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	05/28/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that: The facility failed on 5.26.26 to seal and cover food stored in refrigerator and out in open area of kitchen. These failures could place residents at risk for food contamination and foodborne illness.The findings included: The following observations were made on 5.26.26 beginning at 8:15 AM during initial tour of the kitchen: Observation of the following stored on counter in kitchen:Large baking dish with marble cake sitting out.Large plastic container of coffee grounds with no lid. Observation of the following stored in the refrigerator:Bag of hamburger patties in open box and open bag exposed to the open air.Bag of corn dogs in open box and open bag exposed to the open air.Bag of cheesy garlic breadsticks in open box and open bag exposed to the open air. During an interview and observation on 5.28.26 at 2:59 PM with DM of freezer revealed an open box of hamburger patties, corn dogs, and cheesy garlic bread was still open with bag open to environment. He stated that that should be covered and not exposed to the open air. He stated that it would cause freezer burn or could cause exposure to the elements which could cause the residents to get sick. He stated he would get that fixed immediately. During an interview on 5.28.26 at 10:56 AM with ADMN, he stated DM and staff were responsible for items in fridge and dry storage room and making sure all items are sealed. All staff have been trained on food storage in the refrigerator and dry storage. The facility policy was to have all items sealed. He stated the possible negative outcome could be serving exposed food to residents. Record review of the facility's policy, titled Food Receiving and Storage, revised date 2014, reflected the following:Policy Statement- Foods shall be received and stored in a manner that complies with safe food handling practices.Policy Interpretation and Implementation .7. All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date) . Record review of the FDA Food Code 2022 reflected the federally established standards. derlying surface.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident had a right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one of six residents (Resident # 51) reviewed for accommodation of needs.Resident #51's call light was not left within his reach or within sight.This failure could place residents at risk of not having their needs met and a decline in their quality of care and life.Findings include:Record review of Resident #51's admission record, dated 5.26.26, revealed Resident # 51 was a [AGE] year-old male admitted on 2.3.23 with diagnoses that included, but were not limited to, Cerebral infarction (a medical emergency more commonly known as an ischemic stroke. It occurs when a blood vessel supplying the brain becomes narrowed or blocked, cutting off oxygen and vital nutrients, which leads to the death of brain tissue in that area), Hemiplegia (the severe or complete paralysis of one side of the body, usually affecting the arm, leg, and face), and hemiparesis following other cerebrovascular disease affecting left non-dominant side, and Epileptic seizures related to external causes.Record review of Resident #51's annual MDS, dated [DATE], revealed- a BIMS score of 99 out of 15 which indicated his cognitive status was severely impaired.- required extensive two-person staff assistance with bed mobility and transferring.During an observation and interview on 5.26.26 at 3:30 PM Resident #51 was lying in bed and his call light was up on nightstand above the bed against the wall. Resident #51 stated all he wanted was to be changed. He stated he can't reach his call light but just wanted to be changed. During an observation and interview 5.26.26 at 4:45 PM Resident #51 stated that he was changed. Observation of call light still on night stand up against the wall out of reach of the resident. During an observation on 5.27.26 at 11:27 AM Resident 51's call light revealed it was still out of reach. During an interview and observation on 5.27.26 at 2:15 PM DON stated that Resident #51's call light should be within reach of him. She stated this should have been moved yesterday 5.26.26. She stated she was not sure why any CNA or Nurse had not moved Resident #51's call light within reach. She stated her expectation was for all residents to always have the call lights within reach of them. She stated the policy was in place for the resident's safety and with the call light out of reach the resident could be hurt or need help and not get the assistance they need.During an interview on 5.28.26 at 2:50 PM Administrator stated that it was brought to his attention about the call light in the resident's room. He stated yes, the call lights need to be in reach of the residents so they can get help anytime they need it. He stated if it's not in reach and they need it the resident could get hurt or not get the assistance the residents need. Record review of a facility provided policy titled, Call Lights, Responding To dated May 2023, revealed, PROCEDURES:6. When leaving the patient or resident room, ensure the call light is placed within thepatient's/resident's reach.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to personal privacy and confidentiality of his or her personal and medical records for 1 of 5 residents (Resident #22) reviewed for privacy, in that: The facility failed to ensure opened mail of Resident #22's was not out in a common area for anyone to see. This failure could place residents at risk of having medical information exposed to others and cause residents to feel uncomfortable and disrespected.The findings include: Record review of Resident #22's admission record, dated 5.26.26, revealed Resident # 22 was an [AGE] year-old female admitted on 2.7.24 with diagnoses that included, but were not limited to, hypertension, Metabolic encephalopathy, atrial fibrillation, and Dysphagia. Record review of Resident #22's annual MDS, dated [DATE], revealed- a BIMS score of 99 out of 15 which indicated her cognitive status was severely impaired. During an observation on 5.26.26 at 2:25 pm Resident #22's open mail (Your Medicare Part D Explanation of Benefits) was out in a common area. Resident #22's mail had information such as date of birth , account number, and address. During an observation on 5.27.26 at 11:27 AM Resident #22's open mail was still sitting out in common area exposed to everyone. During an interview and observation on 5.27.26 at 2:15 PM DON stated that Resident #22's mail should be in the resident's room. She stated whether Resident #22 opened it or not, it was the responsibility of the staff to make sure no personal information of any resident was sitting out in a common room for anyone to see. During an interview on 5.28.26 at 2:50 PM Administrator stated that Resident #22's mail sitting out in the common area was brought to his attention. He stated this needs to be taken care of, HIPAA was not protected for the residents. He stated this was important to all residents because it was the responsibly of the staff to protect all residents' personal information. Record review of the facility's policy titled, Safeguards, Posted Protected Health Information, dated March 2013, reflected: POLICY:All employees safeguard electronic protected health information in an effort to fulfill their duty to maintain the confidentiality and integrity of patient/resident health information as required by law, professional ethics, and accreditation requirements. Access to and the use and disclosure of electronic protected health information is limited to the minimum necessary to fulfill the employee's obligations and duties. When accessing systems or applications that contain electronic protected health information including systems or applications administered by health plans or other providers; the following procedures must be followed. Whenever possible, the de-identified information will be used.

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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** Based on observations, interviews, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 2 (Resident #98 and Resident #128) of 12 residents observed for oxygen management and CPAP use. The facility failed on 05/26/2026 to post oxygen in use signs outside Resident #98's and Resident #128's rooms.The facility failed 0n 05/26/2026 to properly store Resident #98's CPAP machine in a bag when it was not in use. This failure could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support, decline in health, at risk for cross contamination, spread of infection, and at risk of fire hazards by not posting oxygen signs outside the residents' rooms.Addendum to; Observation and interview on 05/26/2026 at 9:01 a.m. with Resident #98, he stated he had been in the facility for about one week. Resident #98 stated he was prescribed oxygen therapy and wore his canula throughout the day. It was observed that the resident had an oxygen concentrator in the room at bedside and there was no oxygen-in-use sign posted outside Resident #98's room. Resident #98 stated he needed his CPAP machine to be able to sleep and said he took it off earlier in the morning when he woke up and put it on top of his nightstand. The CPAP mask was observed on top of the nightstand; it was not in a bag, and it was exposed. During an interview on 05/26/2026 at 9:41 AM with CNA C, stated that when a CPAP mask was not in use, it needed to be disinfected, stored in a bag and dated. CNA C stated this procedure was followed to prevent cross contamination and avoid the resident aspirating anything that may have fallen onto the mask if it was not properly stored. CNA C stated the potential negative outcome for leaving a CPAP machine exposed and not properly sanitized and bag could result in the resident aspirating dust or lint which could potentially make them sick to their lungs. CNA C stated it was the responsibility of all CNAs, LVNs, RNs or any staff who work with the residents to make sure their CPAP masks were properly cleaned and stored when not in use. During an interview on 05/26/2026 at 10:36 AM with LVN B, stated when a resident who uses a CPAP machine and they were not using it, the mask needed to be sanitized, bagged, labeled with the date, and stored for when the resident would be using it again. LVN B stated this was necessary to avoid the mask being contaminated with dust, lint, or anything in the air. LVN B stated it was the responsibility of any staff member who worked with the residents to ensure CPAP masks were properly stored when not in use and stated the possible negative outcome for not sanitizing and storing the mask could result in the resident wearing a contaminated CPAP mask which could make them sick to their lungs or their airways. During an interview on 05/27/2026 at 9:53 AM with RN D she said the CPAP machines were worn by some residents during the night to help them sleep better if they had a diagnosis of sleep apnea. RN D stated when residents were not wearing their CPAP mask, it needed to be cleaned, bagged and dated to safely store the equipment when not in use. RN D stated it was all staff's responsibility to ensure these masks were cleaned and stored whenever they made rounds and had contact with the residents. RN D stated there was a possibility that if the masks were not properly disinfected and stored, they could be contaminated by anything in the air such as dust or lint. RN D stated there was also the possibility that a confused resident got into the room and put on the mask, creating cross contamination. RN D stated these possible negative outcomes could make the residents sick from their air pathways or their lungs. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/28/2026 at 10:18 AM the Admn, stated it was an expectation that any CNA, LVN, RN or DON who had contact with the resident and if they saw a CPAP mask not properly store, that they assisted the resident to sanitize, bag and date the CPAP mask to properly store it to avoid cross contamination. The Admn stated that the possible negative outcome for leaving a mask not properly stored could result in it being contaminated and if the resident wore it without cleaning the mask first, they could get sick from their lungs or nasal passage. During an interview on 05/28/2026 at 10:55 AM with the DON, stated that CPAP masks needed to be sanitized, bagged and dated before storing them whenever the residents were not wearing the mask. The DON stated these procedures for storing the CPAP mask were done to avoid cross contamination as it posed an infection control issue if the mask were left exposed and not safely stored. The DON stated it was the responsibility of all CNAs, LVNs, RNs or DON to properly sanitize and store these masks if they had contact with the resident and saw they had a CPAP not properly stored in their room. The DON stated the potential negative outcome for a resident wearing a CPAP mask that was not properly sanitized and stored could result in them getting sick from their lungs or nasal passage. Record review of the facility document titled Infection prevention and control policies and procedures and dated 05/15/2023 revealed in part: Purpose: To establish a facility wide program that incorporates a system for preventing, identifying reporting, investigating, and controlling infections and communicable disease. The program covers all residents, staff, consultants, students in the facility's nurse aide training program or from affiliated academic institutions, volunteers, visitors, and other individuals providing services under a contractual agreement and is a based on the individual facility assessment following accepted national standards. Infection prevention and control program consists of currently acceptable infection control standards, practices, and activities. Examples of these are: Surveillance for healthcare acquired infection (HAI) identification; data analysis, and evaluation. Infection prevention and control program plan (continued) 6. Staff Development: 10) Cleaning, disinfecting and sanitation procedures. Compliance with applicable federal, state, and local regulations concerned with patients/residents and employees. Staff are provided with information and training on: Infection prevention and control information and plans. Hand hygiene, including hand washing and alcohol-based hand rub (ABHR). Universal/standard and transmission-based precautions. Findings included: Record review of Resident #98's face sheet revealed the resident was a [AGE] year-old male. The face sheet revealed an original admission date of 05/18/2026. Record review of Resident #98's History and Physical dated 05/06/2026 revealed diagnoses that included acute respiratory failure with hypoxia (a condition where the body is not receiving enough oxygen), chronic obstructive pulmonary disease (COPD) (a chronic lung disease that makes breathing difficult), atrial fibrillation (an irregular heartbeat) and sleep apnea (a condition that causes interrupted breathing during sleep). The record revealed the resident required supplemental oxygen therapy and oxygen administration via nasal cannula related to respiratory compromise. History and Physical revealed the resident utilized CPAP therapy for sleep apnea. Record review of Resident #98's admission MDS dated [DATE] revealed a BIMS score of 3 out of 15, indicating severe cognitive impairment. Under Section I (Active Diagnoses), the MDS identified active diagnoses that included COPD, respiratory failure. Under Section O (Special Treatments, Procedures, and Programs), the MDS recorded oxygen therapy as a respiratory treatment. Section O also included respiratory treatment categories for CPAP and non-invasive mechanical ventilation. (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 #98's care plan, last revised on 05/21/2026, revealed the resident required staff assistance and monitoring related to cognitive impairment and respiratory conditions. The care plan identified diagnoses including acute respiratory failure with hypoxia and COPD. Interventions included monitoring respiratory status, observing for signs and symptoms of respiratory distress, and implementing oxygen-related safety precautions when oxygen equipment was present or in use. During an observation and interview on 05/26/2026 at 9:01 a.m. with Resident #98, he stated he had been in the facility for about one week. Resident #98 stated he was prescribed oxygen therapy and wore his canula throughout the day. It was observed that the resident had an oxygen concentrator in the room at bedside and there was no oxygen-in-use sign posted outside Resident #98's room. Record review of Resident #128's face sheet revealed the resident was a [AGE] year-old male. The face sheet revealed an original admission date of 05/18/2026. Record review of Resident #128's History and Physical dated 05/11/2026 revealed diagnoses that included coronary artery disease (reduced blood flow to the heart), hypertension (high blood pressure), hyperlipidemia (high cholesterol), anemia (low red blood cell count), and shortness of breath (difficulty breathing). The record revealed respiratory symptoms requiring continued monitoring and nursing oversight. Record review of Resident #128's admission MDS dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact. Under Section I (Active Diagnoses), the MDS revealed respiratory-related diagnoses and symptoms requiring monitoring. Under Section O (Special Treatments, Procedures, and Programs), the MDS revealed oxygen therapy as a respiratory treatment. Record review of Resident #128's Care Plan created on 05/22/2026 revealed respiratory-related symptoms that included shortness of breath. The Care Plan revealed interventions related to monitoring respiratory status, observing for changes in breathing, and implementing oxygen-related safety precautions when oxygen equipment was present or utilized. The Care Plan revealed continued nursing monitoring related to respiratory symptoms and shortness of breath. During an observation and interview on 05/26/2026 at 10:22 a.m. with Resident #128, the resident was in bed watching television, he was wearing his nasal cannula and there was an oxygen concentrator at bedside. Resident #128 stated he needed oxygen therapy to breath better and stated he had been admitted to the facility less than one week ago. There was no oxygen-in-use sign posted outside Resident #128's room. During an interview on 05/26/2026 at 10:27 a.m. with LVN B, she stated oxygen-in-use signs were required to alert staff, residents, and visitors that oxygen was present in the room. She stated the signs served as a fire safety precaution and reminded staff to monitor oxygen use and equipment. She stated LVNs, RNs, and the DON were responsible for ensuring the signs were posted. During an interview on 05/27/2026 at 9:36 a.m. with CNA C, she stated oxygen signs were required so staff, residents, and visitors were aware oxygen was being used in the room. She stated the signs helped ensure residents receiving oxygen were monitored appropriately and alerted others to potential fire hazards. She stated RNs and LVNs were responsible for ensuring the signs were posted. During an interview on 05/27/2026 at 9:50 a.m. with RN D, she stated oxygen signs were required to notify staff and visitors that oxygen was in use and to promote ongoing monitoring of residents (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receiving oxygen therapy. She stated the signs also served as a safety warning to reduce the risk of fire hazards associated with smoking materials or spark-producing devices. During an interview on 05/28/2026 at 10:24 a.m. with the Administrator, he stated oxygen-in-use and no-smoking signs were expected to be posted outside every room containing oxygen equipment. He stated the signs warned staff, visitors, and residents of potential fire hazards and helped prevent unsafe items from being brought into the area. During an interview on 05/28/2026 at 10:58 a.m. with the DON, she stated oxygen signs were expected to be posted outside rooms where oxygen was in use. She stated the signs identified residents receiving oxygen therapy and alerted visitors and staff to associated fire safety risks. She stated LVNs, RNs, ADONs, and the DON were responsible for verifying the signs were in place. Record review of the facility's policy titled Leadership Policies and Procedures, Section IX: Patient/Resident Care, Subject: oxygen supply – monitoring and re-ordering, revised on 11/1/2017, read in part: POLICY: The Facility has established a policy and procedure to ensure an adequate supply of oxygen for the prescribed care of patients and residents. 14. Post oxygen safety sign on the patient/resident's room door. F. Oxygen safety sign placed on patient/resident's room door.

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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. Based on observation and interview the facility failed to ensure that drugs and biologicals used in the facility were properly stored and or disposed of according to professional standards in 2 of 2 (Medication Room Hall 300/400) reviewed for medication storage.The facility failed to dispose of expired IV mixed solution medications.The facility failed to properly store 1 glass bottle medication in the refrigerator which led to the breaking of the bottle. This failure caused the medication to be spilled inside of the plastic zip bag and caused breakdown of the box the mediation was stored in resulting in the medication being unsafe to administer.This failure could place residents receiving medication that is expired at risk of not receiving the intended therapeutic benefit of their medication, or other adverse side effects.The findings include:In an observation on 5/28/2026 at 11:30 AM of the Medication storage room for the 300/400 hall revealed 3 residents had IV medications that had expired. A total of 27 doses of IV mixed solution medications past the date on the labels to have been administered by. A total of 11 doses of Meropenem expired on 5/25/2026, 1 dose of Vancomycin expired on 5/26/2026, 3 doses of Cefazolin expired on 4/1/2026 and 9 doses of Cefazolin expired on 4/6/2026. One refrigerated medication stored in a clear zipper sealed bag had a broken bottle and the medication and box were saturated in a fluid substance making the medication unsafe for administration. In an interview with RN-D on 5/28/2026 at 11:30 AM while observing the medication room, she stated the nurses or the nurse manager were responsible for ensuring out of date medications were removed from the storage room. She stated 3 of the expired medications belonged to residents currently in the facility, and one that had been discharged from the facility. She stated that administering medications that are out of date would not work as well, decrease the efficacy of the dose or cause infection to get worse. RN-D was unaware of the broken bottle of medication stored in the refrigerator. She stated a negative outcome would be the medication would be contaminated and could possibly contaminate other medications in the refrigerator. In an interview with DON on 5/28/2026 at 1:40 PM she stated her expectation was for medications not being used or expired were to be disposed of in the biohazard box in the medication storage room. She stated it was the responsibility of the Charge nurse, ADON and DON to ensure medications are checked to ensure medications are properly stored, labeled, and discarded when not being used or expired. She stated that medication, routine or as needed, was no longer being administered would be kept for the resident until expired in case it was needed again. A negative outcome of administering medications that were not stored properly or were expired could result in the residents not getting medications that are effective for their prescribed treatment. In an interview with ADMN on 5/28/2026 at 1:55 PM, he stated when a medication was out of date or was no longer ordered for a resident, the medication should be removed from circulation and destroyed or sent back to pharmacy for credit. He was unable to state a negative outcome for having expired medication or for contaminated medications. He stated it was the responsibility of the nurse, ADON or DON to check the medication rooms for expired or unused medications. The administrator stated facility did not have a policy related to removal or disposal of expired, broken, or unused non-narcotic medications.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #113) of 3 residents reviewed for infection control.CNA A failed to change her gloves after they became contaminated while assisting Resident #113 with incontinent care. CNA A also used the same wipe to wipe the resident's peri-area several times with the same side of the wipe. (Peri-care is the hygienic cleaning and maintenance of the genital and anal areas to prevent infection, skin breakdown, and odor, especially for individuals who need assistance). These failures could place residents at risk for cross contamination and the spread of infection. Findings included: Record review of Resident #113's face sheet dated 05/27/2026 indicated he was admitted to the facility on [DATE] with diagnoses of stroke and muscle weakness. He was [AGE] years of age. Record review of Resident #113's Quarterly MDS, dated [DATE], revealed Section H - Bladder and Bowel. Urinary Continence = 3. Always incontinent. (no episodes of continent voiding). Bowel continence. 3. Always incontinent (no episodes of continent bowel movements). Record review of Resident #113's care plan revised on 03/25/2026 indicated in part: Resident has functional incontinence of bowel and bladder due to impaired mobility r/t CVA (Stroke) with Left sided weakness. 6/10/25 He complain of urinary pain. Resident will remain clean, dry and odor free and no occurrence of skin break down will occur over next 90 days. Monitor for incontinence per routine rounds and PRN, change promptly and apply a protective skin barrier to skin. Observation on 05/26/2026 at 10:28 AM CNA A performed incontinent care for Resident #113. The CNA sanitized her hands and put on a pair of clean gloves. CNA A then provided privacy and explained to the resident what she was going to do. The CNA undid Resident #113's brief and then took some wet wipes and wiped the resident's peri-area with side to side motions. CNA A then took some more wipes and wiped the resident's peri-area from front to back but would but would then use the same side of the wipe to wipe from the front to the back again. The CNA then turned Resident #113 on his side and took some wet wipes and wiped the resident's rectal area several times from front to back while using the same wipe and the same side of the wipe. While wearing the same gloves, CNA A took a clean brief and fastened it to Resident #113. Interview on 05/26/2026 at 3:10 PM CNA A said she understood that she should have used the wipes only one side at a time and she should have changed her gloves before she fastened the clean brief on Resident #113. The CNA said not changing her gloves or reusing the wipes could lead to cross contamination or infections. Interview on 05/28/2026 at 1:16 PM the DON said that it was expected for the CNAs to use a new wipe every time they wiped the resident's peri-area. The DON said that the CNA should have not wiped back and forth and only front to back. The DON said that the CNA should have changed her gloves and sanitized her hands before she took the clean brief and fastened it to the resident. The DON said that if the CNA did not change her gloves or wipe the correct way then it could possibly lead (continued on next page)

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	05/28/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to cross contamination or the spread of infections. The DON said that they conducted training regarding incontinent care on a mannequin. The DON said that the CNAs received training or skill check-offs from the SDC which were done annually and also on random picks . The DON said if there was a trend or rise of UTIs then they would conduct more incontinent training. Interview on 05/28/2026 at 1:24 PM the SDC said that the CNAs were expected to wipe from front to back when they performed peri-care and not a side to side motion as that could possibly cause the spread of germs. The SDC said the CNAs were trained on an annual basis and at random times. The SDC said it was expected for the CNAs to change their gloves once they became contaminated to prevent cross contamination. The SDC said if the CNAs did not change their gloves, then that could possibly lead to the spread of infections. Interview on 05/28/2026 at 1:45 PM the ADMN said the CNA's were expected to wipe the resident's peri-area from front to back. The ADMN said the CNA should have changed their gloves after they became contaminated to prevent the spread of infections. Record review of the facility document titled Infection prevention and control policies and procedures and dated 05/15/2023 revealed in part: Purpose: To establish a facility wide program that incorporates a system for preventing, identifying reporting, investigating, and controlling infections and communicable disease. The program covers all residents, staff, consultants, students in the facility's nurse aide training program or from affiliated academic institutions, volunteers, visitors, and other individuals providing services under a contractual agreement and is a based on the individual facility assessment following accepted national standards. Infection prevention and control program consists of currently acceptable infection control standards, practices, and activities. Examples of these are: Surveillance for healthcare acquired infection (HAI) identification; data analysis, and evaluation. Infection prevention and control program plan (continued) 6. Staff Development: 10) Cleaning, disinfecting and sanitation procedures. Compliance with applicable federal, state, and local regulations concerned with patients/residents and employees. Staff are provided with information and training on: Infection prevention and control information and plans. Hand hygiene, including hand washing and alcohol-based hand rub (ABHR). Universal/standard and transmission-based precautions. Record review of the facility document titled Staff education/orientation policies and procedures dated 01/12/2024 indicated in part: Competency: Peri-care. Performance criteria. Provides privacy, performs hand hygiene, applies disposable gloves and other PPE as indicated. Male: Gently raises penis and places towel underneath if uncircumcised retracts foreskin. Disposes of soiled gloves, performs hand hygiene, and puts on clean gloves. Washes tip of penis and urethral meatus first using circular motion from meatus outward. Rinses and dries completely unless using no rinse preparation, returns foreskin to normal position. Cleanses shaft to penis with gentle but firm downward strokes, notes abnormalities in underlying surface.