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	02/27/2025

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and time frames to meet a resident mental, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and to ensure the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 8 residents (Resident #6 and #30) reviewed for care plans. 1. The facility failed to ensure Resident #6's diagnoses were addressed in her comprehensive care plan. 2. The facility failed to ensure Resident #30's diagnoses and medications were addressed in her comprehensive care plan. This failure could place residents at risk of not receiving appropriate care. The findings included: 1. Record review of Resident #6's face sheet, dated 02/27/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #6 had diagnoses which included: Dementia (a general term for loss of memory, language, and other cognitive abilities); Generalized Anxiety Disorder (mental health disorder characterized by feelings of worry, fear and anxiety strong enough to interfere with daily life) and Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), Parkinson's disease (Progressive movement disorder of the nervous system), Cortical age-related cataract right eye, Shortness of breath, Repeated falls, Cortical age-related cataract (begins as white, wedge-shaped spots or streaks on the outer edge of the outer edge of the lens cortex).on the left eye (History of), Cognitive communication deficit, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (a condition that causes partial or total paralysis of one side of the body), Visual hallucinations (when someone sees images or things that aren't actually there) and type 2 diabetic mellitus (high glucose in the blood). Record review of Resident #6's quarter MDS assessment, dated 12/14/2024, revealed a BIMS score of 02, iwhich indicated severely impaired cognition. Resident #6 was assessed as feeling down, depressed and had diagnoses which included Dementia, Anxiety Disorder and Depression. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's Order Summary, dated 02/26/2025, revealed physician orders which included the following: - Clorazepate dipotassium - Schedule 1V 7.5 mg (Miligram) Give 2 tablets to equal 15 mg by mouth every 12 hours (9:00 AM and 9:00 PM) for anxiety disorder with a start date of 08/13/2024.; - Mirtazapine Oral Tablet 15 mg Give 1 tablet by mouth one time a day (9:00 PM) for Major Depressive disorder with an order date of 11/06/2024. -Mirtazapine Oral Tablet 7.5 mg Give 1 tablet by mouth one time a day (7:00 AM) for Major Depressive disorder with an order date of 11/06/2024. -Benadryl Allergy (diphenhydramine HCL) tablet, 25mg oral twice a day 7:00 AM and 6:00PM with an order date of 1/31/2024. -Sinemet (Carbidopa-Levodopa) tablet 25-100 mg, Give 2 tablets by mouth 3 times daily for Parkinsonism at 9:00AM, 1:00PM and 5:00 PM with an order date of 12/04/2024. - -Glipizide tablet 5mg oral once a day for 7:00 AM with an order date of 2/27/2024 Record review of Resident #6's Comprehensive Care Plan initiated 12/20/2024 revealed there were no focus areas addressing the resident's diagnoses of Generalized Anxiety Disorder, Depression or Dementia, and no focus areas which indicated the resident's active orders for anti-anxiety, anti-depressants, and anti-Parkinson's disease medications. 2. Record review of Resident #30's face sheet, dated 03/24/2025, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #30 had a diagnosis which included: Generalized Anxiety Disorder (mental health disorder characterized by feelings of worry, fear and anxiety strong enough to interfere with daily life). Record review of Resident #30's quarter MDS assessment, dated 1/13/2025, revealed a BIMS score of 99, which indicated severely impaired cognition. Record review of Resident #6's Order Summary, dated 02/26/2025, revealed physician orders which included: - Lorazepam 0.5 mg by mouth every hours of sleep (between 8:00 PM to 10:00 PM) for anxiety disorder with a start date of 11/5/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN-MDS A on 2/27/25 at 2:47 PM, LVN-MDS A said she had been working as the MDS person for 3 years, she completed care plans, with the Activities Director and Social Services. Resident #6 and Resident #30's Comprehensive Care Plan did not address their diagnoses of Anxiety, Parkinson's Depression or Dementia, and did not address their active orders for anti-anxiety and anti-psychotic medications, but it should have. MDS-A stated these diagnoses and medications were ordered/documented prior to her Care Plan being completed, so should have been included on her Comprehensive Care Plan. LVN MDS-A stated these diagnoses and medications should automatically trigger a Care Area Assessment (CAA) area and she did not know why they were not triggered or why they were missed. LVN MDS-A stated she was responsible for the quarterly and annual assessments of the Comprehensive Care Plan. LVN MDS-A further stated it was important for these diagnoses and medications to be addressed in the Care Plan so staff had the information needed to meet the resident's specific care needs. Interview with the DON, on 02/27/2025 at 4:05 p.m. revealed the Comprehensive Care Plans needed to address and include all of the residents' nursing, mental and psychosocial needs, and contain the interventions and services the resident would need to meet these needs. The DON said she would be assessing and in-servicing staff to ensure the resident needs were being met to include completion of assessments and Care Plans. Record review of the facility's, undated, policy titled Comprehensive Care Planning, revealed Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. 35822

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 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, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 8 residents (Resident #14) reviewed for respiratory care. The facility failed to change Resident #14's oxygen tubing and humidifier bottle every 7 days. This failure could place residents at risk for respiratory infections, unwanted hospitalization and decrease in quality of life. Findings include: Record review of Resident #14's, undated, face sheet revealed a [AGE] year-old female who was admitted to the facility originally on 01/12/22 and again on 02/13/25. Resident #14's had diagnoses which included cerebral infarction (when blood flow to the brain is blocked), spinal stenosis (spaces inside the bones of the spine get too small putting pressure on the spinal cord and the nerves that travel through the spine) , cough, obstructive sleep apnea (intermittent airflow blockage during sleep), Meniere's disease (disease of the inner ear) , hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), and shortness of breath. Record review of Resident #14's annual MDS, dated [DATE], revealed a BIMS score of 15, which indicated the resident cognition was intact. Section O-Special Treatments, Procedures, and Programs reflected the resident was receiving oxygen therapy which consisted of oxygen and BIPAP (non-invasive ventilation technique that provides air to help a person with breathing difficulties). Record review of Resident #14's Comprehensive Care Plan, dated 09/08/2021 and revised on 12/18/2024, reflected the resident was being care planned for diagnoses which included obstructive sleep apnea, history of shortness of breath, and used a BIPAP may use oxygen via NC as ordered by physician; at risk for SOB. The intervention included changing tubing per facility protocol. Record review of Resident #14's Physician Order Summary Report for the month of February 2025 reflected the following orders: -Dated 09/09/21 BIPAP at HS, assure good seal on mask and O2 1L connected to tubing; refill distilled water in BIPAP as needed (DX: obstructive sleep apnea) at bedtime; 8:00PM. -Dated 02/28/23 Oxygen 2 liters PRN via nasal cannula for O2 sat < 92% every shift PRN. -Dated 11/03/23 Equipment Oxygen: Change O2 tubing/nasal cannula/mask/humidification system weekly frequence (once on Sunday). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #14's TAR for the month of February 2025 reflected the resident was receiving BIPAP and oxygen as ordered by the physician. The TAR reflected documentation of oxygen equipment was changed on 02/23/25. The initials on the TAR read. Observation on 02/25/25 at 10:12AM revealed Resident #14 was awake in bed. Further observation was made of an oxygen machine in the room with a humidifier bottle attached to the machine. The date on the humidifier bottle read 02/16/25. The oxygen tubing was dated 2/16/25. Observation on 02/26/25 at 2:04 PM revealed Resident #14 was not the in room. The date on the resident's oxygen tubing read 02/23/25. Further observation of the humidifier bottle revealed it was dated 02/16/25. Observation on 02/27/25 at 9:16 AM revealed Resident #14's oxygen humidifier bottle was dated 02/16/25. Interview on 02/25/25 at 9:16 AM Resident #14 said she used her oxygen at nighttime. Interview on 09/27/25 at 9:16 AM, Resident #14 said she was still being placed on her BIPAP machine with oxygen at night. Interview on 09/27/25 at 9:20 AM, ADON E said she worked at the facility Monday-Friday and was assigned to Halls 300 & 400. ADON E said respiratory equipment should be changed once a week on a Sunday on the night shift. ADON E said this was for infection control. ADON E said when respiratory equipment was not changed as ordered, it placed the resident at risk for upper respiratory infections. ADON E said once the nurse changed out the equipment, it was documented on the TAR that the task was completed. ADON E said it was the responsibility of the ADON's to ensure this was being done. ADON E said when she reported to work, she looked at the oxygen equipment to ensure it was being done. ADON E said each resident had a guardian angel who did room checks as well-made as rounds on each room assigned. ADON E said the guardian angels assigned to Hall 300 were the Maintenance Director and the Medical Records Director. ADON E said LVN K was the nurse who worked the night shift. Interview on 02/27/25 at 9:30 AM, the Medical Records Director said she was not assigned to Resident #14's room but the Maintenance Director was. The Medical Records Director said when she made rounds on resident rooms, she checked for the room being clean and tidy, resident's had fresh water to drink, check the bathroom, make sure resident's were groomed and comfortable, and she also check respiratory equipment making sure that nothing was out dated. The Medical Records Director said if the equipment was outdated, she reported this to the nurse. The Medical Records Director said she utilized a check list of things to observe in the resident rooms. Interview on 02/27/25 at 10:00 AM, the DON said respiratory equipment such as oxygen tubing and oxygen humidifier bottles were changed every week on a Sunday by the night shift nurse to prevent infections. The DON said she would have to investigate what staff dated Resident #14's oxygen tubing for 02/23/25. The DON said the Maintenance Director was on leave on 02/23/25 (Monday) and did not return to work until 02/27/25. The DON said LVN K worked on 02/23/25 (Sunday) and did not return to work until 02/26/25 (Wednesday). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/27/25 at 10:18 AM, the Infection Control Nurse said when staff did not change respiratory equipment per facility protocol (every 7 days), bacteria could form inside the tubing placing the resident at risk for upper respiratory infections. Attempted interview on 02/27/25 at 11:45 AM with LVN K, via phone was unsuccessful, a voicemail was left with a call back number. Interview on 02/27/25 at 5:55 PM, the DON said she spoke with LVN K who said he intended to change Resident # 14's respiratory equipment but got distracted. The DON said she would continue to investigate the matter. Record review of the facility's policy on Respiratory Equipment Change Schedule addressed nasal cannula, revision date February 02, 24 reflected in part: Nasal cannula change weekly, when soiled on an as needed basis or per state regulations

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 16352 Based on observation, interview and record review the facility failed to ensure drugs and biologicals used in the facility were labeled with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for and 2 of 5 medication carts (medication cart Hall 100 and 200) reviewed for medication storage. - The facility failed to ensure the back of 100 and 200 hall medication carts did not contain eyedrops, ointment, cream and nasal spray that were opened and not labeled with the resident's name and date. This failure could place residents at risk of adverse medication reactions and infections. Findings Include: Observation on [DATE] at 2:11 PM revealed the medication cart for 100 hall with MA A. The 100 hall medication cart had the following medications with no open date documented: 1. Latanoprost Ophthalmic solution was open and not dated 2.Timolol Maleate ophthalmic solution was open and not dated 3. Olopatadine hydrochloride solution was open and not dated 4.Lumigan Ophthalmic solution was open and not dated 5.Refresh Celluvisc lubricant eye Gel 30 single use container was open and not dated 6. Lubricant eye was open and not dated 7. Onasl Beclomethasone dipropionate nasal was open and not dated 8. Aerosol 80 mcg per spray was open and not dated 9. Saline Nasal Spray was open and not dated 10 Fluticasone Propionate nasal spray was open and not dated 11. Artificial tears lubricant eye drop was open and not dated 12. Artificial tears lubricant eye drop was open and not dated 13. Artificial tears lubricant eyedrop was open and not dated (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. Artificial tears lubricant eyedrop was open and not dated 15. Artificial tears lubricant eyedrop was open and not dated 16. Artificial tears lubricant eyedrop was open and not dated 17. Artificial tears lubricant eyedrop was open and not dated 18. Lumigan Ophthalmic solution was open and not dated In an interview with MA A on [DATE] at 2:40 PM, MA A said she was off for 2 days and she just came back, regarding medication opened and not dated, MA A said those medications should have an open date on them and it was good for 30 days after it was opened, she said she was in-serviced on drug labeling and storage. Observation of 200 hall nurses cart with LVN K on [DATE] at 2:42 PM revealed the 200 medication cart had the following ointment, cream and jelly with no open date documented: 1. Vaseline pure ultra white petroleum jelly 2. Treat Antifungal ointment moisturizer body lotion 3. Clotrimazole cream USP1% 4. Vaseline pure ultra white petroleum jelly In an interview with LVN F on [DATE] at 2:46 PM, she said when ointment, cream and jelly was open it should be dated because it was good for 30 days for it to be effective. Interview with the DON on [DATE] at 4:08 PM, she said eye drops, ointment and nasal spray when opened should be dated. The DON said she in-serviced staff about 4 weeks ago on dating medication when opened and storage for effectiveness. She said she would had to in-service again. A copy of the policy was requested . DON said the nurses were responsible for dating the medication when opened. Interview with the ADM on [DATE] at 4:15PM, he said the nurses should always date the drug when opened that was his expectations. Record review of the Medication Storage Information.pdf: Eye Drops Room Temp. (Unopened) Room Temp. (Opened) Manf. Exp. on Package Refer to facility P&P Miacalcin Nasal Spray Calcitonin Nasal Spray Refrigerator (Unopened) Room Temp (Opened **STORE UPRIGHT** Manufacture. Expired. On Vial 30 Day

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35822 Based on observation, interview and record review 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 2 of 4 halls reviewed for infection control. 1. The facility failed to dispose soiled linen inside of a waste barrel in the soiled utility room on Hall 200. 2. The facility failed to place a trash bag in the trash barrel instead of on the floor in the utility room on Hall 300. These failures could place residents at risk for cross contamination, infections, and a decrease in quality of life. Findings include: Observation on 02/25/25 at 8:20 AM in the soiled linen room on hall 200 revealed two waste barrels. Sitting on top of one of the barrels was a large plastic bag with soiled linen. Further observation revealed a large towel laying on the floor. Observation on 02/25/25 at 10:26 AM on Hall 300 utility room revealed a trash bag tied up laying on the floor. There were no barrels in the soiled utility room. Interview on 02/25/25 at 8:25AM, Laundry Aide B said all soiled materials should be placed inside of the barrel and not on the floor to avoid cross contamination. Interview on 02/25/25 at 10:26 AM, the Manager of Housekeeping said she was the Manager of housekeeping, laundry, and floor tech. The Manager of Housekeeping said staff should not be placing trash on the floor but inside of the trash barrel receptacles and the same went for soiled linen barrels to avoid cross contamination. The Manager said it was the responsibility of the nursing staff to bring full barrel receptacles for trash and linen to the main soiled utility room and leave by her door to empty. The nursing staff then took an empty receptacle back to the soiled utility room on the halls. The Manager said normally at the end of each shift, the CNA's brought the yellow linen barrels to the main soiled utility room and got an empty barrel for trash and linen to be taken to the soiled utility rooms on each hall. Interview on 02/26/25 at 1:40 PM, LVN A said she was the nurse for Hall 200. LVN A said all soiled material was supposed to be stored inside of the soiled utility rooms inside of designated barrels and not on top of the barrels or on the floor to avoid contamination. Record review of the facility's policy on Infection Control, revised May 15, 2023, reflected in part: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Purpose: To establish a facility wide program that incorporates a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases .proper handling of linen, wastes, equipment and supplies