STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676417	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Oaks Rehabilitation	25150 Lakecrest Manor Dr Katy, TX 77493

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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 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, record review and interview the facility failed to ensure that residents were provided pharmaceutical services to meet the needs of each resident for 1 of 5 residents reviewed for pharmaceutical services (Resident #2). The facility failed to ensure that Resident #2's, medication Metoprolol for high blood pressure was held as ordered by the physician when it was 118/62 and 110/64. This failure placed all residents who received medications at risk of not getting their medications as ordered, which could result in residents not receiving the therapeutic benefits of the medication including decreased in blood pressure and decreased quality of life.Record review of Resident #2's admission face sheet dated 9/29/2025 revealed Resident # 2 was a [AGE] year-old female who was admitted on [DATE]. Resident #2's diagnoses included hypertension (high blood pressure). Record review of Resident #2's MDS dated [DATE] revealed a BIMS score of 15, indicating Resident #2's cognitive skills for decision making were intact. Record review of Resident #2's physician's order summary report revealed an order for Metoprolol 25 mg once a day for hypertension. Hold for SBP was <120. Record review of Resident #2's September 2025 MARs dated 09/26/2025 revealed Resident #2's Metoprolol 25 mg one a day for high blood pressure was administered between 7:00am -11:00am on 09/24/2025 when the SBP was 118/62, and on 09/25/2025 when the SBP was 110/64. the medication was not documented as held as ordered by the physician.Record review of the nurses notes for 9/24/2025 and 9/25/2025 revealed no documentation as to why the medication was not held. Observation on 09/26/2025 at 10:45 am revealed Resident #2 was lying in bed resting. Resident #2 was alert and oriented and could make their needs known. She was clean and well-groomed with no offensive odor. The call light was observed to be within reached. In an interview on 09/26/2025 at 10:45am with Resident #2 revealed sometimes, she did not get her blood pressure medication because her blood pressure was low. She said she was not getting the medication for blood pressure; the medication was to treat her heart. In an interview on 09/26/2025 at 3:00pm with MA B she said she was not the one who gave Resident #2 her medication. She said, if the medication was within the parameter that it should be held, then it should be held. She said the medication should be documented as held by using parentheses or asterisk to indicate it was held. She said if there was no documentation the medication was held then one must conclude it was given. She said, if the blood pressure medication was given when it was ordered to be held, it could cause the blood pressure to drop lower and it could cause the resident to get dizzy, and the resident could fall. In an interview on 09/29/2025 at 11:20am with MA A she said she was the one who gave medications to Resident#2. She said if the blood pressure was low, she should hold the medication. She said she documented in error. She said she was sure the medication was held, and she had forgotten to document it correctly. She said if there was no indication on the MARs then it would be difficult to say it was held. She said if the medication was given to the resident and the blood pressure was low it would make the blood pressure drop lower and the resident would get dizzy and the resident could fall. She said she was aware Resident #2's blood pressure was always low, and she had to hold the medication on several occasions. She said she must pay more attention and always document when medications were given or not given. In an interview on 09/29/2025 at 11:37am, the ADON said blood pressure medication should not be given when the blood pressure was within the parameter the doctor said should be held. She said if medications were held it should be documented and the reason why it was held. She said if the medication was given, when it was supposed to be held the blood pressure could drop lower, and the residents could get dizzy and fall. She said her expectations of the staff were to ensure the physician's orders were followed and documented in the clinical records. She said the plan going forward was to in-service the staff, ensuring blood pressures were checked and supervise the blood pressure medication administration. She said the staff will be in-serviced on documentation in resident's clinical records. Record review of the facility policy titled Physician's Order dated May 5, 2023, Read in Part .Policy: The qualified licensed nurse will obtain and transcribe orders according to the facility's practice guidelines.ProceduresAdmissionThe qualified licensed nurse completes an admission medication regimen review from the transfer record from an acute care hospital, home or other entity.a. A call is placed to the physician to confirm the orders and request any additional orders as needed. Medication/Treatment1. The facility should not administer medications or biologicals except upon the order of a physician/prescriber lawfully authorized to prescribe them.2. Elements of medication include:- Parameters for holding medication if indicated

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete and accurately documented for 2 of 5 Residents (Resident #1 and Resident #2) reviewed for medical records accuracy, in that: Resident #1's September 2025 MARs did not reflect documentation that heart rate and blood pressure was done. Resident #2's September 2025 nurse's notes did not document reasons why blood pressure medication was given when it was supposed to be held. This deficient practice could affect residents whose records were maintained by the facility, by placing them at risk for errors in care, and treatment.Record review of Resident #1's admission face sheet dated 09/26/2025 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included atrial flutter (a condition where the upper chambers of the heart beat too quickly) and Essential hypertension (high blood pressure). Review of Resident #1's initial MDS dated [DATE] revealed a BIMS score of 15, indicating Resident #1's cognitive skills for decision making were intact. Record review of Resident #1's physician's order for September 2025 revealed:Metoprolol Succinate tablet extended release 24 hr:25 mg: Amount to administer 12.5mg oral, once a day. Hold for SBP <110 and heart rate <60 for hypertension.Digoxin tablet 125 mcg (0.125) amount to administer 1 tablet once a day for typical atrial flutter. Hold if pulse was below 60. Record review of Resident #1's Medication Administration Record for September 2025 revealed: Metoprolol 12.5mg was documented as not given on 9/26/2025. The medication order stated to hold if SBP was 110 and heart rate was < 60. There was no blood pressure or heart rate documented as done on the MARs on 9/26/2025. There were blanks on the MARS for the blood pressure and heart rate. Digoxin 125 mcg (0.125mg) mg one tablet was documented as not given on 9/24/2025, however the section on the MARs for the pulse was blank on 9/24/2025. In an interview on 09/26/2025 at 3:00pm with MA B she said she was not the one who gave Resident #1 his medication. She said there should be no blanks on the MARS. She said if there were blanks on the MARs it would be difficult to determine if the medications were given or not given. In an interview on 09/29/2025 at 11:20am with MA A she said she was the one who gave Resident #1 his medications. She said she held the medications and should have documented on the MARs. She said she must pay more attention and always document when medications were given and or not given. Blanks on the MARs could indicate that the medication was given or not given. She said there should be no blanks on the MARs. Record review of Resident #2's admission face sheet dated 9/29/2025 revealed Resident # 2 was a [AGE] year-old female who was admitted on [DATE]. Resident #2's diagnoses included hypertension (high blood pressure). Review of Resident #2's initial MDS dated [DATE] revealed a BIMS score of 15, indicating Resident #2's cognitive skills for decision making were intact. Record review of Resident #2's physician's order summary report revealed an order for Metoprolol 25 mg once a day for hypertension. Hold for SBP <120. Record review of Resident #2's MAR for September 2025 revealed the medication was administered between 7:00am -11:00am on 09/24/2025 when the SBP was 118/62 and 09/25/2025 between 7:00am and 11:00am when the SBP was 110/64. Further record review of the MAR revealed the medication was documented as given on those dates when the blood pressure was within the parameter it should be held. Record review of the nurse's progress notes for 9/24/2025 and 9/25/2025 revealed no documentation as to why the medication was not held. Observation on 09/26/2025 at 10:45 am revealed Resident #2 was lying in bed resting. Resident #2 was alert and oriented and could make their needs known. She was clean and well-groomed with no offensive odor. The call light was observed to be within reached. In an interview on 09/26/2025 at 10:45am Resident#2 said sometimes she did not get her blood pressure medication because her blood pressure was low. She said she was not getting the medication for blood pressure; she was getting it to treat her heart. In an interview on 09/29/2025 at 11:20am with MA A she said she was the one who gave medications to Resident#2. She said if the blood pressure was low, she would have held the medication. She said the documentation was an error. She said she was sure the medication was held and had forgotten to document it correctly. She said she was aware Resident #2's blood pressure was always low, and she had to hold it on several occasions. She said she must pay more attention and always document when medications were given and if not given to document it, and the reason it was given or not given. She said there should be no blanks on the MARS. Blanks on the MARs could indicate that the medication was not given. She said she must pay more attention and always document after completing a task. In an interview on 09/29/2025 at 11:37 AM, ADON said there should be no