STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676207	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Colonnades at Reflection Bay	12001 Shadow Creek Parkway 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 3 of 9 residents (CR#1, Resident #4 and Resident #5) reviewed for ADL's. -The 2:00 p.m.-10:00 p.m. shift failed to consistently provide showers for Resident #4 who was physically impaired, for at least 11 days causing body odor. She was scheduled to have showers on Tuesdays, Thursdays, and Saturdays. She filed a grievance concerning staff not showering her. - The facility failed to provide CR#1 bed baths on Monday, Wednesdays, Fridays on the 2:00-10:00pm shift. -The facility failed to provide Resident #5 with showers on Monday, Wednesdays, Fridays on the 6a-2pm shift causing him to formerly file two grievances with the facility concerning not getting showers. This failure could place ADL dependent residents at risk of experiencing embarrassment from odors, infection, and skin breakdown. Findings Included: Record review of shower schedule provided on 6/2/2025 revealed the following: *CR#1- was scheduled on Tuesdays, Thursdays, and Saturdays on the 2p-10pm shift *Resident #4- was scheduled to have a shower on Tuesdays, Thursdays, and Saturdays on the 2p-10pm shift *Resident #5- was on the schedule for showers on Mondays, Wednesdays, and Fridays on the 6a-2pm shift CR #1 (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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of CR #1's face sheet dated 5/28/2025 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of partial intestinal obstruction (a blockage in the intestines that allows some but not all digested material to pass through), unspecified dementia(cognitive impairment), pressure ulcer of sacral region(injury to skin and underlying tissue due to prolonged pressure), stage 2, pressure-induced deep tissue damage of left heel, dysphagia (difficulty swallowing), hypothyroidism (a condition in which the thyroid gland does not produce produce enough thyriod hormone), and hyperlipidemia (condition in which there are high levels of lipids in the blood). Record review of Discharge summary dated [DATE] from a local hospital revealed CR#1 was discharged on 3/13/2025 with an open abdominal wall wound due to the small bowel obstruction surgery, stage 2 sacral wound, unstageable right heel pressure wound, stage 2 left buttock and dementia. Record review of admission MDS dated [DATE] revealed: *Section C0500- Brief Interview of Mental Status summary score was coded as 03-representing severe cognitive impairment. *Section GG- Functional Abilities: toileting, shower/bathe, oral hygiene, roll left and right, sit to lying, lying to sitting on side of the bed, sit to stand, chair/bed-to-chair transfer, toilet transfer and tub/shower transfer were coded as 01- Dependent on helper for all the effort. Record review of bathing Plan of Care (POC) in the electronic charting system #2 revealed the following: Bed baths for the last 30 days were documented as 5/12 and 5/14/2025. Resident #4 Record review of Resident #4's face sheet dated 5/29/2025 revealed she was a [AGE] year-old female that had been admitted to the facility on [DATE] with diagnoses of rash and other skin eruption. Record review of Resident #4's MDS dated [DATE] revealed: *Section C0500- Brief Interview of Mental Status was coded as 13. This indicted that she was cognitively intact. *Section GG- Functional Abilities revealed- Toileting hygiene, shower/bathe, upper body dressing and lower body dressing were all coded as (2) representing substantial/maximal assistance- helper does more than half the efforts. Record review of Resident #4's care plan dated 6/1/2025 revealed: *Focus: Resident #4 had an ADL self-care performance deficit r/t activity intolerance, limited mobility. There was no goal. The only Intervention was PT and OT evaluation and treatment as per MD. Record review of Plan of care (POC) for last 30 days revealed she was supposed to be showered 3 times a week on Tuesdays, Thursdays and Saturdays: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She did not have a shower between 5/10/2025 and 5/15/2025. -She did not have a shower between 5/15/2025 and 5/27/2025 -Between 5/28/2025-6/3/2025 she did not have a shower . Observation and interview on 5/28/2025 at 9:28am of Resident #4 revealed she had been a resident for 1 year. She stated she had physical therapy every day. She stated her main concern was she was not getting her showers as scheduled and sometimes she had an odor. She stated she asked (unknown)CNA on evening shift several times about her shower and she was told they would get help and come back. She said they would not return. She stated she spoke with a manager about it too. She stated she had not refused any showers. She said twice a small built CNA came in and she asked her to get help as she was heavy and required two people to transfer her from her bed to her wheelchair and then the shower chair. She had a fear of being dropped, but never told them no. Resident #5 Record review of Resident #5's face sheet dated 6/6/2025 revealed he was [AGE] year-old male that was admitted to the facility on [DATE] with diagnoses of acute systolic and diastolic heart failure (two distinct types of heart failure , both affecting the left ventricle), Type 2 diabetes mellitus,(a long-term condition in which the body has trouble controlling blood sugar) and chronic kidney disease (longstanding disease of the kidneys leading to renal failure). Record review of Resident #5's care plan dated 5/1/2025 revealed he had an ADL self-care deficit, impaired balance, and limited mobility. Goal: Resident #5 would maintain current level of function in through review date 7/30/2025 Interventions: Resident #5 was totally dependent on staff for bathing/showers Record review of plan of care (POC) for the last 30 days showed Resident #5 had a shower on 5/28/2025, 6/2 and 6/4/2025 did not have showers on 5/5, 5/7, 5/9, 5/12, or 5/21/2025. Record review of grievance for last 3 months (March, April and May 2025) revealed residents filed the following grievances: *5/20/2025-Residnet #4 filed a grievance stating shestating she had not been showered in over 11 days. *5/6/2025- Resident #5 filed a grievance stating the 2-10 shift was not giving him his showers. Observation and Interview with Resident #5 on 5/29/2025 at 11:49am, he said he had been a resident for about 1 month. He stated the only concern he had was not getting his showers. He stated he was supposed to get a shower at least three times a week. He said Mondays, Wednesdays, and Fridays on the morning shift. He stated he asked staff about his showers, and they never came back or they would say it was not his day for a shower. He denied refusing showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 5/29/2025 at 12:01pm with CNA A said she had been employed for 1 year on 6-2pm shift. She stated some of her duties were to feed residents, give showers, dental hygiene, getting residents dressed, change resident briefs, and drain catheters. She said they were able to enter showers into the electronic charting system #2. She denied not providing bed baths for CR#1, and showers for Residents #4 and Residents #5. She said she gave her the Residents showers as scheduled. She said if they were unable to shower the residents she had to report that to the charge nurse. She said nurses were told about any refusals. An interview with LVN A on 5/29/2025 at 12:09pm, she said she had been employed for 1 years as a charge nurse on 6a-2p. She said her duties were to make rounds, assessments, take blood sugars, vitals, insulin, g-tube feedings and sign off on CNA tasks were completed. She documented any refusals for brief changes, re-positioning or showers in the electronic charting system #2. She said there had been some issues with CNA's giving showers on second shift and they had an in-service about it. She said she had to talk to several CNAs on her shift as well. She said she went behind CNAs if they said there was a refusal. She said most residents will not deny care if you explain the importance An interview with CNA B on 5/29/2025 at 12:25pm, stated that she had been employed at the facility for about 4 years on both 6-2 and 2-10pm shifts. She stated her duties were to help residents with all of their care, such as hygiene, showers, brief changes, grooming and any other needs. She said some CNAs did not have access to the electronic charting system #2. There had been some log in issues for some of the staff. She was able to access the electronic charting system #2and stated that she documented at the end of her shift. She said if she did not get to a shower, she told the nurse because there is so much time in the day. In an observation and interview with LVN B on 5/29/2025 at 1:42pm, she said she had been employed at the facility for about 2 years. She stated she was the charge nurse on Hall where Residents #4 and 5 resided. She said the shower sheets are placed in a basket after the care givers provide showers. She stated she sometimes helped CNAs give shower and that was how she made sure they were done. She proceeded to show me the shower sheets. There was a stack of sheets in a basket located at the nursing station near Hall 100 dating back to March 2025. She stated she was not aware of who was responsible for inputting the shower sheets into the electronic charting system #2. She said her job was to make sure the care staff provided showers as scheduled and requested. She said sometimes staff told her residents refused showers and she had to ensure this was the case. She said most times, the residents will take a shower. She stated she could not recall Resident #4 refusing showers. She said it could be embarrassing for a resident not to get a shower. Hygiene is very important. In an interview with the Administrator on 5/29/2025 at 1:53pm, she stated she had been employed at the facility for 2 years. After she was shown the basket of shower sheet by LVN B from March 2025, she stated CR#1's RP never complained to her about not getting her bed baths, Resident #4 had refused showers and Resident #5 might have missed one shower and they did it the next day. She said it was her expectation that all residents received their showers as scheduled. She stated that the CNA s did not keep a binder with ADL documentation. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an Interview with the DON on 5/29/2025 at 4:20pm, she stated she had been employed at the facility since March 2025. She said some of her duties were to make rounds, assessing charts, auditing charts, make sure orders are in, ensure staff are doing their jobs and the overall clinical management of the building. She stated she was not told residents were not getting showers. She stated that it was her expectation that showers are given as scheduled. In an interview on 6/3/2025 a confidential staff. She stated she had been employed at the facility for less than 1 year and worked the 2-10pm shift. She stated that she worked on the Hall where CR#1, Resident #4 and Resident #5 resided. She stated she helped with showers and bed baths. She stated CR#1, Resident #4 or Resident #5 refused showers. She stated they recently had an in-services about showers not being provided. She stated there are always call-ins and this creates an issue for other staff. Record review of the facility's ADL policy 6/2011 read in part . 6. A CNA ADL Tracking Record (see form 7-4) must be maintained in accordance with the MDS coding guidelines and specific to the Patient's individual needs. The CNA ADL Tracking Record for each patient must be kept in a binder and documented daily on each shift. CNA ADL Tracking Records must be regularly monitored by the DON or designee to ensure that tasks are being performed as scheduled. At the end of the month, the completed CNA ADL Tracking Record for each Patient is filed in the Patient's medical record under the medication/treatment tab.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to provide care consistent with professional standards of practice promoting healing and prevent new pressure ulcers from developing for 1 (CR#1) of 7 residents reviewed for pressure ulcers. -The facility failed to ensure CR #1 received the care and services to prevent a stage 2 pressure wound on her sacral from deteriorating to a Stage 4 measuring 7 (L) x 13 (W) x 3 (D). CR#1 was sent to a local hospital after family intervention and was diagnosed with fever and Sepsis. -The facility failed to immediately begin treatment after CR #1 was admitted on [DATE], a referral made by primary Physician on 3/14/2025 and the first visit by the wound care doctor/NP was on 3/26/2025. -The facility failed to implement new interventions when the sacral wound was not healing and required debridement for necrotic tissue. -The facility failed to ensure re-positioning was performed for CR #1, Resident #2, and Resident #3and did not have documentation on repositioning/turning frequency. An Immediate Jeopardy (IJ) was identified on 05/30/2025 at 1:28pm. While the IJ was removed on 6/4/2025 at 12:39pm., the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of pain, worsening of wounds, infection, emotional distress, hospitalization, and death. Findings Included: Record review of CR #1's face sheet dated 5/28/2025 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of partial intestinal obstruction (a blockage in the intestines that allows some but not all digested material to pass through), unspecified dementia(cognitive impairment), pressure ulcer of sacral region(injury to skin and underlying tissue due to prolonged pressure), stage 2, pressure-induced deep tissue damage of left heel, dysphagia (difficulty swallowing), hypothyroidism (a condition in which the thyroid gland does not produce produce enough thyriod hormone), and hyperlipidemia (condition in which there are high levels of lipids in the blood). Record review of CR #1's Discharge summary dated [DATE] from a local hospital revealed CR#1 was discharged on 3/13/2025 with an open abdominal wall wound due to the small bowel obstruction surgery, stage 2 sacral wound, unstageable right heel pressure wound, stage 2 left buttock and dementia. Record review of CR #1's admission MDS dated [DATE] revealed the following: *Section C0500- Brief Interview of Mental Status summary score was coded as 03-representing severe cognitive impairment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Section GG- Functional Abilities: toileting, shower/bathe, oral hygiene, roll left and right, sit to lying, lying to sitting on side of the bed, sit to stand, chair/bed-to-chair transfer, toilet transfer and tub/shower transfer were coded as 01- Dependent on helper for all the effort. *Section H0400- Bowel Incontinence- was coded 3. Always incontinent *Section M0150- Risk of pressure ulcers were coded 1. Yes *Section M0210- Skin Condition Unhealed pressure ulcer was coded 1. For the number of unhealed ulcers (1) *Section M0300- C. Stage 3 number of ulcers was coded (1). Number of pressure ulcers that were present upon admission. *G. Unstageable - Deep tissue injury (1). Number of unstageable wounds *Section M1200- Check all that apply revealed: pressure reducing device for chair and bed, nutrition or hydration intervention, pressure ulcer, surgical wound, application of ointments and application of dressings to feet. Further review revealed Turning and re-positioning was not checked. Record review of CR #1's updated care plan dated 5/20/2025 revealed the following: *Focus: Wound management *Goal: CR#1 wound to show signs of improvement, will be free of signs of infection, management of pressure ulcer and prevention of future pressure ulcers. *Interventions: Administer antibiotic treatment as prescribed, encourage resident to elevate legs, if drainage present get order for culture, measure ulcer on regular intervals, monitor ulcer for signs of progression or declination and notify provider if no signs of improvement on current wound regiment. Further review of the care plan revealed the wound care focus did not have the location of the wound (s). Record review of CR #1's Care plan dated 4/14/2025 revealed: *Focus: Pressure ulcer prevention *Goal: CR#1 will remain free of skin breakdown *Interventions: Barrier cream, encourage floating heels, pressure redistribution mattress, turn/reposition q2 hours and PRN and use suspension devices, pillows, and/or wedges. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's Braden scale for predicting pressure sore risk dated 3/13/2025 had a score of 9. This represented she was at high risk due to her being bedfast, limited mobility, poor nutrition, and constantly being moist. According to the score sheet, a total score of 12 or less represented high risk. Record review of CR #1's Wound Care progress note dated 3/14/25 written by Nurse A stated CR#1 was a new admission, skin assessment performed upon admission. Resident noted with surgical wound of the abdomen, wound to the sacrum, bilateral heel, also noted with G-tube and foley. Wound team will follow up with CR#1 on Wednesday/Friday during their next weekly visit. Record review of CR #1's Physician's progress notes for March 2025 written by Primary Physician or NP indicated: *3/14/25 the Primary physician wrote Chief Complaint: Evaluation and management of resident small bowel obstruction, stroke, lacunar infarct, glaucoma, and unstageable sacral wound. NPO and foley catheter noted. Referral to wound care. It was e-signed by primary physician on 3/18/2025 at 9:23pm *3/16/25 NP B wroteB wrote Chief complaint: Evaluation and management of resident small bowel obstruction, stroke, lacunar infarct, glaucoma, and unstageable sacral wound. Skin/breast: Abdominal wound covered with dressing, sacral wound. It was e-signed by NP B on 3/18/2025 at 9:56 p.m. *3/17/25 NP A wrote Chief complaint: Follow-up for small bowel obstruction, constipation, sacral wound reported, surgical site infection and CVA. Plan: Pain management, PT/OT, Vitamins, plan discussed with patient and nursing. It was e-signed by NP A on 3/22/2025 at 9:41pm. Record review of CR #1's weekly skin assessment dated [DATE] written by Nurse A revealed weekly evaluation completed by Wound doctor. Resident noted with post-surgical wound to the abdomen (13 w x 0.1 x not measurable, Stage 3 wound to sacrum was (0.5 X 1 X 0.2) noted to have no tunneling/normal skin (Zinc and turn and repositioning Q2 hours)and DTI to left heel (2 X2 X unmeasurable). Updated care plan notified family and physician. E-signed by WCN A on 3/19/2025 at 3:29pm Record review of Wound care doctors' initial assessment for CR#1 dated 3/26/25 were as follows: *Site #1-Post surgical wound abdomen full thickness (LxWxD) 13x 0.1x not measurable. *Site #2 - Stage 3 pressure wound sacrum measured 8x10x0.2 cm. Dressing treatment - Zinc ointment apply once daily and as needed for 16 days. Secondary dressing: Gauze Island w/bdr apply and as needed for 16 days. Turn side to side in bed every 1 -2 hours. Group 2- mattress; Reposition per facility protocol. *Site #3- Unstageable DTI of the left heel Record review of CR #1s weekly skin assessment written by Nurse A dated 3/26/2025, Weekly wound evaluation completed by wound doctor revealed CR#1 post-surgical wound to the abdomen (13 x 0.1 x not measurable depth, wound to sacrum (8 X 10 X 0.2) apply zinc cover with dry dressing. Low air mattress, offload bony prominences. Turn and reposition q2hours. Right foot abrasion (non-pressure) resolved. Left heel had the same measurements of 2X2X unmeasurable. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR #1's Weekly skin assessments written by Nurse A from 4/2/25 to 4/9/25 indicated: - dated 4/2/2024, Surgical abdominal wound was resolved. Stage 3 pressure injury sacrum wound 6x12x0.2 - Low air mattress, offload bony prominences. Turn and reposition q2hours, vitamin therapy wound supplement were nutritional interventions. Left heel had the same measurements of 2X2X unmeasurable. - dated 4/9/2024, Stage 3 pressure injury sacrum wound 6x14x0.2 - Low air mattress, offload bony prominences. Turn and reposition q2hours, vitamin therapy wound supplement were nutritional interventions, xeroform treatment. Left knee- scratch- resolved 4/9/2025. Record review of CR #1's Physician's progress notes dated 4/14/25 written by NP A revealed, Sacral wound reported- Decubitus ulcer of sacral wound care daily and PRN. Wound care following blisters to the wound was reported by wound care NP. It was e-signed by NP A on 4/15/2025 at 9:09 pm Record review of CR #1's Weekly skin assessments written by Nurse A from 4/16/25 to 4/23/25 indicated: *dated 4/16/25, Stage 3 pressure injury sacrum measured 6x15x not measurable treatment changed from xeroform to calcium alginate Santyl. Response to treatment: No change. Left heel had the same measurements of 2X2 X unmeasurable. *dated 4/23/25, Stage 3 pressure injury to sacrum changed to a Stage 4 on 4/23/2025 and measured 6x15x not measurable. Record review of CR #1's Wound care doctors' progress note dated 4/23/2025 revealed CR#1's sacrum wound was now a Stage 4 and measured at 6 x14 x unmeasurable (due to presence of nonviable tissue and necrosis (death of body tissue). Debridement performed on the sacral. Record review of CR #1's Wound care doctor's progress note dated 5/28/2025 revealed he did a debridement of CR#1's sacrum wound to decrease necrotic tissue. The wound measured at 5(L) x 14 (W) x 1 cm(D). Record review of CR#1's Medication administration log for March 1-31, 2025 3/14/2025 Jevity 1.2 cal 0.06 gram - 1.2 kcal/mL oral liquid order date 3/13/2025 discontinued 3/16/2025 Wound supplement (30cc) one time daily starting 3/14/2025 discontinued 3/16/2025. Multivitamin with minerals 1 tab oral one time daily Aspirin 81 mg tablet delayed release G-tube every one day starting 3/14/2025 Enoxaparin 40mg /0.4 mL subcutaneous syringe every one day starting 3/14/2025 (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Vitamin C 500 mg tablet oral two times daily start 3/15/2025 discontinued 3/16/2025 Lidocaine patch 4% topical patch every one day 3/16/2025 Jevity 1.2 cal 0.06 gram oral liquid (60ml/hr) starting 3/16/2025 Levothyroxine 88 mcg tablet every one day starting 3/14/2025 Melatonin 3 mg tablet Multi vitamin with minerals (1 tab) G-tube one time daily Vitamin C 500 mg tablet (1 tab) two times daily Liquid wound supplement (30 cc) one-time daily G-tube Doxycycline hyclate 100 mg tablet two times daily for seven days starting 3/19/2025 for local infection of skin (abdomen) 3/25/2025- Isosource HN 0.05 gram- 1.2 kcal/mL liquid tube feed (replaced Jevity) Record review of treatment administration log for March 2025, revealed the wound care doctor ordered Zinc Oxide one time daily starting on 3/27/2025. The order notes stated: Cleanse sacrum with normal saline or wound cleanser, pat dry, apply Zinc Oxide and cover with dry dressing. Further review revealed there were X's representing treatments were not done between March 1-27, 2025. Record review of CR#1's medication administration for April 1-30, 2025, revealed the following medications had no administration times nor a specified date range: -Multivitamin with minerals -Vitamin C 500 mg tablet two daily -Amoxicillin 875 mg g-tube every 12 hours Record review of CR#1's medication administration record for May 2025 revealed an order for wound supplement one time a day for wound, Give 30 cc -start date 5/3/2025 and discontinued 5/9/2025. -Protein supplement had X's from May 1-31st. This represented medication not given. Record review of POC (Plan of Care) bed mobility for CR#1 from 5/1/25-5/30/25 was documented as follows : -BED MOBILITY: SELF-PERFORMANCE - How resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture. (continued on next page)

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-BED MOBILITY: SUPPORT PROVIDED - How resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture. Further review revealed there was no documentation of assistance with bed mobility on 5/6/25, 5/9/25, 5/13/25, 5/17/25 nor 5/23/25-5/26/25. Observation of CR#1 on 5/28/2025 at 9:33 am revealed her to be asleep in supine position. There was a stench odor in her room. She was covered with a blanket. Observation of CR#1 on 5/28/2025 at 10:27am, observed to be in supine position FM and EMT inside of the room. An interview with CR#1's RP on 5/28/2025 at 3:20pm she stated before CR#1 was admitted to the facility, she resided at an assisted living facility but had been hospitalized due to a bowel obstruction. She said the hospital recommended she go to a rehabilitation for therapy. She said her family visited CR#1 almost daily. She said every time she visited, she had to ask staff about changing her briefs and/or giving her a bed bath. She said her room had a stench smell. She said she was not aware of the sacral wound was opened or infected until a few days ago . She said the wound care doctor and nurses provided care before 8am in the morning and she usually came much later in the day. She said this was why she did not know about the sacral wound. She stated they would come in and change her, yet they never said anything about her wound, it was covered. She denied staff informing her of the condition of CR#1's wounds. She stated that she had photos from the hospital a day before being admitted to the facility and the sacral wound was the size of a pea. She said the sacral wound she saw a couple of days ago had a large hole that she could put her fist inside of it. She said she was sickened by what she saw. She said she called 911 today (5/28) to get her emergency medical attention. She said CR#1 was lethargic and not herself on the previous day. An interview with attending physician for CR#1 at a local hospital on 5/28/2025 at 3:37pm, said CR#1 was admitted on [DATE] with a low-grade fever of 100.4 degrees Fahrenheit, had elevated WBC, a kidney infection and sepsis. He stated the Sepsis was likely coming from the wound in his clinical assessment. He stated that the sacrum wound had been measured at 7 (L) x 13 (W) x (3) depth upon admission. The hospital started CR#1 on IV fluids and two different antibiotics, vancomycin and Septra. He stated the wound was badly infected. The measurement taken at the hospital was larger than what the facility's wound care doctor documented on the same day . He stated that CR#1 had been admitted to the facility from their hospital. He stated that CR#1's wound was tunneling. He said it was not even opened when she left their hospital. He had reviewed her history. An interview with CR#1's primary doctor's NP on 5/29/2025 at 10:22am, she stated she had been in the building for about 1 year. She said some of her duties see all of the patients and provide medical care. She stated she visited the facility once a week. She stated upon initial assessment they look at the skin and if there are wounds the WC team follow the wounds. She said Wound care Doctor and nurses at the facility made up the wound care team. She stated CR#1 had wounds in her lower extremities but the sacral wound was not seen recently. She her abdomen wound had healed. She was not compliant with offloading and had a right to refuse. CR#1 was on an air mattress and was usually sitting up 45 degrees when she visited. She stated CR#1 did not like those heel boots. She said CR#1 had a poor prognosis. She said her nutritional status does not get great absorption with G-tube. She was not making any progress, so it was just about doing your best. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	She said she made the family aware of her poor prognosis and recommended hospice. She said she did not recall talking with CR#1's RP about the wound, just medically she was declining. She said repositioning was important for all patients especially if they were not ambulatory. She said CR#1 had an air mattress and it deflated in one area and inflated in another. It helped with moving but it was beneficial for someone to turn her. She said as a medical professional, some form of offloading and turning was necessary. She said she did not see her every day, so she had no way of knowing if she was being re-positioned and turned Q2 hours or not. She said she was not sure of her BIM score. She said CR#1 could nod or say no. She was not able to make two-or three-word sentences. She said the last visit with CR#1 was on 5/21/2025 when she saw herher, she was sitting up at 30-40 degrees, she noticed that her secretions had decreased. She would pocket secretions in her mouth. She said she did not have her boots on her heels. She allowed staff to put them on her. She encouraged her to wear the heel boots. She did not view the sacral ulcer that day. She did not see the dressing. Vitals were stable, no signs of infection to her. An interview on 5/29/2025 at 12:01pm with CNA A said she had been employed for 1 year on 6-2pm shift. She stated some of her duties were to feed residents, give showers, dental hygiene, getting residents dressed, change resident briefs, and drain catheters. She said she had not worked on CR#1's hall. She said CNAs did not assist with wound care. She said she had residents down her hall that had wounds. She said the wound care nurse and doctor are the only two that are in the room. She said in the past she had assisted with wound care by changing the briefs or helping to turn or re-position residents for treatment. She said they are supposed to turn residents every two hours. She said they were able to put in every time they provided care when they had electronic charting system 1. Now they have electronic charting system 2, and it only allowed them to check when they assisted with bed mobility. She said the nurses were able to enter care into electronic charting system 2, as2, as well. An interview with LVN A on 5/29/2025 at 12:09pm, she said she had been employed for 2 years as a charge nurse on 6a-2p. She said her duties were to make rounds, assessments, take blood sugars, vitals, insulin, g-tube feedings and sign off on CNA tasks were completed. She said she had to do wound care from time to time and TAO (triple antibiotic ointment) was used until there was a physician order. She said they had two fulltime wound care nurses so she rarely did wound care. She said she did not have CNA's help with wound care when she had to do it. She said the doctor, or his NP were the only people in the room. She stated she had not done wound care for CR#1. She said she documented any refusals for brief changes, re-positioning, and showers in the electronic charting system 2,.2, She said there had been some issues with CNA's giving showers on second shift and they had an in-service about it. She said she had to talk to several CNAs on her shift as well. She said she went behind them if they said there was a refusal. She said most residents will not deny care if you explain the importance. She said turning and re-positioning was vital to wounds healing. She said the electronic charting system 2 had turning and re-positioning on their task list. She said she would check off for the entire shift that they had been done. There was no way for nurses to document for example that it was done at 1pm, 3pm, or 5pm. She said keeping the residents clean and dry, showered, and re-positioning was important for wound healing or to prevent new wounds. An interview with CNA B on 5/29/2025 at 12:25pm, stated that she had been employed at the facility for about 4 years on both 6-2 and 2-10pm shifts. She stated CNAs did not assist with wound care. She said usually it was the nurse, doctor, or his NP. She denied observing CR#1's wound. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	She denied being asked to change CR#1's brief. She stated turning and re-positioning and keeping them dry was important for residents' wounds to heal especially on the sacral, but also on hip and heels. She said they did not document every time they turned because they keep up with it themselves and tell the nurse at the end of the shift that it had been done. The nurse would then check it off that it was done on their shift. She said some CNAs did not have access to the electronic charting system 2. There had been some log in issues. She was able to access the electronic charting system and stated she documented at the end of her shift. She said she turned all her patients to the left and then right every two hours. She said she kept up with it on her own. In an interview with the Wound care doctor on 5/29/2025 at 12:45pm, he said he had been coming to the facility about 6 months and saw about 25 patients a week. He stated his NP would also visit during the week. He said most of their visits were early mornings starting at about 6am. He said he saw CR#1 on yesterday (5/28/2025). He said he started visiting with CR#1 back in March 2025. She had wounds on her sacral, heels and the knee and surgical wounds were resolved. He said initially the sacral pressure wound was a stage 3 and it had deteriorated and became unstageable with necrotic tissue. He stated in the last two weeks, he had been debriding her slowly and it was improving. There was no necrotic tissue remaining on yesterday (5/28/2025). He said she did have a completely necrotic wound, one like hers was done gently and carefully. The remaining necrotic tissue was removed on yesterday. He said wounds are sometimes unavoidable due to co-mobility, nutrition, mental status, or infection of the wound. He said a combination of all of that determined whether they heal, stall or deteriorated. He denied the sacral wound was infected. He said his goal was to remove all of her necrotic tissue and that was done. He said she was not on any antibiotics because he had not identified any infection on her. He said he typically would round and order a wound culture before ordering antibiotics. He said her primary doctor could also order antibiotics/ labs if she had access or received the results of the wound culture before he does. He said he had not ordered a wound culture because she had no necrotic tissue left and no reason to order antibiotics. He said CR#1 was not able to follow directions. He said she did not have the capacity to turn herself nor remove the boots off her heels. He stated the wound care nurse made calls to inform FM of change in condition. He said CR#1 never refused care from him. He said she was not verbal. He said the nurse never notified him of any issues. He said when he visited her, she was often in the supine position, and this was not best for her sacral wound. He said she should not be in the supine position for more than 2 hours. He said turning and re-positioning was vital for wounds healing. He denied the sacral wound had an odor. He stated he ordered Daiken as it was a wound cleanser. It helps with odors, but that was not his reason for using it, just as a cleanser. He stated CR#1's wound had 0% necrotic tissue when he left her on 5/28/2028 around 6:45am. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with wound care nurse A on 5/29/2025 at 1:56pm, she stated she had employed at the facility about here 1 year as WCN on day shift. She stated she worked on CR#1's hall and conducted wound assessments weekly for her. She stated CR#1 sacrum wound was difficult to heal since she was bedfast, and she required re-positioning every 2 hours. She said her right heel wound was resolved. She stated she had boots for her heels to prevent breakdown. She was admitted with the heel and sacrum wounds. She said she could not recall what the sacrum looked like when she was admitted . She could not recall the size. She said her documentation that the wound was a Stage 3 pressure injury wound and measured (0.5 X 1 X 0.2) noted to have no tunneling/normal skin (Zinc and turn and repositioning Q2 hours) when CR#1 was admitted on [DATE]. She said that was the measurements at the time. She said CR#1's measurements the next week was (8 X 10 X 0.2) came from the wound care doctor, who gave her the measurements and she documented that. She said he did the measuring. She said she cleaned and replaced CR#1's dressing daily. She said her treatment started when she was first admitted with maybe TAO but changed to alginate and calcium once the wound care doctor saw her for the initial visit. She said she was not sure why CR#1 was not seen by the wound care doctor until 3/26/2025. She said CR#1's doctor had made the referral a day or so after her admission. She said at some point, CR#1 was on IV antibiotics and this caused a lot of loose stool so she needed to be changed more often than 2 hours. She said this might be why the family said she had an odor. She said the residents sacral did have a slight odor. She said the WCD ordered Daikin which was also called sodium hypochlorite. He ordered it on yesterday (5/28/2025). She said the WCD would often start the Daikin if there was an odor. She said odor was a sign and symptom of infection. She stated she could not be sure if staff were turning and re-positioning her as needed. She stated turning and re-positioning was vital to helping heal wounds. She said CR#1 would say yes or no. But, never spoke using a full sentence. She said CR#1 never refused or said no to her. She said they do not use the assistance of CNA's while providing wound care. She said CR#1's wound was covered. She said loose stool could make a wounds worst on the sacral, especially since CR#1 had loose stools. She said she updated care plans with changes and called FM about changes as well. An interview with CR#1's primary physician on 5/29/2025 at 3:54pm she said she had been CR#1's physician for about two months. CR#1 was admitted with small bowel obstruction, dementia, stroke and not able to swallow. She had a feeding tube. She came to the facility for OT/PT, and with wounds. She stated as far as she knows the sacrum wound had improved and was smaller than when she was admitted . She said she did not measure the wound. She said the facility's WCN told her there was a wound and so she made the referral. She stated re-positioning would be important to be done every 1-2 hours for anyone bedfast or not mobile. She stated the resident had a poor prognosis, and the wounds were unavoidable because they were doing everything for her. She had an air mattress, g-tube feeding and was taking Vitamin C and a multi-vitamin. She did not recall if she had any protein or if she was on any antibiotics. She stated she did not know why the vitamins had not been given in April, she would have to check on that information. She said she recalled writing it as a tablet and then realized it had to be given via G-tube, but she made that change quickly because she was NPO. She said Daikin was used as a wound cleanser. She said odor was a sign and symptom of infection. She said she could not attest to the size or condition of the wound. She understood it was smaller than when she arrived. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an Interview with the DON on 5/29/2025 at 4:20pm, she stated she had been employed at the facility since March 2025. She said some of her duties were to make rounds, assessing charts, auditing charts, make sure orders are in, ensure staff are doing their jobs and the overall clinical management of the building. She stated she had not personally met CR#1. She stated she had not observed her wounds. She said they had a WC team that gave report at morning meetings if there were any issues. She said once a week they would discuss the wound report. The clinical team was made up of charge nurse, DON, ADON and wound care nurses. She said the WCN was required to perform weekly assessments. She said every Friday she printed the report to ensure weekly assessments are done. She stated she had not heard CR#1's wound was deteriorating. She said Daikin was used as a cleanser and could be used due to odors. She said odors were a sign and symptom of infection. She stated if a wound upon admission was a Stage 2 and now a stage 4 if would appear that it had gotten worst. She said some of the reasons some sacral wounds does not heal was due to not being turned and positioned, nutritional status, and not being adequately hydrated. She denied any complaints from CR #1's RP about her not being changed or re-positioned. She expected CNA's to change briefs at least every 2 hours, provide hygiene care and wound care nurses to assess, treat and let her know if there are any issues. In an interview on 6/3/2025 a confidential staff stated she had been employed at the facility for less than 1 year and worked the 2-10pm shift. She stated she worked on the Hall where CR#1 resided. She stated when CR#1 was admitted , she saw the spot on her sacral. She said CR#1 was incontinent of bowel and had a lot of diarrheas. She said the sacral was the size of a quarter, but it had healed and was not opened. She stated the last month or so, the wound was covered, and she had no idea how bad it had gotten. She said most of the time her boots were not on. She said she was not sure who took them off, but she was not capable of taking them off herself. She said they must keep up with every 2-hour turning and re-positioning themselves or put under bed mobility. She said she did not think it was made clear on where to put it because they had turning/re-positioning in the ecteronic charting system 1, but not in the electronic charting system 2, just bed mobility which was where she documented. She said she went down the hall and turned all Residents in the same direction and then 2 hours later to the opposite side. In an interview on 6/3/2025 at 3:45pm CNA D stated she had been employed at the facility for 1 month. She worked on the 6-2pm shift but working a double today on Hall 100. She stated her duties were to shower residents, hygiene, personal care and turn them every 2 hours. She stated she was aware CR#1 had a sacral wound, but it was always covered by a patch or dressing when she went in to change her. She stated CNAs did not assist with wound care. She said she heard recently that the wound was bad. She stated she never saw it. She said the doctor rounded with the wound care nurse. She stated CR #1 had a stench smell and received bed baths. She stated she always gave her bed baths and showers as scheduled. She said no one wanted to have an odor. She stated re-positioning was not in the electronic charting system 2, it was under bed mobility, and they have to put whether they assisted CR#1 or not. She denied CR#1 refused care. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 6/3/2025 at 3:45pm CNA D stated she had been employed at the facility for 1 month. She worked on the 6-2pm shift but working a double today on Hall 100. She stated her duties were to shower residents, hygiene, personal care and turn them every 2 hours. She stated she was aware CR#1 had a sacral woundwound, but it was always covered by a patch or dressing when she went in to change her. She stated CNAs did not assist with wound care. She said she heard recently that the wound was bad. She stated she never saw it. She said the doctor rounded with the wound care nurse. She stated CR #1 had a stench smell And received bed baths .baths. She stated she always gave her bed baths and showers as scheduled. She said no one would wanted to have an odor. She stated re-positioning was not in the electronic charting system 2, it was under bed mobilitymobility, and they have to put whether they assisted CR#1 or not. She denied CR#1 refused care. . 2. Observations of Resident #2's positioning while in bed revealed the following: 6/2/2025 at 11:47am- observed on to be on right side 6/2/2025 at 12:59pm- Observed on right side 6/2/2025 at 2:49pm- Observed to be on right side 3. Observation of Resident #3's positioning while in bed revealed the following: 6/2/2025 at 11:46 am - Observed to be on his back 6/2/2025 at 2:47pm- Observed on his ba

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident who was incontinent of bowel/bladder and each resident with an indwelling catheter received appropriate treatment and services to prevent urinary tract infections, for 1 of 3 residents (Resident#6) reviewed for incontinent care and for indwelling urinary catheters. -Resident #6 Foley catheter bag was lying in the bed near his left calf on 6/4/2025 and hanging to the floor on 6/6/2025. This failure could place residents at risk for accidental dislodgement of the catheter and trauma to the bladder and urethra Findings Included: Record review of Resident #6's face sheet dated 6/4/2025 revealed he was a 59 year59-year male that was admitted to the facility on [DATE] with diagnoses of malignant neoplasm of rectois sigmoid junction, infection of continent stoma, chronic kidney disease, artificial opening of urinary tract. Record review of Resident #6's MDS dated [DATE] revealed: *Section GG- Functional Abilities - Toileting hygiene, shower/bathe, upper and lower body dressing were all coded as (1)- dependent *Section H- Bladder incontinence was coded as (9) - which was not rated, resident had a catheter, (indwelling, urinary ostomy or no urine output in 7 days. Bowel Incontience was coded as (9) not rated, resident had an ostomy or did not have a bowel movement. *Section C500- Brief Interview of mental status was coded as 15. This indicated Resident #6 was cognitively intact. Record review of Resident #6's care plan dated 5/10/2025 revealed: Focus: Resident required the use of an Ostomy Goal: Resident dignity will be maintainedmaintained, and the ostomy will remain functional over the next 90 days. Interventions: Document ostomy care in the clinical record, monitor site for swelling, pain, redness, provide otstomy care per MD orders and keep ostomy patent. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview with Resident #6 on 6/4/2025 at 2:04pm, he stated he had not been in the facility long and would be leaving soon. He said he had colon cancer and had both an ostomy bag and foley catheter. His foley bag was observed near his knee lying on the bed. He stated the facility had not strapped the catheter down and it hurt when it hung from the bed. He said it was embarrassing to have it showing in his bed and most times tried to keep it covered. He said it would get heavy from so much urine and hurt his stomach. He stated he was going home soon on home health. In an interview with LVN E on 6/4/2025 at 2:15pm, she stated she had been employed for about 3 months and worked the 6a-2pm shift. She stated that the CNAs emptied foley and ostomy bags. She stated that Nurses check the site for swelling and infection and ensure the site is clean and document that the ostomy care and foley care was done. She said the best location would be down below his bladder, but he moved it. She stated the bag not being below the bladder could cause UTI's. She stated she had not educated the resident on the risk of the location of the bag. She said this could be embarrassing for a resident to have his bag lying in his bed. She said everyone should be treated with dignity and respect. Observation of Resident on 6/6/2025 at 1:51pm, revealed his foley bag was observed to be hanging on the floor. In an observation and interview with the DON on 6/6/2025 at 2:08pm, she stated theystated they were going to strap his foley bag to his thigh. She stated it should not have been on the floor. In a subsequent interview with the DON on 6/6/2025 at 3:20pm, she stated she had been employed for 3 months. She said some of her duties were to make rounds, assessing charts, auditing charts, make sure orders are in, ensure staff are doing their jobs and the overall clinical management of the building. She stated the foley catheter bag should be placed below the bladder. She stated the nurse had not previously talked to him about moving the bag into his bed or on the floor. She stated she had not personally talked to him about why he should not have the bag lying in his bed. She said she did today but had not documented it yet. She said her expectation was for CNAs to empty the foley and ostomy bags as ordered and as needed, ensure the bag is below the bladder and for the nurses to check the sites for swelling, pain and infection. She stated she had strapped the foley catheter bag to his thigh. She denied Resident #6 told her he was embarrassed. She admitted that she did not ask him how it made him feel. In an interview with the Administrator on 6/6/2025 at 3:31pm, she stated she was not clinical, but from her understanding the foley bag tubing should be placed below the bladder. She said urine had to flow and backup into the bladder and cause infection. She said she expected staff to drain the bags as ordered and as needed and for nurses to ensure the site was clean and for the bag to be secure in the proper location below the bladder. Record review of catheter care policy dated September 2014 state in part .The purpose of this procedure is to prevent catheter associated urinary tract infections. Maintaining Unobstructed urine Flow: 3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676207	A. Building B. Wing	06/06/2025

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

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Changing catheters: 2.Ensure that the catheter remains secured with a strap to reduce friction and movement at the insertion site (note: catheter tubing should be strapped to the resident's inner thigh.)