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	02/18/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16989 Based on observation, interview, and record review, the facility failed to ensure 2 residents (CR #2 and Resident #10) were provided with respiratory care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences, in that: -CR #2 had an order for continuous oxygen but was documented several times as being on room air. -CR #2 had changes of condition regarding his breath sounds that were not reported to the physician. -CR #2 had a documented O2 saturation of 84%, and the physician was not notified. -Staff did not provide continuous supervision with CR #2's nebulizer treatment as was policy. -Staff did not properly assess Resident #10's O2 saturations following a nebulizer treatment, then documented a 98% O2 saturation. These failures could place both residents at risk for respiratory complications. Findings include: CR #2 CR #2 was a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease, malignant neoplasm of unspecified broncus or lung (lung cancer), pulmonary embolism without acute cor pulminal (a condition where a blood clot travels to the lungs and blocks one or more of the pulmonary arteries, but does not cause an immediate and significant impairment of the right ventricle's [heart muscle on the right side of the heart] function). CR #2's Care Plan dated [DATE] read, in part, .[CR #2] unable to maintain 02 saturation. Receives Oxygen at 3L/min. Record review of the Physician's Order dated [DATE] revealed Oxygen (O2) at 3L/min per nasal cannula per shift. (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

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	02/18/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of History and Physical dated [DATE] noted Review of systems: Respiratory: Mild shortness of breath on oxygen. Physical exam: Respiratory: mild SOB on oxygen.- NP Record review of CR #2's [DATE] TAR (Treatment Administration Record) revealed pre nebulizer treatment breath sounds on [DATE] at 9:00 a.m. were Diminished. Breath sounds following treatment was documented as Clear. RN E initialed the TAR for those entries Record review of CR #2's [DATE] TAR revealed the breath sounds on [DATE] at 5:00 p.m. for both pre- and post- Nebulizer treatment indicated Wheezing. The pre-and post-treatment breath sounds reflected on [DATE] at 11:00 p.m. were Clear. RN K initialed the TAR for those entries. Record review of CR #2's Vitals Check revealed her Oxygen Saturation (O2 sat) on [DATE] at 8:51 a.m. was 94% on ,d+[DATE] liters per minute (lpm) of oxygen (RN E). The O2 sat at 4:43 p.m. was 96% on room air (RN K). The O2 sat at 8:30 p.m. was 91% on ,d+[DATE] lpm of O2 (RN K). Record review of CR #2's Vitals Check revealed on [DATE] at 5:27 a.m. the resident exhibited an O2 sat of 84% post-nebulizer. The documentation reflected the resident was on room air. The documenting nurse was LVN T. Review of the Nurse's Notes (NN) for [DATE] did not reveal the physician was notified. The NN did not reflect any interventions were implemented. In an interview with the physician on [DATE] at 4:45 p.m., she said CR #2 was on continuous oxygen. The physician said 88% was the target saturation level for residents with COPD. She said the nurse should have rechecked the resident's O2 saturation level and the oxygen should have been reapplied. She said O2 saturations in the low 80s would be a reason to notify the physician. In an interview with ADON on [DATE] at 4:05 p.m., she said the resident was not always breathing appropriately, she had diminished breath sound and/or wheezing, and those were not considered normal breath sounds . She said when a resident had wheezing or diminished breath sounds it could be atelectasis (collapsed lung), or fluid in the lungs. She said staff should have contacted the MD if there were diminished breath sounds. She said the resident came in with diminished breath sounds and was on 02 at 3 liters of oxygen. She said it was important for the nurse to monitor for change of condition and to get a baseline. She said the resident was continuously on O2. She said there would be no reason the resident would be off O2. She said signs of respiratory distress are labored breathing, shortness of breath SOB, and change in color. She said if a resident was showing signs of deviation from the norm, then staff would check on the resident more often than q 2hs to ensure they were not in respiratory distress. She said the risk of being in respiratory distress for an extended time was your CO2 levels can increase along with decreased O2 to the brain and death was the worst that could happen. In an interview on [DATE] at 8:10 a.m. with the DON, she said vitals were to be checked every shift and as needed. She said vitals would be checked if resident was not in the baseline. She said based on nursing school teachings if resident was less responsive, or not at baseline then vitals were checked. She said there was no difference for someone with COPD vs another resident without COPD when checking vitals. She said the vitals minus blood pressure would be checked before and after a nebulizer treatment. (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	02/18/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview via telephone on [DATE] at 8:37 a.m., LVN T said she checked on CR #2 at 10:00 p.m. on [DATE]. She said the resident had her nasal cannula on at that time but did not provide an explanation why she documented 'room air.' She said the resident had an order for continuous O2. She said the resident was never on room air. That was her mistake. She said signs of respiratory distress are labored breathing, wheezing, nail beds and lips blue, or if the resident verbalized they could not breathe, or O2 below 92%. She said the risk of not having O2 as ordered was the risk of respiratory distress or COPD exacerbation. If a resident had respiratory issues, she would do full assessment and vitals, notify doctor and notify 911 and the DON. She said when monitoring a resident documentation was only made by exception and if nothing was going on then, nothing would be charted. In an interview on [DATE] at 11:25 a.m., the Administrator said the risk of not having O2 as ordered was the resident might not get enough O2 to brain and then begin system failures. The risk of a resident that appeared to have respiratory issues and not checking on them was they could go into failure and potentially die. She was not aware any change in condition. She said NP rounded the previous night in the evening and did not see a change of condition of the resident. She said if it was a true change of condition then staff would notify the doctor or the NP. If a resident that did not have COPD had wheezing or diminished breathing then would that would be considered a change of condition and she would notify the doctor. In an interview via telephone on [DATE] at 5:18 p.m., LVN T denied providing the nebulizer treatment for CR #2 on [DATE] at 5:,d+[DATE]:28 a.m. She said she documented it in error. She said the vital signs she documented were taken at 11:00 p.m. on [DATE]. She said the resident refused the morning nebulizer treatment when she checked on her at 11:00 p.m. on [DATE] . She said she documented the pre-nebulizer O2 sats in error, just as she had documented the post-nebulizer O2 sats in error, as well as documenting 'room air' in error . When asked if the physician should be notified if CR #2's O2 sat was 84%, she said yes, but denied the resident had that reading. She said that was probably the resident's pulse, not O2 sat. Record review of the Vital Signs revealed LVN T documented CR #2's pulse was 87 bpm at that time . In an interview on [DATE] at 5:40 p.m., the DON said when a resident exhibited an O2 sat less than 90% the physician should be notified. If the resident refused a nebulizer treatment, the computer would prompt that a note should be entered. She said 'per shift' vital signs could be taken at any time during the shift, but should either be documented at the time obtained, or if documented later, the time obtained should be noted. She said the pre-nebulizer and post-nebulizer O2 sat values required individual manual entry. When presented with the 84% O2 reading reflected on [DATE] at 5:27 a.m., the DON said the nurse should have notified the physician at the time it was obtained, regardless if it was obtained at 11:00 p.m. on [DATE] or at 5:28 a.m. on [DATE]. She said LVN T did not address the Resident's needs. She said the risk to the resident when not reporting a change of condition to the physician was the patient would deteriorate. Review of the NN dated [DATE] - [DATE] revealed no entries by LVN T. In an interview on [DATE] at 11:30 a.m. the Administrator said the nurse is supposed to observe a resident during a nebulizer treatment. The reason a nurse is supposed to observe a resident during a breathing treatment is to observe for any side effects of the medication. The administrator said the risk of a resident being left alone during a nebulizer treatment is the resident having an adverse reaction to the medication, more respiratory failure up and to including death. (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	02/18/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nurse's Note (NN) dated [DATE] at 9:30 a.m. revealed CR #2 was discovered at 6:45 a.m. by a Medication Aide to be unresponsive. CPR was initiated and 911 was called. Upon arrival, an EMT assessed CR #2 and advised discontinuation of CPR. The resident was pronounced deceased . Resident #10 Record review of the Face Sheet for Resident #10 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), pulmonary embolism without acute cor pulminale (a condition where a blood clot travels to the lungs and blocks one or more of the pulmonary arteries, but does not cause an immediate and significant impairment of the right ventricle's [heart muscle on the right side of the heart] function), and heart failure. Resident #10's Physician's Order for nebulizer treatment dated [DATE] read, in part, albuterol sulfate concentrate 2.5 mg/0.5 mL solution for nebulization 6 Times Daily. Route: inhalation. Physical monitors: Post Neb Tx Breath Sounds, Post Neb Tx Pulse ox . Observation on [DATE] at 6:40 p.m. revealed LVN Z providing a nebulizer treatment for Resident #10. Prior to administering the treatment, LVN Z obtained the resident's blood pressure with an electronic monitor. She placed a pulse oximeter (pulse ox) on the resident's right index finger. The Resident exhibited an O2 saturation of 98%. His pulse was 81 bpm. LVN Z auscultated Resident #10's breath sounds, then administered the resident's nebulizer treatment. At 6:49 p.m. LVN Z said she did not see any more medication in the nebulizer mask reservoir, and she removed the mask and turned off the nebulizer pump. She checked the resident's blood pressure with the electronic monitor. She did not apply the pulse ox onto the resident. LVN Z rinsed the nebulizer mask and washed her hands. LVN Z gathered the monitor and pulse ox, then exited the room. Continued observation revealed LVN Z said I'm going to document now. LVN Z accessed Resident #10's TAR. She entered the resident's pre-neb pulse, respirations, and O2 sat (98%). She then entered Resident #10 had a 98% O2 sat post-nebulizer treatment. At that time the Surveyor informed LVN Z she did not use the pulse ox on the resident after the nebulizer treatment. LVN Z responded, I don't remember. The Surveyor asked LVN Z how she obtained the 98% O2 percent for the post-nebulizer reading. LVN Z answered, From watching him breathe. The Surveyor asked LVN Z if she was supposed to use the pulse ox after the treatment. She said she should have used it. Observation revealed the pulse ox had no memory function. In an interview on [DATE] at 7:25 p.m., the DON said the nurse was supposed to check breathing sounds, and use the pulse ox to monitor pre- and post-nebulizer treatment O2 sats. She said if they were not checked, the nurse would not know if the treatment was effective. The Surveyor asked the DON to check Resident #10's O2 sats. Observation on [DATE] at 7:30 p.m. revealed the DON check Resident #10's O2 sats. Her pulse ox reflected 91%. She said she would recheck it with the nurse's pulse ox. She and LVN Z rechecked the residents O2 sats with LVN Z's pulse ox. The reading was 98%. (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	02/18/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Charting and Documentation (revised [DATE]) read, in part, .The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The policy also read, in part, .Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. The facility policy Nebulizer read, in part, .Nebulizer Treatment .It is the policy of the facility that patients receive a nebulizer treatment .to relieve bronchospasm, deliver medications, improve effectiveness of the cough and to relieve mucosal edema .Responsibility: Licensed Nurse .Administer therapy until medication is depleted, treatments require a minimum of 15 minutes. Monitor patient for side effects of treatment: a. Nervousness b. Bronchospasm c. Hypoventilation/hyperventilation d. Infection e. Tachycardia. Monitor heart rate, respiratory rate, and breath sounds before, during and after treatment .

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	02/18/2025

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47479 Based on observation, interview, and record review 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 of 2 of 10 residents (CR #1 and Resident #440) reviewed for pharmaceutical services 1. The facility failed to ensure accurate administering of all drugs and biological to meet the needs of Resident #440, who was administered morphine more frequently than prescribed by the physician on [DATE] and who was administered with the incorrect dosage on [DATE]. 2. The facility failed to acquire, dispense, and timely administer all medications to meet the needs of CR#1, who missed 4 doses of Posaconazole (antifungal) 100mg delayed release tablet between [DATE] and [DATE]. An Immediate Jeopardy was identified on [DATE] at 1:28 PM, and on [DATE] at 9:27 AM. While the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on [DATE]. due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place the resident at risk for not receiving medications as ordered resulting in serious injury, decline in health, and death. Findings included: 1. Record review of Resident #440, who was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of the prostate (growth in the prostate gland), urethral stricture (narrowing of the urethra), and stage 4 pressure ulcer to the sacral region (full thickness tissue loss that extended to the underlying muscle, tendon, or bone). Record review of Resident #440's Baseline Care Plan dated [DATE] revealed, the resident was alert & cognitively intact and on high-risk pain medications (narcotics). Record review of Resident #440's physician orders dated [DATE] revealed the resident was on morphine ER (extended release) 30 mg tablet, extended release every 12 hours. Record review of Resident #440's physician orders dated [DATE] revealed the resident was on morphine IR (immediate release) 15 mg tablet, every 6 hours as needed. . Record review of Resident #440's February 2025 medication administration record revealed morphine 30 mg tab ER, every 12 hours was administered as a scheduled order on [DATE] at 7: 00 AM and 7:00 PM. (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	02/18/2025

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #440's Controlled Drug Record revealed morphine 15 mg tab IR, every 6 hours as needed, was administered on [DATE] by the Med-Aides at 5:00 AM (1 tab), 8:00 AM (2 tabs), 11:30 AM (1 tab), 3:00 PM (1 tab), 11:00 PM (1 tab). [DATE] at 4:00 AM (2 tabs), and 8:00 PM (2 tabs) were administered. Review of Resident #440's progress note dated [DATE] revealed that while the NP was rounding, the residnet was alert x's 1 (person) and lethargic. She gave order to administer Narcan due to excessive sedation. Resident #440 was on continued monitoring by LVN K after Narcan administration. Record review of Resident #440's February 2025 indicated that the residnet was administered Narcan by LVN K on [DATE] at 4:00 PM. Record review of Resident #440's vital signs on [DATE] at 11:00AM indicated a Blood Pressure of , d+[DATE]; Resipration-18; and oxygen saturation of 96% on room air, however, his pulse was not recorded. His oxygen saturations were record on [DATE] at 4:04 PM with an oxygen saturation of 97% on room air. Vital sign reading post narcan administration on [DATE] at 5:00 PM indicated a blood pressure of ,d+[DATE]; Respiration-18; oxygen saturation and pulse was not recorded. Observation and interview on [DATE] at 12: 58 PM with Resident #440 lying in bed. He was alert to person. He said he did get his pain meds earlier today and was without c/o pain. Resident #440 was less verbal than on [DATE] and [DATE]. He said he did not have an appetite but was very thirsty. The CNA was at bedside assisting the resident with his water intake. Telephone interview [DATE] at 3:57 PM with Med-Aide C, who said she administered Resident #440 Morphine IR 15 mg (2 tabs) instead of Morphine ER 30 mg 1tab after clarification with RN E on [DATE] at 8:00 AM and 11:30 AM. She said she was aware of the discrepancy between the medication administration record and the blister pack. However, she was given the ok to administer the Morphine IR 15 mg (2 tabs) instead of the scheduled Morphine ER 30 mg by RN E. She said the risk of administering too much morphine could cause decreased blood pressure, drowsiness, and/or death. Telephone interview on [DATE] at 7:16 PM with RN E, who said Resident #440 was administered Morphine for pain. She said the side effects of administering too much Morphine was sedation. RN E said the MD should be contacted if the resident shows signs of oversedation. She said Resident #440 was administered Narcan as ordered as an antidote for an overdose of opioids, after the NP was rounding and observed a decrease in his alertness and cognition. She said the risk of Morphine overdose was a resident could go in respiratory distress and may require rapid response/CPR. Interview on [DATE] at 7: 30 PM with the DON, who said Morphine was a pain medication. She said there was a discrepancy between the Morphine 30mg ER that was ordered and the Morphine 15mg IR that was administered. She said her expectation was that the staff would follow the MD's orders and clarify orders with the MD if they were incorrect or if the staff had questions or concerns regarding the orders. She said the risk of not following the orders and administering the correct Morphine dosage could cause the resident to go into respiratory distress. (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	02/18/2025

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview at [DATE] at 11:18 AM with Dr D., who said she ordered Morphine IR 15mg Q 6 hours prn and scheduled Morphine 30mg ER q 12 hours. She said the difference in the 2 medications ordered was the onset, peak, and duration. She said just because the order was for morphine 30mg does not mean that the staff could give Morphine 15 mg, 2 tabs to equal 30mg because the difference was the morphine 15 mg IR tabs were PRN and Immediate release, and the Morphine 30 mg ER tabs were scheduled q 12 hrs and extended release. Dr. D said when she gives an order, the staff should follow the order or call for clarification if there are any concerns or questions. She said Resident # 440 should have been administered the Morphine ER, as ordered. She said the milligrams of the Morphine administered were the same, but the long-acting and short have different onset and duration of the medication. The NP was rounding, so she gave the Narcan, which was appropriate due to his drowsiness. She said the risk of not following the orders could lead to a bad outcome. Record review of pharmacy services policy, revise date ,d+[DATE], read in part .Policy Interpretation and Implementation: 4. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. 5. Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration . Record review of the medication administration policy, undated, read in part . 2. The 6 Rights of Mediation Administration. b. Right Drug. Verify prescription label to [DATE] times in different ways: i. Drug name ii. Drug strength. c. Right Dose. Verify the label to MAR, these MUST MATCH. e. Right Time. Confirm med-pass time window (1 hr. before to 1 hr. after administration time on MAR . On [DATE] at 1:18 PM, the administrator was informed that an Immediate Jeopardy situation was identified due to the above failures and a Plan of Removal was requested. Observation on [DATE] at 9:43AM of medication administration in-service was conducted by the DON to include the weekend supervisors with the initiation of the posttest. Interview on [DATE] at 11:17 AM with MA A, who works the ,d+[DATE] halls. She said the last in-service on medication administration and pharmaceutical services was on [DATE], and she had a competency post-test after the in-service. She said she would inform the nurse of a missed or unavailable medication. She said she would follow up with the nurse but would notify the DON and the doctor if it were still missing. MA A said the nurses have access to the E-Kit and can pull medication from it. If the medications were not in the E-Kit, the nurse would send a STAT order to the pharmacy. Interview on [DATE] at 11:26 AM with RN C, who said she was last in-service on medication administration and pharmaceutical services was [DATE]. She said she would check for missing/unavailable medication in the Pyxis and/or E-Kit. If it was not available in E-Kit, she said she would contact the pharmacy and MD regarding the missing medication. RN C said that she would fax the medication order to the pharmacy for new admission. She said the fax machine gives an ok confirmation that the pharmacy received the fax. She said the pharmacy delivers between ,d+[DATE] hrs after faxing the order. She said she would contact the doctor if the medication was unavailable after the ,d+[DATE] hours to see if there was a compatible medication or contact the pharmacy to get the medication STAT. She said she would also inform the weekend supervisor and/or DON that the medication was missing or unavailable. (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	02/18/2025

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 11:38 AM with LVN B, who said her last in-service was on [DATE] with the DON on missing medication with a post-test at the end. She said the process was to 1st go to the E-Kit if the medications were missing. Contact the pharmacy for a STAT medication If the meds were not in the Pyxis or E-kit. She said she should contact the weekend supervisor and MD if not available and let them know that the medication was unavailable. Interview on [DATE] at 12:11 PM RN D, who said her last in-service was [DATE] with the DON on missing medication with post-test at the end. She said we initially would look in the pyxis for the missing medication. She said that if medications are not in Pyxis, the pharmacy delivery comes within ,d+[DATE] hours. She said for new residents, we fax the medication order to the pharmacy and receive an ok from fax machine, but we can also call to verify the orders were received. We get short slip for unavailable meds, but not for every medication. We let the DON know the medication was missing. We inform the MD to let them know that we need an order for another medication. We can also contact the pharmacy for the medication to be delivered Hot Shot (STAT). Record review on [DATE]-[DATE] of the pharmacy delivery sheets. Record review on [DATE] revealed and Immediate release and extended-release medication in-service was conducted by the regional nurse for the DON and Nurse managers. CR# 1 of undated facesheet revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including Acute Myeloblastic Leukemia and Neutropenia (a condition characterized by an abnormally low number of neutrophils in the blood). CR#1 was immunocompromised due to the low neutrophil count. Review of CR#1's MD progress notes dated [DATE] revealed the resident was on neutropenic precautions (Important preventive steps you need to take while you have neutropenia). Review of CR#1's physician's orders revealed on [DATE] the resident was prescribed Posaconazole 100mg (3 tablets) one time daily, which is an antifungal. Review of CR#1's [DATE] medication administration record revealed Posaconazole was not administered as ordered on [DATE],[DATE], [DATE], and [DATE] because they were unavailable. Interview [DATE] at 10:11 AM with the RP, who said the staff did not administer CR#1's antifungal medications during his stay at the facility. She said his antifungal and antiviral medications were his most important meds due to his completion of chemotherapy and neutropenic status. The RP said on [DATE], she informed LVN J that she had his Posaconazole medications available in the resident's room. LVN J declined the medication and said his medications had to come from the facility's pharmacy. She said CR#1 was readmitted to the hospital on [DATE] because he had a fever at his MD appointment. Interview [DATE] at 3:19 PM with RN A, who said CR#1's physician's orders included Posaconazole 100mg tablet, delayed release (3 tablets). She said the medication was reconciled and faxed to the pharmacy on [DATE]. She said she gave report to the floor nurse after completing the initial admission process. She said CR#1's medication should have been administered to the resident as ordered by the physician. She said the resident who was immunocompromised and had a fever was an indication of infection. She said not receiving his antifungal medication for 3 days can lead to a serious illness and/or death. (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	02/18/2025

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 3:51 PM with LVN C, she said most medications are usually delivered on the next pharmacy delivery if it is unavailable from the E-Kit (emergency medication kit). The next scheduled delivery was [DATE]. She said residents should have all medications administered as ordered within 24 hours. She said neutropenic residents were immunocompromised. LVN C said a fever (temperature >100.3) was an indication of infection. She said residents who were immunocompromised and had not received their antifungals for several days could cause the resident to be hospitalized and/or death. Interview [DATE] at 4:17 PM with the DON, who said the medication was not received until [DATE] at 11:00 PM. She said the staff did not administer the medication at that time because CR#1 was not in the facility until the early morning of [DATE]. The DON said the staff did not administer the medication when the resident returned to the facility, and she was uncertain why the medication administration did not occur upon arrival. She said the staff should have notified the physician that the medication had not been administered to CR#1 on [DATE], [DATE], [DATE], and [DATE]. The DON said that the nurses should have followed up with the pharmacy and/or doctor to see if the facility could have received a compatible antifungal until the medication arrived. She also said the facility could have accepted the medication offered by the RP and administered it to the resident. She said that based on his medical history and the resident being immunocompromised, fever was an indication of possible infection. She said not administering CR#1 prophylactic antifungal medication could place the resident at risk for his health being in danger. Telephone Interview on [DATE] 4:58 PM with Med-Aide A, who said she administered all medications that were available for CR#1. She said missing or non-available medications were reported to the nurse. She said she verbally reported to the nurse that CR #1 did not have his Posaconazole but does not remember the day. Interview on [DATE] at 5:23 PM with Med-Aide B, who said she informed the nurse on [DATE] that CR#1 was missing his Posaconazole. She said she does not remember the name of the nurse she reported to. Interview on [DATE] at 5:53 PM with MD, who said CR#1 was admitted to the facility with a neutropenic fever. She said the facility should have administered all medications, including Posaconazole, as ordered due to his neutropenia. She said the resident had an increased risk of infection because he did not receive his medication as ordered. Telephone Interview on [DATE] at 12:05 PM with the contracted pharmacist, Dr. X, who said he received the order for the Posaconazole on [DATE]. He said the medication was delivered on [DATE] at 11:22 PM. Telephone interview on [DATE] at 1:02 PM with LVN J, who said the admitting nurse (RN A) conducted the admit assessment and reconciled the orders. She denied getting report for CR#1 from the admitting nurse on [DATE]. She said the RP informed her on [DATE] that she had available meds for CR#1, but LVN J said the facility used their own pharmacy to administer medications. Interview [DATE] at 10:54 AM with the administrator, who said she was unaware that the Posaconazole was not administered until [DATE]. She said it was a specialty med, and the pharmacy could not get the medication sooner. The administrator said the process was for the nurse to notify the DON and the MD of the missing Posaconazole. The risk of CR #1 not having his Posaconazole could cause injury or harm if the resident required his medication because of a fungal infection. (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	02/18/2025

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The administrator was informed of an Immedicate Jeopardy situation on [DATE] at 1:28 PM, and on [DATE] at 9:27 AM. A Plan of Removal was requested. The following Plan of Removal was submitted by the facility and accepted on [DATE] at 11:16 AM. Immediate Action: An Emergency QAPI was held to review the findings of the citations and the community's present practices and processes. The DON and administrator will have a collaborative effort with respect to monitoring medications upon admission, and daily thereafter for established residents regarding missing or unavailable medications. There will be ongoing daily monitoring by DON or designee, to review medications for compliance. Upon notification of the deficient practice on [DATE], the following measures were put into place for nurses and medication aides as well as in-services to be completed by [DATE] (the DON/designee will teach the in-services) to ensure that the deficient practice will not recur: a 100% audit of all residents receiving both immediate release and extended-release medications will have MAR to Cart audits daily to ensure appropriate medications are being given. -Initiation of the Medication Availability Log, in which each Nurse/Med-Aide validates that they have all available medications for Administration each shift. This will be kept in the Narcotic Count Book and will be brought to the morning meetings for review and further evaluation by the Nurse Managers. After hours the Charge Nurses will notify the DON/Administrator of any deficits, the Weekend Supervisor will complete this on the weekends. -24- hour report will be reviewed 2x daily in clinical stand up for morning and afternoon shift to review communication with physician on medications not available, this will be done by the DON/Designee of Nurse Management. -A New order report will be printed every morning by the DON/Nurse Managers, this will be crossed referenced to validate physical availability of new medications in the community. -Pharmacy Delivery Sheets will be reviewed every morning by DON/Nurse Managers for medications that were delivered the previous evening. -The Clinical Smart Board, which is within our EMR, displays missed medications, will be reviewed twice daily, by the DON/Nurse managers, in clinical stand up for both morning and afternoon shift to review medications given, missed medications. -The DON/Nurse Management will communicate with pharmacy regarding medications not available and get estimated time of arrival or need to STAT medications. -The DON/Nurse Management will communicate with physician and/or medical director on medications missed or not available on patients that issues were identified. -The DON/Nurse Management will communicate all with physician and/or medical director on medication errors. (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	02/18/2025

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	_The DON/Nurse Management will notify the Administrator on all issues identified with pharmacy and medication delivery, availability and missed doses as well as medication errors. In addition to education on utilizing the Pyxis and Pharmacy Service in-services, a review of current policies and procedures were completed with the QAPI team determining that the current policy was sufficient and new protocols were put into place to achieve compliance. The Plan of removal was accepted on [DATE] at 11:16 AM and reflected the following: Record review of the 24-hour Report started on [DATE] and review twice daily. Record review on [DATE] of new medication order report. Record review of the clinical smart board review on [DATE] for both morning and evening shifts. Record review of missing medication log with administration signature and date noted on [DATE]. Record review on ,d+[DATE] and [DATE] of pharmacy communication log regarding medication not available and get estimated time on arrival or need for STAT. Record review on ,d+[DATE] and [DATE] of the Physician communication log regarding medication missed or medication not available. [DATE], no information noted on the pharmacy log. Record review of in-services that were conducted by the DON and administrator on [DATE] and [DATE] with topics to include: Pharmaceutical services (reviewing the 24-hour report for missing medications, how to review the smart board for missing medication and communicating with pharmacy regarding medications not available to get and estimated arrival or need to STAT medications), 6 Rights of Medication administration with competency validated by a posttest, Verifying prescription label to MAR, and Notification to physician of missing or unavailable medications. Record review revealed on [DATE], the facility completed an audit of all residents in the facility with orders for new admission medications and exiting residents' medication availability. Interview on [DATE] at 3:04 pm with LVN A. Who said she did attend the medication in-service was conducted by the DON. She said for new admits, she would verify the orders and place them in the system. She said the medication should be at the facility. She would look in the facility to ensure the medication was not in the Med room, on a med cart, or in the Pyxis. She said if she still was unable to locate the medication, she would contact the pharmacy to check if it had been ordered. If the medication was not ordered, she would fax the orders to the pharmacy and call and verify with the pharmacy that the order was received. She said staff should notify the DON, provider, and pharmacy if medications are missing. She said staff should always follow-up with DON, physician, and pharmacy if medications are missing. (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	02/18/2025

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 3:45 PM with MA B, who said she did attend the medication in-service conducted by the DON. She said she documents the missing medications on the Missing Medication Log on her cart and reports the missing medications to the nurse and the DON. She said once the resident reaches the last blue line of the blister pack, she can scan and fax the sticker to pharmacy. She said the nurse would also follow up with the pharmacy. She said the difference between extended release and immediate release mediations was the duration it takes for the medication to last. MA B was able to provide the 6 medication administration rights, which included the right resident, dose, route, time, medication, and diagnosis. She said If the blister pack label was different from the MAR, she would inform the nurse so they could clarify with the doctor. Interview on [DATE] at 3:58 PM with MA C, who said she did attend the medication in-service conducted by the DON. She said she would notify the nurse of missing medications and document the missing medication on the new non-available medication log. She said depending on the type of medication it may be found in the Pyxis/E-kit. MA C said that for new residents, the staff should notify the nurses, who would check the pyxis to see if the medication was available. She said the nurse should contact the doctor to see if the MD wanted to use a substitute for the unavailable medication. She said that if medications are not available for the resident, I would also follow up with the pharmacy for STAT delivery. MA C provided the 6 medication administration rights to include the right name, dosage, resident, reason, route, and time. She said the difference between Immediate release and extended release was immediate release works immediately, while extended release was over time. She said she could not give the medication if the MAR and blister pack were different. She said she would report it to the DON if needed for medication clarification. Interview on [DATE] at 4:13 pm with MA H, who said if there were missing medications, we would notify the nurse. She would look in the Pyxis, and they would contact the DON. She said the 6 rights of medication administration were to verify the right resident on the MAR, the label, the dosage, route, and the right time. She said IR meds last for 6 hours and ER last for 12 hours. She said she would check the MAR, inform the nurse that a medication was missing, and document in the administrative notes. Interview on [DATE] at 4:31PM with LVN O, who said if medications were unavailable, she would notify the supervisor and the physician. She said if meds were missing, she would notify the supervisor, check with the pharmacy, and document on the EMR. She said the 6 rights were the right resident, medication, dose, route, time, documentation, and indication. She said the difference between ER and IR medications, was that immediate release meds are designed to start working immediately 4 to 6 hour and extended release last for 12 hours. LVN O said that for new residents, she would verify the medications with physician, enter them into the system, and fax to pharmacy with facesheet. She said if the resident does not get their medication, she would follow up with pharmacy, document, and fill out the medication reconciliation sheets. (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	02/18/2025

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 4:38 pm with LVN Z, who said she would contact the DON, doctor or NP and document if a medication was unavailable or missing. She said with new residents, she would enter the medication into the EMR, verify the meds with doctor, and fax orders to the pharmacy and would call to confirm that the orders were received. She said to follow up on missing meds, she would call the pharmacy, call doctor and ask if there were any alternative meds. LVN Z said the 6 rights included the right resident, mediation, route, dose, time, documentation, and indication. She said Immediate release was based on the duration of the medications. Interview on [DATE] at 5:21 AM with LVN N, who said if medication was not available, he would check the Pyxis. He would notify the MD and the ADON/DON if the meds were still not there. He said that as soon as he got a new admission, he would contact the MD and verify medication orders. He would enter the orders into the system, print them, and fax the order to pharmacy. LVN N said the duration of ER medications was 12 hours, and the duration of IR was 4 to 6 hours. Interview on [DATE] at 5:27 AM with LVN T who said we check the med carts and pyxis for missing/unavailable medications. If we cannot get it STAT, we notify the doctor, pharmacy, and DON. LVN T said for new admits, after orders are verified with MD, we fax the medication order to the pharmacy. She said if it's a narcotic, she would get assistance for the DON with the ordering process; however, if the family had home meds, she would put the order in the system and make sure it matches the MD orders. She said the process for administering meds was to look at the label, verify the name, dose, and route, and compare it the MAR. LVN T said IR medication last from ,d+[DATE] hours, and ER meds can last up to 12 hours. Interview on [DATE] at 5:36 am with LVN S, who said that the staff calls the pharmacy, DON, and MD know that there are missing or unavailable meds. She said for the new admits, we verify orders from the doctor, put the orders in the system, and print and fax the order to the pharmacy. She said the rights for medication administration was the right resident, time, dose, route, reason, and the right medication. She said we should document all meds that are not available and place them on the medication log. LVN S said the difference between IR-immediately release, which lasts ,d+[DATE] hours and ER, which lasts for 12 hours. Observation on [DATE] at 7:50 AM of the med cart (100 and 300 hall) med pass performed by MA B without discrepancies. Missing Medication log noted on the med cart. No missing/unavailable meds were noted on the log. Interviews were conducted from [DATE] to [DATE] with staff from all shifts (6:00 AM.to 2:00 PM., 2:00 PM. to 10:00 PM., 10:00 PM. to 6:00 AM) The Administrator was informed the Immediate Jeopardy was removed on [DATE] at 9:03 AM. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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	02/18/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16989 Based on observation, interview, and record review, the facility failed to maintain clinical records that were complete and accurately documented for two residents (CR #2 and Resident #10) in accordance with accepted professional standards and practices, reviewed for resident records, in that: -A nurse had documented pre- and post- nebulizer oxygen saturation percentage levels for CR #2 and later said she did not provide a nebulizer treatment. -LVN T did not document CR #2's vital signs at the time they were obtained. -Resident #10 was provided a nebulizer treatment. The nurse documented a post-nebulizer oxygen saturation level without checking the resident's oxygen saturation. These failures could result in delay or omission of necessary interventions due to inaccurate data. Findings included: CR #2 CR #2 was a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), malignant neoplasm of unspecified broncus or lung (lung cancer), and pulmonary embolism without acute cor pulminal (a condition where a blood clot travels to the lungs and blocks one or more of the pulmonary arteries, but does not cause an immediate and significant impairment of the right ventricle's [heart muscle on the right side of the heart] function). CR #2's Care Plan dated 10/08/24 read, in part, .[CR #2] unable to maintain 02 saturation. Receives Oxygen at 3L/min. CR #2's Physician's Order dated 10/23/24 read, in part, .ipratropium 0.5 mg-albuterol 3 mg (2.5 mg base)/3 ml AMPIL FOR NEBULIZATION (ML) Inhalation Three Times Daily for Seven days Starting 10/23/2024 CR #2's History and Physical dated 10/28/2025 read, in part, .Review of systems: Respiratory: Mild shortness of breath on oxygen. Physical exam: Respiratory: mild SOB on oxygen.- NP Record review of CR #2's Vital Signs Report (printed on 02/17/25) revealed LVN T documented the resident's blood pressure on 10/29/24 at 05:28 a.m. was 133/76 mmHg. LVN T documented CR #2's pulse was 87 bpm at that same time. LVN T documented she used a pulse oximeter to obtain CR #2's O2 saturation on 10/29/24 twice at 5:27 a.m. (84% and 97.3%), and at 5:28 a.m. (97.0%). The 84% O2 saturation reading was documented as post-nebulizer treatment. (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	02/18/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview via telephone on 02/16/25 at 5:18 p.m., LVN T said she did not provide a nebulizer treatment for CR #2 on 10/29/24. She said she documented the pre- and post-nebulizer O2 saturation percentages in error. In an interview on 02/16/25 at 5:40 p.m., the DON said vital signs should either be documented at the time obtained, or if documented later, the time obtained should be noted. She said the pre-nebulizer and post-nebulizer O2 sat values required individual manual entry. Review of the NN dated 10/28/24 - 10/29/24 revealed no entries by LVN T. Resident #10 Record review of the Face Sheet for Resident #10 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), pulmonary embolism without acute cor pulminale (a condition where a blood clot travels to the lungs and blocks one or more of the pulmonary arteries, but does not cause an immediate and significant impairment of the right ventricle's [heart muscle on the right side of the heart] function), and heart failure. Resident #10's Physician's Order for nebulizer treatment dated 02/17/25 read, in part, albuterol sulfate concentrate 2.5 mg/0.5 mL solution for nebulization 6 Times Daily. Route: inhalation. Physical monitors: Post Neb Tx Breath Sounds, Post Neb Tx Pulse ox . Observation on 02/17/25 at 6:40 p.m. revealed LVN Z providing a nebulizer treatment for Resident #10. Prior to administering the treatment, LVN Z obtained the resident's blood pressure with an electronic monitor. She placed a pulse oximeter (pulse ox) on the resident's right index finger. The Resident exhibited an O2 saturation of 98%. His pulse was 81 bpm. LVN Z auscultated Resident #10's breath sounds, then administered the resident's nebulizer treatment. At 6:49 p.m. LVN Z said she did not see any more medication in the nebulizer mask reservoir, and she removed the mask and turned off the nebulizer pump. She checked the resident's blood pressure with the electronic monitor. She did not apply the pulse ox onto the resident. LVN Z rinsed the nebulizer mask and washed her hands. LVN W gathered the monitor and pulse ox, then exited the room. Continued observation revealed LVN W said I'm going to document now. LVN Z accessed Resident #10's TAR. She entered the resident's pre-neb pulse, respirations, and O2 sat (98%). She then entered Resident #10 had a 98% O2 sat post-nebulizer treatment. At that time the Surveyor informed LVN Z she did not use the pulse ox on the resident after the nebulizer treatment. LVN Z responded, I don't remember. The Surveyor asked LVN Z how she obtained the 98% O2 percent for the post-nebulizer reading. LVN Z answered, From watching him breathe. The Surveyor asked LVN Z if she was supposed to use the pulse ox after the treatment. She said she should have used it. Observation revealed the pulse ox had no memory function. In an interview on 02/17/25 at 7:25 p.m., the DON said the nurse was supposed to check breathing sounds, and use the pulse ox to monitor pre- and post-nebulizer treatment O2 sats. She said if they were not checked, the nurse would not know if the treatment was effective. The Surveyor asked the DON to check Resident #10's O2 sats. (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	02/18/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/17/25 at 7:30 p.m. revealed the DON check Resident #10's O2 sats. Her pulse ox reflected 91%. She said she would recheck it with the nurse's pulse ox. She and LVN Z rechecked the residents O2 sats with LVN Z's pulse ox. The reading was 98%. The facility policy Charting and Documentation (revised July 2017) read, in part, .The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The policy also read, in part, .Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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	02/18/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16989 Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, reviewed for infection control, in that: -Staff entered a room with Enhanced Barrier Precautions and transferred Resident #44 with no PPE except gloves. -The staff removed the Enhanced Barrier Precautions sign from Resident #44's door and exited the area without performing hand hygiene. -Two staff provided incontinent care for Resident #92, who had Enhanced Barrier Precautions, without any PPE except gloves. These failures could place the residents receiving care at risk for cross contamination. Findings include: Resident #44 Record review of Resident #44's Face Sheet revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, cerebral infarction (stroke), high blood pressure, and hemiplegia (loss of use) of his right side. Record review Resident #44's Physician's Order dated 11/03/24 revealed the resident was on Enhanced Barrier Precautions (EBP) because he had a G-tube (feeding tube). The Order read, in part, .Gowns and gloves are recommended when performing high-contact resident care activities. Record review of Resident #44's Annual MDS assessment dated [DATE] revealed he required total assist for transfers. He exhibited moderate cognitive impairment, and was incontinent of bowel and bladder. Record review of Resident #44's Care Plan (undated) revealed he was on EBP for the G-tube. The Care Plan read, in part, .GOAL: The spread of an MDRO will be reduced over the next 90 days INTERVENTIONS: Implement Enhanced Barrier Precautions. (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	02/18/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/11/25 at 1:10 p.m. revealed CNA C propel Resident #44 to his room in his wheelchair. There was an Enhanced Barrier Precautions sign on the resident's door. CNA C was already wearing a mask. She donned gloves. She did not don a gown. CNA C assisted the resident to transfer to the bed by picking him up by his waist band. The resident required extensive assist. CNA C then removed her gloves and walked towards the hallway. She had not washed or sanitized her hands. The Surveyor asked her to stop prior to her entering the hallway. The Surveyor asked CNA C to read the Enhanced Barrier Precautions sign on the door and asked her what it meant. CNA C said, I think that's old. CNA C removed the sign from the door and took it down the hall. In an interview on 02/11/25 at 11:15 a.m., LVN R, the hall Charge Nurse, said Resident #44 was on Enhanced Barrier Precautions secondary to having a G-tube. The precautions had not been discontinued. At that time, CNA C returned to the area. LVN R informed CNA C the resident was still on Enhanced Barrier Precautions. CNA C went down the hall and retrieved the sign. She taped the sign to the door and pointed at the PPE. She then asked, So, I have to put this stuff on? Resident #92 Record review of Resident #92's Face Sheet revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to cerebral infarction (stroke), hemiplegia (loss of use) of his left side, and two pressure ulcers. Record review of the Clinical Note dated 02/13/25 at 3:23 p.m. revealed Resident #92 had a pressure sore on his right lateral ankle and unstageable DTIs on both heels. Record review of Resident #92's Care Plan (undated) revealed he was on EBP for the G-tube. The Care Plan read, in part, .GOAL: The spread of an MDRO will be reduced over the next 90 days INTERVENTIONS: Implement Enhanced Barrier Precautions. Observation and interview on 02/11/25 at 1:33 p.m. revealed Resident #92's room door was closed. An Enhanced Barrier Precautions sign was on the door. The Surveyor knocked twice, but did not hear a response. Upon opening the door, the Surveyor observed CNA B and CNA C in the room. They both had on masks and gloves, but no gown. The resident was lying on the bed. CNA C was adjusting the resident's linens. CNA B had a bag of used linens in her hand. CNA B exited the room, carrying the bag of linens. The Surveyor asked CNA B to read the Enhanced Barrier Precautions sign on the door and then asked if she should have worn a gown in the room when providing care. CNA B said she was about to end her shift, and said, It just slipped my mind. CNA C then exited the room (not wearing gloves) and walked down the hall. In an interview on 02/11/25 at 1:35 p.m., CNA B said she and CNA C were providing incontinent care for Resident #92. Observation and interview on 02/11/25 at 1:36 p.m. revealed CNA C was in the hallway near the nursing station. The Surveyor asked CNA C what kind of care she and CNA B were providing for Resident #92. CNA C walked past the Surveyor and pointed at a resident's door that had an Enhanced Barrier Precautions sign on it. CNA C then said, There's a sign on that door. No equipment. I'm tired of that. (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	02/18/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/11/25 at 1:40 p.m., the ADON said Enhanced Barrier Precautions were used for residents with dialysis, catheters, wounds, IVs, and G-tubes. She said, They're supposed to put on a gown. In an interview on 02/11/25 at 1:42 p.m., the DON said Enhanced Barrier Precaution is for infection control. She added, They need to gown up. In an interview on 02/14/25 at 9:35 a.m., the facility Infection Control Preventionist, LVN I, said staff should be wearing a gown when transferring residents or providing incontinent care for residents on Enhanced Barrier Precautions. The Enhanced Barrier Precautions sign read, in part, .Everyone Must: Clean their hands, including before entering and leaving the room .Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities: .Transferring .Changing Linens .Providing Hygiene . The CDC document entitled Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes (published 06/28/24) read, in part, .Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).