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	10/24/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure all alleged violations involving, abuse, neglect, exploitation or mistreatment are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegations involved abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in seriously bodily injury to the state survey agency for 1 of 4 residents (Resident #2) reviewed for abuse and neglect reporting. 1. The facility failed report to the SSA when Resident #2 eloped from the facility on 06/05/2025. 2. The facility failed report to the SSA when Resident #2 eloped on 06/21/2025 when she was found across the street at an apartment complex. This failure could place residents at risk of further abuse, physical harm, mental anguish, and/or unsafe elopements. Findings include: Review of Resident #2's face sheet reflected a [AGE] year-old-female admitted on initially admitted on [DATE] and discharged on 07/06/2025 with diagnoses of end stage renal disease (final stage of chronic kidney disease when the kidneys have deteriorated and no longer perform their functions), unspecified dementia (condition where a person experiences cognitive decline), unspecified convulsions (seizures where the specific cause cannot be determined), altered mental status (a change in a person's level of consciousness, alertness, and cognitive function), repeated falls, dependence on renal dialysis (medical necessity for a person to use a machine to filter their blood because their kidneys failed to do so), muscle weakness, and difficulty walking. Review of Resident #2 care plan dated 05/01/2025 with revision date of 07/07/2025 reflected Resident #2 had an ADL self-care performance deficit related to confusion, dementia impaired balance, and limited mobility. Further review reflected Resident #2 had a potential risk for elopement as evidenced by history of attempt to leave facility unattended. Review reflected Resident #2 was found in the front parking lot on 06/06/2025 and attempted to leave premises, trying to cross the street with revision date of 07/07/2025 with interventions to assess for alternative placement frequent monitoring, and provide 1:1 sitter at bedside. Review reflected Resident #2 has impaired cognitive function, difficulty making decisions, short term memory loss with revision date of 07/07/2025 with interventions to cue reorient and supervise as needed. Review of Resident #2 quarterly MDS dated [DATE] reflected Resident #2 had not exhibited wandering behavior. Resident #2 had a BIMS of 12. Review of Resident #2 elopement risk assessment dated [DATE] reflected Resident #2 was at risk and was cognitively impaired, able to ambulate and has intentionally or unintentionally attempted to leave the community. Review of both PCC (electronic health record) and MyUnity (electronic health record) reflected there were no elopement assessments completed prior to 06/21/2025. Review of nursing progress notes dated 06/05/2025 by LVN BB reflected Resident #2 was noticed by staff wheeling herself outside the facility trying to cross the road. Resident was approached by staff and brought back to the facility. [Resident #2] said she was trying to get to her family. Resident was brought back to her room and monitored continuously till end of shift. Oncoming nurse notified of [Resident #2's] elopement behavior. Review of nursing progress notes dated 06/06/2025 by LVN BB reflected Resident #2 was found wandering outside the street trying to cross the road. She was brought back into the building and helped to her room. Review of nursing progress note dated 06/21/2025 at 12:34 PM reflected Resident #2 was last seen at about 10:58 [am] when she refused to get her blood sugar checked, at about 11:18 [am], RN H came state someone saw a woman across the street with her head tied, message related to supervisor by the receptionist. The description looks like resident. RN H and other staff members also searched neighborhood, resident could not be seen at this time. [LVN CC] and another nurse crossed the street walked through the apartment complex resident was not seen. [LVN CC] notified 911, on call MD. DON aware. Review of nursing progress note by LVN CC dated 06/21/2025 at 1:40 PM, reflected head to toe assessment was done with no physical injury noted. During an interview on 10/21/2025 at 3:08 PM, the DON stated that she worked as the DON of the facility since March 2025. The DON stated she recalled working with Resident#1 and that she was a bit difficult. The DON stated that Resident #2 often refused to take medication and go to dialysis. The DON stated Resident #2 was forgetful and had some memory loss. The DON stated that she was contacted on 06/21/2025 by LVN CC that Resident #2 was outside. The DON stated that when she arrived the facility Resident #2 was across the street at the apartments. The DON stated Resident #2 told the DON that she wanted to visit her daughter. The DON stated that she found Resident #2 before 1:00 PM and that it was sometime between 11:00 AM and 1:00 PM, but she was unsure exactly when it was. The DON stated that Resident #2 had no injuries

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs for one (Resident #1) of five residents reviewed for care plans, in that:The facility failed to care plan Resident #1's history of refusal of medication from 05/06/2025 until 06/16/25.This failure could place residents at risk of not receiving services and interventions for the residents' individual needs for person-centered care.Findings included:Review of Resident #1's face sheet dated 10/320/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including traumatic subdural hemorrhage with loss of consciousness status unknown, sequela (bleeding on the brain's surface) where the patient lost consciousness, but the duration is unknown, and it's a sequela, meaning a condition resulting from a previous illness or injury), generalized idiopathic epilepsy and epileptic syndromes (a group of epilepsy syndromes characterized by seizures that originate in both hemispheres of the brain and affect the entire body), and other seizures (a type of seizure that is not a tonic-clonic (a type of generalized seizure that affects the entire brain) seizures).Review of Resident #1's quarterly MDS assessment, dated 07/31/25, reflected a BIMS score of 3, indicating severe cognitive impairment.Record review of Resident #1's care plan dated reflected the following focus areas:focus dated 08/01/25 potential for complications related to seizure disorder and anticonvulsant therapy (the use of medications to prevent or control seizures, also known as convulsions) with intervention dated 08/01/25 give medications per order and monitor labs-report focus dated 08/01/25 Resident #1 had a seizure disorder with intervention dated 08/01/25 give seizure medication as ordered by doctor. Further review revealed the residents medication refusals were not addressed. Review of Resident #1's orders reflected administration of Nicotine Patch 24-hour 7 MG/24 (concentration is equivalent to concentration is equivalent to 2.4% nicotine by volume) apply 1 patch transdermally (the administration through the skin) one time a day 7:00 am for smoking sensation and remove per schedule start date 04/26/25 discharge date [DATE]. Record review of Resident #1's eMAR for June 2025 reflected administration of Nicotine Patch 24-hour 7 MG/24 (concentration is equivalent to concentration is equivalent to 2.4% nicotine by volume) apply 1 patch transdermally (the administration through the skin) one time a day 7:00 am for smoking sensation and remove per schedule start date 04/26/25 discharge date [DATE]. LVN C entered eMAR Code #2 (resident refused) for the following dates: 06/03/25, 06/06/25, 06/09/25, 06/11/25, 06/12/25, 06/13/25, and 06/13/25.Review of Resident #1's orders reflected give 1 tablet MG Folic Acid (a vitamin of the B complex, found especially in leafy green vegetables, liver, and kidney) by month one time a day at 7:00 am for vitamin deficiency start date 05/01/25 and discharge date [DATE].Review of Resident #1's eMAR for May 2025 reflected administration of 1 tablet MG Folic Acid (a vitamin of the B complex, found especially in leafy green vegetables, liver, and kidney) by month one time a day at 7:00 am for vitamin deficiency start date 05/01/25 and discharge date [DATE]. MT B entered eMAR Code #2 (resident refused) for the following dates: 05/13/25, 05/20/25, 05/21/25, 05/23/25, 05/26/25, 05/27/25, 05/28/25, 05/29/25, 05/30/25.Review of Resident #1's eMAR for June 2025 reflected administration of 1 tablet MG Folic Acid (a vitamin of the B complex, found especially in leafy green vegetables, liver, and kidney) by month one time a day at 7:00 am for vitamin deficiency start date 05/01/25 and discharge date [DATE]. MT A entered eMAR Code #2 (resident refused) on 06/01/25 and MT B for the following dates: 06/02/25, 06/03/25, 06/04/25, 06/05/25, 06/06/25, 06/09/25, 06/10/25, 06/11/25, 06/12/25 06/13/25, and 06/16/25. Review of Resident #1's orders reflected one 3 MG tablet Melatonin (a hormone naturally produced by the pineal gland in the brain that plays a crucial role in regulating the body's sleep-wake cycle, known as the circadian rhythm) by mouth at bedtime for sleep start date 05/01/25 and discharge date [DATE]. Review of Resident #1's eMAR for June 2025 reflected one 3 MG tablet Melatonin (a hormone naturally produced by the pineal gland in the brain that plays a crucial role in regulating the body's sleep-wake cycle, known as the circadian rhythm) by mouth at bedtime for sleep start date 05/01/25 and discharge date [DATE]. MT A entered eMAR Code #2 (resident refused) on 06/01/25. Review of Resident #1's orders reflected one 15 MG tablet of Mirtazapine (antidepressant used to treat major depressive disorder) by mouth at bedtime for depression start date 05/01/25 and discharge date [DATE].Review of Resident #1's eMAR for June 2025 one 15 MG tablet of Mirtazapine (antidepressant used to treat major depressive disorder) by mouth at bedtime for depression start date 05/01/25 and discharge

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #2) of 4 resident reviewed for accidents and hazards. The facility failed to ensure Resident #2 did not leave the facility without supervision and/or staff knowledge on 06/06/2025 when she was found trying to cross the street and on 06/21/2025 when Resident #2 was found across the street at an apartment complex. The noncompliance was identified as PNC (past noncompliance). The Immediate Jeopardy (IJ) began on 06/05/2025 and ended on 07/06/2025. This failure could place residents at risk of unsafe elopements, injuries, hospitalization and/or death. Findings included: Review of Resident #2's face sheet reflected a [AGE] year-old-female admitted on initially admitted on [DATE] and discharged on 07/06/2025 with diagnoses of end stage renal disease (final stage of chronic kidney disease when the kidneys have deteriorated and no longer perform their functions), unspecified dementia (condition where a person experiences cognitive decline), unspecified convulsions (seizures where the specific cause cannot be determined), altered mental status (a change in a person's level of consciousness, alertness, and cognitive function), repeated falls, dependence on renal dialysis (medical necessity for a person to use a machine to filter their blood because their kidneys failed to do so), muscle weakness, and difficulty walking. Review of Resident #2 quarterly MDS dated [DATE] reflected Resident #2 had not exhibited wandering behavior. Resident #2 had a BIMS of 12. Review reflected Resident used a wheelchair or scooter and was able to independently ambulate. Review of Resident #2 care plan dated 05/01/2025 with revision date of 07/07/2025 reflected Resident #2 had an ADL self-care performance deficit related to confusion, dementia impaired balance, and limited mobility. Further review reflected Resident #2 had a potential risk for elopement as evidenced by history of attempt to leave facility unattended. Review reflected Resident #2 was found in the front parking lot on 06/06/2025 and attempted to leave premises, trying to cross the street with revision date of 07/07/2025 with interventions to assess for alternative placement frequent monitoring, and provide 1:1 sitter at bedside. Review reflected Resident #2 has impaired cognitive function, difficulty making decisions, short term memory loss with revision date of 07/07/2025 with interventions to cue reorient and supervise as needed. Review of Resident #2's elopement risk assessment dated [DATE] reflected Resident #2 was at risk and was cognitively impaired, able to ambulate and has intentionally or unintentionally attempted to leave the community. Review of both EMR # 1 and EMR #2 reflected there were no elopement assessments completed prior to 06/21/2025. Review of nursing progress notes dated 06/05/2025 written by LVN BB reflected Resident #2 was noticed by staff wheeling herself outside the facility trying to cross the road. Resident was approached by staff and brought back to the facility. [Resident #2] said she was trying to get to her family. Resident was brought back to her room and monitored continuously till end of shift. Oncoming nurse notified of [Resident #2's] elopement behavior. Review of Resident #2's nursing progress notes dated 06/06/2025 written by LVN BB reflected Resident #2 was found wandering outside the street trying to cross the road. She was brought back into the building and helped to her room. Review of Resident #2's nursing progress note dated 06/21/2025 at 12:34 PM written by LVN CC reflected Resident #2 was last seen at about 10:58 [am] when she refused to get her blood sugar checked, at about 11:18 [am], RN H came state someone saw a woman across the street with her head tied, message related to supervisor by the receptionist. The description looks like resident. RN H and other staff members also searched neighborhood, resident could not be seen at this time. [LVN CC] and another nurse crossed the street walked through the apartment complex resident was not seen. [LVN CC] notified 911, on call MD. DON aware. Review of Resident #2's nursing progress note by LVN CC dated 06/21/2025 at 1:40 PM, reflected head to toe assessment was done with no physical injury noted. Observation on 10/22/2025 at 8:30 AM reflected a four lane street in front of the facility with a sign posted the speed limit was 50 mph. During an interview on 10/22/2025 at 6:14 PM, LVN CC stated she worked on 06/21/2025 and was the nurse for Resident #2. She stated Resident #2 refused to go to dialysis and that she called and reported this to the doctor. LVN CC stated that Resident #2 was upstairs initially and LVN CC went to check on Resident #2 after her dialysis refusal and Resident #2 was not in her room. LVN CC stated that the receptionist stated sent someone upstairs to tell the nurse that Resident #2 was seen downstairs and that the receptionist was not used to Resident #2 being downstairs. LVN CC stated that she went downstairs and someone told her that someone was seen crossing the street. LVN CC stated she walked to

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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 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record reviews, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for one of eight residents (Resident #4) reviewed for enteral nutrition. The facility failed to ensure Resident #4 was not laid in a flat position while her feeding tube was actively flowing by CNA E on [DATE].The facility failed to ensure LVN D provided timely nursing care/interventions in response to Resident #4's possible aspiration on [DATE].An Immediate Jeopardy (IJ) situation was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 10:39 AM. While the IJ was removed on [DATE] at 2:20 PM, the facility remained out of compliance at a scope of isolate and severity level of actual harm because all staff had not been trained on safe positioning for residents receiving enteral feeding, aspiration precautions and timely interventions.This failure could place residents at risk of tube malfunction, aspiration, and death.Findings include:Review of Resident #4's face sheet, dated [DATE], reflected an [AGE] year-old female admitted to the facility on [DATE] and discharged [DATE]. Her diagnoses included gastroesophageal reflux disease (a chronic condition where stomach acid flows back into the throat), gastrostomy status (an surgical external opening into the stomach for nutritional support), hemiplegia affecting right dominant side (paralysis to the right dominant side of the body), chronic obstructive pulmonary disease (chronic lung disease that limits airflow and causes ongoing respiratory symptoms), cerebral infarction (a blood clot that impairs blood flow through the artery in the brain), and dysphagia (difficulty swallowing). Review of Resident #4's significant change of status MDS, dated [DATE], reflected a BIMS score of 00 which indicated severe cognitive impairment. Review of Resident #4 care plan report, effective date [DATE], reflected Problems: [Resident #4] is at risk for impaired nutritional status and complications due to enteral [the delivery of nutrients directly into the stomach] feeding. with Interventions: Elevate HOB at least 30 degrees during and 1 hour after feeing. Monitor for s/s of Aspiration.Review of Resident #4's medication administration record, dated 02/2025, reflected Fibersource HN 0.05 gram-1.2 kcal/mL liquid for tube feed (65 cc/hr x 22) liquid enteral tube by shift starting [DATE] and signed off on [DATE] days by LVN A with 520.00 indicating the total milliliters Resident #4 was administered that shift. Review of Resident #4's treatment administration record, dated 02/2025, reflected G-tube - check for residual three times daily starting [DATE] with notes Check GT for residual. If more than 60 cc's hold feedings for 2 hours and recheck. Notify MD if residual remains above 60 cc's after holding for 2 hours. Also reflected was, G-tube - Elevate HOB () by shift starting [DATE]. Neither order reflected a signature on [DATE]. Review of Resident #4's nurses note, dated [DATE] at 11:23 PM, and written by LVN D reflected During routine rounds, the patient was observed with decreased respirations and a weak pulse. A reassessment was conducted, and vital signs were unobtainable. The patient was unresponsive with no signs of respiration or circulation. The attending hospice provider, Director of Nursing (DON), and family were notified of the patient's passing. The family was provided with emotional support and education on next steps per hospice protocol. The physician was notified, and the time of death was confirmed. Post-mortem care was provided according to hospice guidelines. The funeral home was contacted per the family's request. No signs of distress noted. Funeral home arrived around 2:30 pm and provided with required documentation.Observation of video footage without audio provided by Resident #4's FM D, dated [DATE], revealed the following with timestamps in military time as provided:12:20:40-12:20:49 - CNA E lowered the HOB to lay Resident #4 flat. The video stopped as CNA E was removing the top sheet from Resident #4. The feeding pump on the left side of the screen appeared to have the screen lit up, indicating it was on. 12:21:23 - Video resumed and Resident #4 was sitting with the head of her bed elevated approximately 45 degrees. CNA E then left the room. Resident #4 did not appear in any distress at that time. 12:22:52-12:23:04 - CNA E returned to room, followed by LVN D. Resident #4 started at that time with a moderate amount of white fluid coming from her mouth and down the right side of her chin. LVN D was looking at Resident #4 then walked into the bathroom.12:23:18 - CNA was observed using a cloth to clean the white liquid off Resident #4's chin. LVN D was observed returning to the room as she was putting on gloves and the video stopped briefly.12:23:46-12:26:10 - The video resumed and LVN D was looking behind the nightstand next to the bed with an oral suction device in her hand. She appeared to locate the power cord to the suction machine and plugged it in. LVN D then appeared to be looking around the room and in drawers for something. LVN D appeared to not be able to find what she was looking for and left the room

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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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure that residents who needed respiratory care were provided with such care, consistent with professional standards of practice, for 1 of 4 residents (Resident #3) reviewed for quality of care. The facility failed to ensure Resident #3 had orders for tracheostomy care and that tracheostomy care was completed on 03/14/2025 and 03/15/2025. This failures could place residents at risk of inadequate care, respiratory distress and hospitalization. Findings include: Review of Resident #3 face sheet reflected a [AGE] year-old-male admitted on [DATE] at 7:00 PM and discharged on 03/15/2025 at 12:15 PM. Diagnoses included hypertensive heart disease (condition where prolonged high blood pressure damages the heart muscle), chronic kidney disease (condition where the kidneys gradually lose their ability to filter waste from the blood), malignant neoplasm of thyroid gland (cancer that develops in the thyroid gland). Review of admission MDS dated [DATE] reflected Resident #3 Section O titled Special Treatments, Procedures and Programs reflected tracheostomy care was not selected. Review of baseline care plan dated 03/15/2025 by ADON reflected Resident #3 was alert / cognitively intact. Review of care plan dated 03/15/2025 reflected Resident #3 was on enhanced barrier precautions with feeding tubes selected for the reason and tracheostomy was not selected. Review of admission/ re-admission charge nurse report form dated 03/14/2025 by RN ZZ reflected Resident #2 had a thyroidectomy, shortness of breath, neck swelling, and a peg tube. Review reflected Resident #3 was alert and oriented x3 (person, time, place, situation). There was no information that Resident #3 had a tracheostomy. Review of nursing admission assessment with admission date of 03/14/2025 reflected no tracheostomy was present for Resident #3. Review of Resident #3 hospital discharge instructions dated 03/14/2025 reflected Resident #3 required a portable trach suctioning, had a shiley (size 6) and a cuffless trach (reusable inner cannulas). Review reflected does patient have a tracheostomy?: Yes. Review of physician orders and treatments dated 03/15/2025 reflected there were no orders for tracheostomy care or suctioning. Review of the MAR/ TAR for Resident #3 dated 03/15/2025 reflected there were no treatments provided for tracheostomy care. Review of nursing progress notes dated 03/15/2025 by LVN O at 1:19 PM Resident #3's family member stated that Resident #3 complained of back pain and requested to be sent to the hospital. LVN O scheduled transportation with vital signs within normal limits. Interview was attempted with Resident #3 on 10/20/2025 at 3:14 PM , however, the number provided for Resident #3 was out of service. An email was sent at 3:17 PM on 10/20/2025 with no response. During an interview on 10/21/2025 at 10:51 AM, LVN O stated he has worked at the facility since December 2024. He stated that if residents were admitted with a tracheostomy, there was a suctioning machine set up in the residents room and the nurse had to make sure the resident had tracheostomy care per doctor's orders. LVN O stated this included PRN suctioning orders as well. LVN O stated it was hard to say often residents needed to be suctioned because secretions are different for every resident. LVN O stated that usually tracheostomy care was done in the morning between 4:00 am and 6:00 am. LVN O stated he worked overnight and he usually provided tracheostomy care in the morning which included to change the dressing of the tracheostomy. LVN O stated that if a resident was a new admission then orders were received from the hospital and then verified by the on-call doctor. LVN O stated that after admission the on-call provider would be notified that a resident admitted with a tracheostomy and the provider would give orders for care to be put into the system. LVN O stated he did not recall Resident #3 and whether or not the resident had a tracheostomy. During an interview on 10/22/2025 at 12:42 PM, MD G stated if a resident admitted to the facility with a tracheostomy then there is an order set for tracheostomy care that staff can put into the system and it was expected that they do so and verify orders with the provider. During an interview on 10/22/2022 at 3:24 PM, RN ZZ stated she did not recall Resident #3 or if he had a tracheostomy. RN ZZ stated that sometimes nurses will take report for other nurses and taking report did not always mean they completed the admission for the resident. RN ZZ stated there was a respiratory therapist that provide care a few times a week and that charge nurses also provided tracheostomy care. RN ZZ stated that usually tracheostomy care was done every shift and at least assessed. RN ZZ stated that if dressing was soiled it will get changed and it was also changed when tracheostomy care is provided. RN ZZ stated that there are also orders put into place as to when to provide tracheostomy care. RN ZZ stated for new admissions, the doctor usually put the orders for tracheostomy care. RN ZZ stated that there were also standing orders for tracheostomy care that the DON will put in. RN ZZ stated that usually suctioning was completed every four

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews, the facility failed to ensure that nurse aides were able to demonstrate competency in skills and techniques and ensure that all licensed nurses had the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for one of eight (Resident #4) residents. The facility failed to ensure Resident #4 was not laid in a flat position while her feeding tube was actively flowing by CNA E on [DATE].The facility failed to ensure LVN D provided timely nursing care/interventions in response to Resident #4's possible aspiration on [DATE].An Immediate Jeopardy (IJ) situation was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 08:04 PM. While the IJ was removed on [DATE] at 2:20 PM, the facility remained out of compliance at a scope of isolate and severity level of actual harm because all staff had not been trained on safe positioning for residents receiving enteral feeding, aspiration precautions and timely interventions.These failures could place residents at risk for being provided care by staff who do not have the skills and competencies necessary for providing care and services. Findings included:Review of Resident #4's face sheet, dated [DATE], reflected an [AGE] year-old female admitted to the facility on [DATE] and discharged [DATE]. Her diagnoses included gastroesophageal reflux disease (a chronic condition where stomach acid flows back into the throat), gastrostomy status (an surgical external opening into the stomach for nutritional support), hemiplegia affecting right dominant side (paralysis to the right dominant side of the body), chronic obstructive pulmonary disease (chronic lung disease that limits airflow and causes ongoing respiratory symptoms), cerebral infarction (a blood clot that impairs blood flow through the artery in the brain), and dysphagia (difficulty swallowing). Review of Resident #4's significant change of status MDS, dated [DATE], reflected a BIMS score of 00 which indicated severe cognitive impairment. Review of Resident #4 care plan report, effective date [DATE], reflected Problems: [Resident #4] is at risk for impaired nutritional status and complications due to enteral [the delivery of nutrients directly into the stomach] feeding. with Interventions: Elevate HOB at least 30 degrees during and 1 hour after feeing. Monitor for s/s of Aspiration.Review of Resident #4's medication administration record, dated 02/2025, reflected Fibersource HN 0.05 gram-1.2 kcal/mL liquid for tube feed (65 cc/hr x 22) liquid enteral tube by shift starting [DATE] and signed off on [DATE] days by LVN A with 520.00 indicating the total milliliters Resident #4 was administered that shift. Review of Resident #4's treatment administration record, dated 02/2025, reflected G-tube - check for residual three times daily starting [DATE] with notes Check GT for residual. If more than 60 cc's hold feedings for 2 hours and recheck. Notify MD if residual remains above 60 cc's after holding for 2 hours. Also reflected was, G-tube - Elevate HOB () by shift starting [DATE]. Neither order reflected a signature on [DATE]. Review of Resident #4's nurses note, dated [DATE] at 11:23 PM, and written by LVN D reflected During routine rounds, the patient was observed with decreased respirations and a weak pulse. A reassessment was conducted, and vital signs were unobtainable. The patient was unresponsive with no signs of respiration or circulation. The attending hospice provider, Director of Nursing (DON), and family were notified of the patient's passing. The family was provided with emotional support and education on next steps per hospice protocol. The physician was notified, and the time of death was confirmed. Post-mortem care was provided according to hospice guidelines. The funeral home was contacted per the family's request. No signs of distress noted. Funeral home arrived around 2:30 pm and provided with required documentation.Observation of video footage without audio provided by Resident #4's FM D, dated [DATE], revealed the following with timestamps in military time as provided:12:20:40-12:20:49 - CNA E lowered the HOB to lay Resident #4 flat. The video stopped as CNA E was removing the top sheet from Resident #4. The feeding pump on the left side of the screen appeared to have the screen lit up, indicating it was on. 12:21:23 - Video resumed and Resident #4 was sitting with the head of her bed elevated approximately 45 degrees. CNA E then left the room. Resident #4 did not appear in any distress at that time. 12:22:52-12:23:04 - CNA E returned to room, followed by LVN D. Resident #4 started at that time with a moderate amount of white fluid coming from her mouth and down the right side of her chin. LVN D was looking at Resident #4 then walked into the bathroom.12:23:18 - CNA was observed using a cloth to clean the white liquid off Resident #4's chin. LVN D was observed returning to the room as she was putting on gloves and the video stopped briefly.12:23:46-12:26:10 - The video resumed and LVN D was looking behind the nightstand next to the bed with an oral suction device in her hand. She appeared to locate the power

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs for one (Resident #3) of six residents review for pharmacy services. The facility failed to administer the following medication to Resident #1: Nicotine Patch 05/01/25, 05/02/15, 05/05/25, 05/09/25, 05/15/25, 05/16/25, and 05/27/25 Folic Acid Tablet 05/01/25, 05/02/15, 05/05/25, 05/09/25, 05/15/25, 05/16/25, and 05/27/25 and 06/27/25 and 06/28/25 multiple vitamin tablet 5/01/25, 05/09/25, and 05/15/25 vitamin B1 05/01/25, 05/09/25, and 05/15/25 Docusate Sodium 05/01/25, 05/09/25, and 05/15/25 levetiracetam Solution 05/01/25, 05/09/25, and 05/15/25 Tylenol 05/01/25, 05/09/25, 05/13/25, and 05/15/25 Enteral Feed 05/01/25, 05/02/25, 05/14/25, 05/30/25, 06/06/25 and 06/12/25 This failure could place residents at risk of experiencing worsening of their condition, increased risk of falls, pain, and injury. Findings included:Review of Resident #1's face sheet dated 10/320/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including traumatic subdural hemorrhage with loss of consciousness status unknown, sequela (bleeding on the brain's surface) where the patient lost consciousness, but the duration is unknown, and it's a sequela, meaning a condition resulting from a previous illness or injury), generalized idiopathic epilepsy and epileptic syndromes (a group of epilepsy syndromes characterized by seizures that originate in both hemispheres of the brain and affect the entire body), and other seizures (a type of seizure that is not a tonic-clonic (a type of generalized seizure that affects the entire brain) seizures).Review of Resident #1's quarterly MDS assessment, dated 07/31/25, reflected a BIMS score of 3, indicating severe cognitive impairment.Record review of Resident #1's care plan reflected focus dated 08/01/25 potential for complications related to seizure disorder and anticonvulsant therapy (the use of medications to prevent or control seizures, also known as convulsions) with intervention dated 08/01/25 give medications per order and monitor labs-report focus dated 08/01/25 Resident #1 had a seizure disorder with intervention dated 08/01/25 give seizure medication as ordered by doctor. Record review of Resident #1's order dated 02/11/25 reflected may give medication by mouth or via G-Tube (a feeding tube inserted through a surgical opening in the abdomen directly into the stomach to deliver nutrition, fluids, and medication). Record review of Resident #1's orders reflected Nicotine Patch 24-hour 7 MG/24 (concentration is equivalent to concentration is equivalent to 2.4% nicotine by volume) apply 1 patch transdermally (the administration through the skin) one time a day at 7:00 am for smoking sensation and remove per schedule start date 04/26/25 discharge date [DATE]. Record review of Resident #1's eMAR for May 2025 for administration of Nicotine Patch 24-hour 7 MG/24 (concentration is equivalent to concentration is equivalent to 2.4% nicotine by volume) apply 1 patch transdermally (the administration through the skin) one time a day at 7:00 am for smoking sensation reflected blank spaces for the following dates: 05/01/25, 05/02/15, 05/05/25, 05/09/25, 05/15/25, 05/16/25, and 05/27/25. Review of Resident #1's orders reflected give Folic Acid Tablet (prevents and treats low levels of folate (vitamin B9) in your body) 1 MG via G-Tube one time a day for vitamin deficiency start date 06/27/25 discharge date [DATE]. Review of Resident #1's eMAR for May of 2025 for Folic Acid Tablet (prevents and treats low levels of folate (vitamin B9) in your body) 1 MG tablet one time a day at 7:00 am via G-Tube for vitamin deficiency start date 06/27/25 discharge date [DATE] blank spaces for the following dates: 05/01/25, 05/09/25, 05/15/25. Review of Resident #1's eMAR for June of 2025 for Folic Acid Tablet (prevents and treats low levels of folate (vitamin B9) in your body) 1 MG tablet one time a day at 7:00 am via G-Tube for vitamin deficiency start date 06/27/25 discharge date [DATE] blank spaces for 06/27/25 and 06/28/25. Review of Resident #1's orders reflected multiple vitamin tablet give 1 tablet by mouth one time a day at 7:00 am for supplement start date 05/01/25 and discharge date [DATE]. Review of Resident #1's eMAR for May reflected multiple vitamin tablet give 1 tablet by mouth one time a day at 7:00 am for supplement start date 05/01/25 and discharge date [DATE] blank spaces for 05/01/25, 05/09/25, and 05/15/25.Review of Resident #1's orders reflected vitamin B1 (Essential for the proper functioning of the nervous, cardiovascular, and digestive systems) give 1 tablet by mouth one time a day at 7:00 am for supplement start date 05/01/25 and discharge date [DATE].Review of Resident #1's eMAR for May 2025 reflected vitamin B1 (Essential for the proper functioning of the nervous, cardiovascular, and digestive systems) give 1 tablet by mouth one time a day at 7:00 am for supplement start date 05/01/25 and discharge date [DATE] blank spaces for the following dates: 05/01/25, 05/09/25, and

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records review, the facility failed to ensure that medical records were accurately documented for one (Resident #1) of five residents reviewed for accurate clinical records, in that:The facility failed to document in Resident #1's EMR progress notes from 05/13/25 through 06/16/25 that the NP or MD and RP were notified of Resident #1's medication refusals.This failure put residents at risk for inaccurate medical records, decreased quality of care and decline in quality of life.Findings included:Review of Resident #1's orders reflected administration of Nicotine Patch 24-hour 7 MG/24 (concentration is equivalent to concentration is equivalent to 2.4% nicotine by volume) apply 1 patch transdermally (the administration through the skin) one time a day 7:00 am for smoking sensation and remove per schedule start date 04/26/25 discharge date [DATE] Record review of Resident #1's eMAR for June 2025 reflected administration of Nicotine Patch 24-hour 7 MG/24 (concentration is equivalent to concentration is equivalent to 2.4% nicotine by volume) apply 1 patch transdermally (the administration through the skin) one time a day 7:00 am for smoking sensation and remove per schedule start date 04/26/25 discharge date [DATE] reflected eMAR Code #2 (resident refused) entered by LVN C for 06/03/25, 06/06/25, 06/09/25, 06/11/25, 06/12/25, 06/13/25, and 06/13/25.Review of Resident #1's orders reflected give 1 tablet MG Folic Acid (a vitamin of the B complex, found especially in leafy green vegetables, liver, and kidney) by month one time a day at 7:00 am for vitamin deficiency start date 05/01/25 and discharge date [DATE].Review of Resident #1's eMAR for May 2025 reflected administration of 1 tablet MG Folic Acid (a vitamin of the B complex, found especially in leafy green vegetables, liver, and kidney) by month one time a day at 7:00 am for vitamin deficiency start date 05/01/25 and discharge date [DATE] reflected eMAR Code #2 (resident refused) entered by MT B for 05/13/25, 05/20/25, 05/21/25, 05/23/25, 05/26/25 through 05/30/25.Record review of Resident #1's progress notes for May 2025 reflected no notification to the MD, NP, or RP indicating that Resident #1 refused administration of 1 tablet MG Folic Acid (a vitamin of the B complex, found especially in leafy green vegetables, liver, and kidney) by month one time a day at 7:00 am for vitamin deficiency start date 05/01/25 and discharge date [DATE] for dates 05/13/25, 05/20/25, 05/21/25, 05/23/25, 05/26/25 through 05/30/25. Review of Resident #1's progress notes for June 2025 reflected no notification to the MD, NP, or RP indicating that Resident #1 refused administration of administration of 1 tablet MG Folic Acid (a vitamin of the B complex, found especially in leafy green vegetables, liver, and kidney) by month one time a day at 7:00 am for vitamin deficiency start date 05/01/25 and discharge date [DATE] for 06/01/25, 06/02/25 through 06/06/25, 06/09/25 through 06/13/25, and 06/16/25Review of Resident #1's orders reflected multiple vitamin tablet give 1 tablet by mouth one time a day at 7:00 am for supplement start date 05/01/25 and discharge date [DATE]. Review of Resident #1's eMAR for May 2025 reflected multiple vitamin tablet give 1 tablet by mouth one time a day at 7:00 am for supplement start date 05/01/25 and discharge date [DATE] reflected eMAR Code #2 (resident refused) entered by MT B for 5/13/25, 05/19/25 through 05/21/25, 05/23/25, 05/26/25 through 05/30/25. Record review of Resident #1's progress notes for May 2025 reflected no notification to the MD, NP, or RP indicating that Resident #1 refused administration of multiple vitamin tablet give 1 tablet by mouth one time a day at 7:00 am for supplement start date 05/01/25 and discharge date [DATE] for 5/13/25, 05/19/25 through 05/21/25, 05/23/25, 05/26/25 through 05/30/25.Review of Resident #1's orders reflected vitamin B1 (Essential for the proper functioning of the nervous, cardiovascular, and digestive systems) give 1 tablet by mouth one time a day at 7:00 am for supplement start date 05/01/25 and discharge date [DATE]. Review of Resident #1's eMAR for May 2025 reflected vitamin B1 (Essential for the proper functioning of the nervous, cardiovascular, and digestive systems) give 1 tablet by mouth one time a day at 7:00 am for supplement start date 05/01/25 and discharge date [DATE] reflected eMAR Code #2 (resident refused) entered by MT B for 05/13/25, 05/20/25, 05/21/25, 05/23/25, and 05/26/25 through 05/30/25.Record review of Resident #1's progress notes for May 2025 reflected no notification to the MD, NP, or RP indicating that Resident #1 refused administration of vitamin B1 (Essential for the proper functioning of the nervous, cardiovascular, and digestive systems) give 1 tablet by mouth one time a day at 7:00 am for supplement start date 05/01/25 and discharge date [DATE] for 5/13/25, 05/19/25 through 05/21/25, 05/23/25, 05/26/25 through 05/30/25.Review of Resident #1's orders reflected Docusate Sodium (a type of laxative known as a stool softener) oral tablet 100 MG give one tablet by mouth every 12 hours at 8:00 am and 7:00 pm for constipation start date 05/01/25 and discharge date [DATE]. Review of Resident