| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676207 | A. Building<br>B. Wing | 12/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Colonnades at Reflection Bay | 12001 Shadow Creek Parkway<br>Pearland, TX 77584 |

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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37059<br><br>Based on observation, interview, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 5 (Resident #1) reviewed for resident rights, in that:<br><br>The facility failed to ensure Resident #1's call light was within reach.<br><br>This failure could place residents at risk of not able to call for assistance.<br><br>Findings included:<br><br>Record review of Resident #1's face sheet dated 12/4/24 reflected an [AGE] year-old female who was admitted to the facility originally on 3/8/24 and most recently on 11/1/24 with diagnoses including: General muscle weakness, cerebral infarction (the pathologic process that results in an area of necrotic (dead) tissue in the brain) and need for assistance with personal care.<br><br>Record review of Resident #1's 5-day re-entry MDS assessment, dated 11/1/2024, did not reflect a BIMS score or ADL assistance.<br><br>Record review of Resident #1's care plan, updated 9/2/24, reflected the following in part:<br><br>Problem: .Bedfast status .<br><br>Intervention - Ensure call light is in reach, answer promptly .<br><br>Observation and interview on 12/4/24 at 9:32 AM, in Resident #1's room revealed the call light was found hung on the bed headboard out of arms reach. Resident #1 did not answer questions asked.<br><br>Observation on 12/4/24 at 10:47 AM, in Resident #1's room revealed the call light was found hung on the bed headboard out of arms reach.<br><br>(continued on next page) |



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

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 12/4/24 at 10:49 AM, with LVN A (unit manager) said Nurses and CNAs were responsible for call lights being in reach for residents. She said Resident #1's call light may have been left on the headboard after care was provided. She said Resident #1 would not be able to call for assistance because the call light was not in reach. She said she rounded every two hours to make sure residents had their needs met.<br><br>Interview on 12/4/24 at 4:41 PM, with the Administrator, said it was the Nurse's and CNA's responsibility to ensure call lights were in reach for residents. She said if the call light was not in reach the resident would not be able to notify staff when assistance was needed.<br><br>Record review of the facility's policy titled, Answering Call Light dated 9/22, revealed the following in part:<br><br>.when a resident is in bed or confined to a wheelchair be sure call light is within reach.<br><br>Record review of the facility's policy titled, Call System, Resident dated 9/22, revealed the following in part:<br><br>.Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station.<br><br>Policy Interpretation and Implementation<br><br>1. Each resident is provided with a means to call staff directly for assistance from his/her bed . |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37059<br><br>Based on observations, interviews, and record review the facility failed to ensure the resident had a right to and the facility provided a safe, clean, comfortable, and homelike environment for 1 (Resident #3) of 5 resident rooms reviewed for cleanliness.<br><br>The facility failed to ensure soiled sheets and urine odor was removed from Resident #3's room.<br><br>This failure could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life.<br><br>Findings included:<br><br>Review of Resident #3's Face sheet, not dated, reflected he was an [AGE] year-old-male admitted to the facility on [DATE]. His diagnoses included muscle weakness, unspecified dementia (memory loss), lack of coordination, and epilepsy (brain disorder with reoccurring seizures).<br><br>Record review of Resident #3's Care Plan dated 9/5/24, revealed the following in part:<br><br>Problem - [Resident #3 requires limited - extensive assistance with ADL functional mobility toileting, grooming, personal, hygiene and overall ADL 's due to .increased risk for falls, cognitive deficits, complex medical conditions . Goals - [Resident #3] will maintain a sense of dignity .Interventions - Anticipate needs .<br><br>Observation and interview on 12/4/24 at 10:24 AM revealed, Resident #3 was sitting in his wheelchair watching T.V. in his room. There was a strong urine smell as Surveyor entered the room. Resident #3's white bed sheets had layers of gradient brown circular wet stains in the middle of the mattress. Resident #3 said he was waiting for the staff to finish his bed. Resident #3 said he smelled the urine, soiled sheets and was waiting for the sheets to get changed. He said he had been sitting for about 30 minutes.<br><br>Interview on 12/4/24 at 10:30 AM with LVN B said she was not aware Resident #3's sheets were soiled. She said they should have been changed immediately. She said she had been downstairs for about 20 minutes. She said, the urine smell hit me at the door as she entered the room. She said, the sheet on Resident #3's bed had two dried rings of urine . She said CNA A left to assist another resident at the request of a family member. LVN B said CNA A should have finished changing Resident #3's linen before leaving to assist another resident or have another staff complete it. LVN B said CNAs or nurses were responsible for changing resident linens. LVN B said Resident #3's dignity and comfort were affected by him sitting in his room with the foul odor and soiled sheets.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 12/4/24 at 12:21 PM with CNA A said she left to get clean sheets for Resident #3 and was distracted. She said she left Resident #3's room, in his wheelchair and the room smelled of urine . She said she felt pressured to assist another resident because a family member screamed through the camera intercom in that resident's room. She said the other resident did not have an emergent reason to be showered before she changed Resident #3's linens. She said she was going to go back to Resident #3's room and finish changing the sheets. CNA A said it was not fair that Resident #3 had a delay in his sheets being changed. CNA A said other nurses or CNAs could have assisted Resident #3. She said Resident #3's needs were not met. She said she was trained to finish care provided to a resident before assisting another resident or ask for help.<br><br>Record review of facility policy titled Resident Rights (Revised 2/21) revealed the following in part:<br><br>Employees shall treat all residents with kindness, respect, and dignity.<br><br>1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:<br><br>a. a dignified existence;<br><br>b. be treated with respect, kindness, and dignity .<br><br>Record review of facility policy titled. Activities of Daily Living (dated 6/2016) revealed in part the following:<br><br>1. Every effort must be made to assure that assignments of nurses and nurse aides to Patients are as consistent as possible. |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37059<br><br>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so the facility is free of pests for 1 of 1 facility in that:<br><br>The facility failed to keep resident rooms free from roaches. Observed a cockroach in Resident #2's room.<br><br>This deficient practice could place residents at risk of residing in an environment with pests.<br><br>The findings included:<br><br>Observation on 12/4/2024 at 2:40 p.m. revealed a live brown roach in Resident #2's room between the laundry basket and bedside nightstand.<br><br>Interview on 12/4/2024 at 2:40 p.m. with Resident #2 said she saw roaches in her room all the time. She said they are seen more when the lights are off in her room. Resident #2 yelled out kill it when she saw the roach on the floor. She said she is not able to get up and was fearful the roach would crawl in her bed.<br><br>Records review Pest Control Vendor Service Form dated 11/4/24, revealed the pest control company had been to the facility on [DATE] and 11/27/2024. The facility was treated for roaches.<br><br>During an Interview on 12/4/2024 at 4:14 p.m. with the Administrator said the facility has had problems with roaches on the 500 and 1000 halls. She said when it rained the roaches would worsen. She said the facility had pest control come out each time there was roach or any insect sighting. The Administrator said the pest control was monthly, and she had called out in between monthly visits. She said resident rooms should have been free from all insects. She said insects in resident rooms was not sanitary. She said all staff were responsible and should report any sightings of insects.<br><br>Record review of facility policy Pest Control (revised May 2008) revealed the following in part:<br><br>Our facility shall maintain an effective pest control program.<br><br>1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents . |