possibility of Resident #71 putting the expired eyedrops in her eyes causing increased eye pressure and blindness. During observation and interview on [DATE] at 2:40 pm, surveyor asked Resident #71 if she could open the vial of eyedrops. Resident #71 said yes and demonstrated how to open the vial of eyedrops. Resident #71 attempted to administer eyedrops until surveyor and ADON intervened. During interview [DATE] at 2:50 pm, the ADON said Resident #71 can open the eyedrops herself. She can potentially administer the eyedrops herself and harm her eyes. His expectation is for all residents to have orders for their medications and not have any medication bedside. He said they did not have residents who self-administered medications in the building. He stated all residents receive their medications from MAs & nurses. He stated that medications are not supposed to be in a bedside drawer at any time unless ordered by MD and approved by facility. He stated all medications were to be kept under lock in designated areas. Record review of Items not allowed in resident room, no date indicated residents are not allowed to have eyedrops in room. Record review of the facility's policy titled, Administering Medications, revised April/2019 indicated.1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so.4. Medications administered in accordance with prescriber orders, including any required time frame. 27. Residents may self- administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision- making capacity to do so. safely.		