

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/20/2025
NAME OF PROVIDER OR SUPPLIER  The Colonnades at Reflection Bay		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on interviews and observations the facility failed to ensure the residents environment remained as free of accident hazards as possible for 2 (Rm#1 and Rm#2) of 6 bathrooms reviewed. The facility failed to ensure that sharps containers were not past the full line in 2 resident bathrooms. This failure could place residents at risk of being stuck by needles and cause infection. Finding included: During an observation on 11/20/25 at 9:30 am revealed RM#1 and RM#2 bathrooms sharps containers were observed above the full line. During an observation and interview on 11/20/25 at 10:05 am, the ADON and surveyor did a walk-through of RM#1 and RM#2. The ADON stated housekeeping and nursing staff were responsible for emptying out the sharp containers. During an interview on 11/20/25 at 11:10 am, LVN G stated the sharps container should be emptied once it got to the full line. LVN G stated the charge nurses had the key for the containers and sharps were disposed of in the red hazard bags. During an interview on 11/20/25 at 11:30 am, RN F stated when sharps containers were at full line then it was time to replace the container. RN F stated residents were endangered with getting their fingers stuck. During an interview on 11/20/25 at 11:10 am, LVN E stated the sharps containers should be eye balled daily and changed when the sharps were at the full line. LVN E stated the sharps container needed to be changed to prevent exposure to body fluids. During an interview on 11/20/25 at 1:15 pm, the Housekeeping Supervisor stated they did not have the key to the sharps containers and were not responsible for changing them. During an interview on 11/20/25 at 1:30pm, the Executive Director stated that she did not have a policy for emptying out the sharps containers. The Executive Director stated the sharps container should be emptied before it was full to help prevent staff and residents from hurting themselves and possibly caused infection. The Executive Director stated that infection control policy did not address sharps containers specifically, but nursing staff had been educated about the sharps container. The Executive Director stated very few residents had sharps containers in their bathrooms. The Administrator stated the LVNs were responsible for checking and changing those out.</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/20/2025
NAME OF PROVIDER OR SUPPLIER  The Colonnades at Reflection Bay		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interviews and record reviews, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for 1 (MC#2) out of 14 medication carts. The facility failed to ensure the medication cart was free of expired insulin vial dated 09/07 on [DATE]. The failures could place residents at risk of poor insulin blood sugar control from expired insulin. Finding included: During an observation on [DATE] at 5:34 am on MC#2, the surveyor observed 1-Insulin LSP Inje 100/ml was dated 09/07. During an interview and observation on [DATE] at 5:35 am LVN C stated the insulins were supposed to be dated when opened. LVN C stated that he did not administer insulin during his shift and did not touch the insulin. During an interview on [DATE] at 6:25 am, LVN E stated depending on the type of insulin it could stay on the cart for 28 days after being opened. LVN E stated expired medication should be properly exposed of by giving it to the ADON. During an interview on [DATE] at 2:18 pm, the ADON stated expired medication should not be left on the medication cart. During an interview on [DATE] at 6:40 am, LVN D stated insulin should be dated when opened. LVN D stated the insulin was good for 30 days depending on the type of insulin. During an interview on [DATE] at 1:45 pm, the Executive Director stated she started in-servicing staff and completed the POC on [DATE] for locking the medication cart and dating the opened insulin vials and insulin injectable pens. The Executive Director stated she had 14 medication carts and the carts were audited. Record review of facility policy titled Medication Labeling and Storage, revised 02/2023 reflected, medication storage.3. If the facility has discounted, outdated. medications and biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying medications.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/20/2025
NAME OF PROVIDER OR SUPPLIER  The Colonnades at Reflection Bay		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interviews and record reviews, the facility failed to ensure drugs and biologicals were secure and labeled for 7 (MC#1, MC#2, MC#3, MC#4, MC#5, MC#6, and MC#7) out of 14 medication carts. The facility failed to ensure medication carts were: 1. Locked and secured when not in use. 2. Drugs and biologicals were labeled. The failures could place residents at risk of drug diversion, use of expired medication and harm. Finding included: During an observation on [DATE] at 1:50 pm MC#1 was left unlocked, unsecure with drawers faced outward. The surveyor observed the key lock protruding outward with a red visible dot. During an interview on [DATE] at 2:10 pm, CMA A stated she was near the cart. CMA A stated the cart should have been locked when she stepped away. CMA A stated residents could get into the cart and take medications. During an observation on [DATE] between 5:30am to 6:10 am revealed: MC#1 and MC#2 on the 1st floor were unlocked, and unsecure with drawers faced outward. Observed the key lock protruding outward with a red visible dot. The surveyor observed MA A not in view of the medication carts. MC#3, MC#4, MC#5, MC#6, MC#7 on the 2nd floor were unlocked, and unsecured with drawers faced outward. Observed the key lock protruding outward with a red visible dot. Observed LVN C on the opposite side of the nursing station and not in view of the medication carts. Observed MC#6 had the cart keys inside of a binder on top of the cart. Observed the following biologicals on MC#2, MC#3, MC#4 and MC#5: 1-Insulin LSP Inje 100/ml was undated and not labeled with resident information* 9 - Insulin LSP Inje 100/ml was undated* 1-Humlin inj 100/ml was undated* 4-Lantus solo inject 100 unit/ML was undated* 2-Heparin Sod inject 5000/ml was undated. During an interview and observation on [DATE] at 5:35 am LVN C stated the medication cart should be locked when not in use to protect residents from taking medication from the cart. LVN C stated the insulins were supposed to be dated when opened. LVN C stated that he did not administer insulin during his shift and did not touch the insulin. Observed LVN D checking insulins on the other medication carts on the 1st floor that were not left unlocked. During an interview on [DATE] at 6:04 am, LVN B stated the medication carts should not be left open. Observed the Executive Director on [DATE] at 6:10 am, locking the medication carts on the 2nd floor. During an interview on [DATE] at 6:25 am, LVN E stated insulin should be dated when opened. LVN E stated medication carts should be locked to prevent residents, staff, or visitors from taking medications. LVN E stated there were biological and routine medications on the cart that could harm the residents if they took the wrong medication. LVN E stated depending on the type of insulin it could stay on the cart for 28 days after being opened. During an interview on [DATE] at 6:40 am LVN D stated the medication carts should stay locked when not in use. LVN D stated insulin should be dated when opened. LVN D stated the insulin was good for 30 days depending on the type of insulin. During an interview on [DATE] at 2:18 pm, the ADON stated medication carts should be locked if nursing staff were not standing in front of the cart. The ADON stated locking the cart prevented residents from getting into the cart. During an interview on [DATE] at 1:45 pm, the Executive Director stated she started in-servicing staff and completed the POC on [DATE] for locking the medication cart and dating the opened insulin vials and insulin injectable pens. The Executive Director stated she had 14 medication carts and the carts were audited. The Executive Director stated the medication carts should be locked when nursing staff are not using them, and insulin should be labeled when opened. Record review of facility policy titled Medication Labeling and Storage, revised 02/2023 reflected, Medication Labeling . 1. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. 5. Multi-dose vials that have been opened or accessed (e.g . needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vials .</p>		