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	05/01/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation and interview, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles for 3 of 6 medication carts (halls 100, 300, 600) reviewed for labeling and expired medications. The facility failed to label a Lantus vial and a mupirocin ointment tube with resident specific information in the medication cart located on the 300 hall.The facility failed to label a Nuedexta bottle with resident specific information in the medication cart located on the 600 hall.The facility failed to label Tetrahydrozoline HCL 0.05% with resident specific information in the medication cart located on the 100 hall. These failures had the potential to result in medication administration errors.An observation of the medication cart for hall 300 on 4/30/2026 at 10:00 a.m. revealed 2 medications not labeled with resident specific information. A vial of Lantus 100 units/ml insulin was not labeled located in a Lantus box. A tube of mupirocin ointment usp 2% was not labeled. In an interview on 4/30/20206 at 10:05 a.m., LVN A said the medication should be labeled with the resident's name/date of birth . She said she checked the medication before administration. An observation of the medication cart for hall 600 on 4/30/2026 at 10:45 a.m. revealed a bottle of Nuedexta 20mg/10mg not labeled with resident specific information. In an interview on 4/30/20206 at 10:50 a.m. with LVN D, she said the Nuedexta bottle should have been labeled with resident's name and date of birth . She said without it being labelled they could not know who it belonged. An observation of the medication cart for hall 100 on 4/30/2026 at 12:49 p.m. revealed a bottle of tetrahydrozoline HCL 0.05% eye drops not labeled with a resident specific information. In an interview on 4/30/20206 at 12:50 p.m. with MA T, she said the eye drops should be labeled with resident information. She said if it was not labeled, they could not be sure who it belonged to. In an interview on 4/30/2026 at 1:00 p.m. with the Unit Manager, she said medications should always be labeled with resident information or they could not administer it. The facility's policy titled Medication Administration revised on 12/1/2025, stated in the policy: Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. The facility's policy titled Pharmacy Services dated 12/1/2025, revealed in the policy: Pharmaceutical Services refers to: The process (including documentation, as applicable) of receiving and interpreting prescriber's orders; acquiring, receiving, storing, controlling, reconciling, compounding, dispensing, packaging, labeling, distributing, administering, monitoring responses to, using and/or disposing of all medications, biologicals, chemicals (e.g., povidone iodine, hydrogen peroxide); Compliance Guidelines: The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice.

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident had the right to be treated with respect and dignity for 1 of 31 residents (Resident #96) reviewed for resident rights. The facility failed to ensure Resident #96's right to be treated with respect and dignity on 4/15/26 when LVN U asked CNA Y to witness medication administration. A staff member poured medications in her mouth and LVN U asked her to open her mouth to ensure she swallowed them. Resident #96 had the ability to take medications independently. The failure could place residents at risk of emotional distress, embarrassment, and loss of dignity. Findings included:Record review of Resident #96's admission Record generated on 4/30/26 revealed she was admitted to the facility on [DATE] with diagnoses of pleural effusion (an abnormal, excess accumulation of fluid in the space between the lungs and chest cavity), interstitial pulmonary disease (a broad term for over 200 chronic, often progressive, lung conditions causing inflammation and scarring (fibrosis) of the lung tissue), bipolar disorder (a chronic mental health condition characterized by extreme mood swings, alternating between intense highs, including mania/hypomania, and severe lows, including depression), neuropathy (nerve damage causing pain, numbness, tingling, or weakness, primarily in the hands and feet due to damaged peripheral nerves), and anxiety disorder (mental health conditions involving excessive, persistent fear or worry that interferes with daily life). She was [AGE] years old. Record review of Resident #96's admission MDS assessment dated [DATE] revealed she had a BIMS of 15, indicating she had no cognitive impairment. The assessment determined she had no functional impairments of her upper extremities and required set-up or clean-up assistance with eating. Record review of Resident #96's care plan dated 4/10/26 revealed the resident was on pain medication therapy and was taking Hydrocodone and Pregabalin. Record review of Resident #96's Nurse Progress Note dated 4/15/26 at 9:50pm revealed, at approximately 07:30, patient requested PRN medications, patient was informed than an emergency situation was in progress and that medication would be administered when available. Patient initially verbalized understanding. During this time, while Iwas (sic) attending to another patient experiencing an emergency, patient became verbally aggressive, yelling from her room and making threatening statements including, ?I'm calling 911.' ?I'm a nurse, I know how to get this place shut down.'. I proceeded to administer medication to patient. Upon approach, patient became physically aggressive, grabbing my arm, bending my fingers to snatch the medication out of my hands, and striking my arm. patient also made accusatory statements, stating the nurse was stealing and taking her medication followed by yelling out [NAME] the nurse is withholding her medication. disengaged, administered medication, and ensured safety. Record review of Resident #96's care plan dated 4/17/26 revealed the resident had a behavior problem, including verbal and physical aggression and accusatory behavior related to bipolar disorder. Interventions included administering medications as ordered, anticipating and meeting the resident's needs and providing opportunities for positive interaction and attention. Record review of a provider investigation report dated 4/20/26 revealed on 4/16/26, Resident #96 reported an incident that occurred on 4/15/26 around 8:00pm. The investigation summary revealed, Patient stated that the charge nurse refused to give her pain medications when requested. The patient tried to grab the medication from the nurse and she pulled her hand away causing the medication and cup to fall to the floor. The patient stated that the nurse picked up the medication from the floor and left the room. [Resident #96] said that the nurse returned with the c.n.a. and the c.n.a. was instructed to pour the medication into her mouth and had her open her mouth to verify she had taken them. In an interview on 4/28/26 at 9:21am, Resident #96 said she recently encountered a nurse who was abusive toward her. She said one evening, she was upset that her medications were late and she was becoming vocal about it and speaking loudly. She said the situation could have been de-escalated quickly. She said instead, the nurse (name unknown) was (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upset with the resident, started filming the resident on her cell phone and told the resident that she could call 911. She said the medication cup spilled which caused her medications to fall to the floor. She said she felt that the nurse was taunting her. She said the nurse came back with a CNA (name unknown), and the CNA poured her medications into her mouth from a cup and asked the resident to open her mouth to show that she took them. She said taking medications like that made her feel like she was in prison. In an interview on 4/29/26 at 6:13pm, CNA Y said on the day that she worked with Resident #96, she answered the resident's call light when Resident #96 asked for her pain medications. She said she told the nurse (name unknown) when the nurse returned from a break. She said later, the nurse asked her to go in Resident #96's room as a witness to the nurse giving the resident her medications. When asked by the surveyor how the medications were administered, CNA Y said the nurse asked the resident to open her mouth, then the nurse poured the medications in the resident's mouth, and then said, Let me see. She said the resident opened her mouth to show that she took the medications. In an interview on 4/30/26 at 10:50am, MA T said Resident #96 reached for the medication cup and took her medications independently by mouth when MA T gave her medication. In an interview on 4/30/26 at 3:50pm, LVN U said she remembered caring for Resident #96. She said she checked on Resident #96 around 4:00pm. She said Resident #96's as-needed pain medications were due between 4:00pm and 6:00pm. She said Resident #96 asked for them around 8:00pm or 8:30pm. She said around 7:45pm, she was handling an emergency with another resident. She said Resident #96 began yelling around that time, stating that she needed her medication. She said around 8:00pm, Resident #96 was screaming bloody murder. She said a few minutes later, she walked into Resident #96's room to give her medication. She said she had a medicated cream and a cup of medications in her hand. She said Resident #96 was seated upright at the end of the bed. She said Resident #96 grabbed the nurse's shirt by the shoulder area, causing the cream to fall and hit the floor and caused the cup of medications to fall out of the cup and into the nurse's hand. She said when she bent over to pick up the cream, Resident #96 grabbed the nurse's hand, grabbed the pills and threw the pills into her (Resident #96's) mouth. She said she then backed away from the resident to the door, called for CNA Y, then gave her a beverage and asked her to open her mouth to make sure she swallowed her pills. She said she asked CNA Y to witness Resident #96 take her medications because, I didn't want her to say she didn't take them. In a follow-up interview on 4/30/26 at 6:09pm, CNA Y confirmed that when she witnessed Resident #96's medication administration, the nurse poured the medication in the resident's mouth, then asked the resident to open her mouth to show that she took the pills. In an interview on 5/1/26 at 1:20pm, the Administrator discussed the incident regarding Resident #96. She said she thought it was a concern that LVN U had a witness come into the room to watch medication administration. She said she thought it would be appropriate that LVN U checked to see if Resident #96 took her medication. She said she could see both sides. The Administrator said, I can see why the nurse asked to see that she took the meds, and I see why the resident would be upset. Record review of the facility's policy regarding Resident Rights dated 2/21/26 read, Employees shall treat all residents with kindness, respect and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness and dignity.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure a post-discharge plan of care was developed with the participation of the resident and ensure post-discharge medical and non-medical services were arranged for 1 of 4 residents (CR #1) reviewed for discharge process. The facility failed to review discharge instructions with CR #1 upon her discharge from the facility.The facility failed to provide CR #1 with a copy of the discharge summary at the time of discharge which caused delay in receiving her motorized wheelchair.The facility failed to provide CR #1 with a reconciled medication list upon discharge, resulting in CR #1 being discharged home without her medications, including prescribed pain medications. CR #1 did not receive her medications until the following morning after discharge. This failure placed residents at risk for unmanaged pain, interruption of essential medications, and decline in condition. Findings included:Record review of CR #1's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] and discharged home on [DATE]. Her diagnoses included: polyneuropathy (the simultaneous dysfunction of multiple peripheral nerves, causing symmetric numbness, tingling, and muscle weakness), Type II diabetes mellitus (a chronic metabolic condition where the body develops insulin resistance and inadequate insulin production, leading to high blood sugar), urinary tract infection (a bacterial infection affecting the bladder, urethra, or kidneys), and essential hypertension (is high blood pressuregreater than 130/80mmHg without a single known cause).Record review of CR #1's discharge MDS dated [DATE] revealed a BIMS score of 13 out of 15 indicating her cognition was intact. Further review of the discharge summary revealed:Resident received scheduled and PRN pain medication regimen within the last 5 days.Resident experienced occasional mild pain within the 5 days.Record review of CR #1's care plan initiated on [DATE] and cancelled on [DATE] revealed a focus area for having a raised bruise area to the right shin. Intervention included to monitor for pain, give med per order, monitor for relief.Record review of CR #1's discharge summary revealed CR #1 was discharged home on [DATE] at 6:56pm. Further review of the discharge summary revealed a section labeled Current Medications, with columns for Medication, Last Administered, Related Diagnoses, Start Date, and End Date. The Current Medications section contained no entries.Record review of CR #1's discharge instruction form, signed on [DATE] by RN B, revealed discharge information including a contact number for home health services, follow-up appointment details, and a section for patient Education/Teaching. The following items were indicated as completed:a. Medications called into pharmacyb. Medication education reviewed with patient/patient representativec. Take all medications as prescribedd. Go to physician appointments as schedulede. Share medication list with health care providersf. Contact physician before taking any additional medications not on the listg. Contact physician or pharmacist regarding medication storageh. Contact physician or pharmacist regarding disposal of expired or discontinued medicationsi. Bathe and moisturize skin at least three times weeklyj. Follow dietary recommendationsk. Prescriptions provided to patient/patient representative (see medication list for amount sent home)Further review of the discharge instruction form revealed a notation at the bottom stating, I acknowledge receipt of the current reconciled medications and agree to take the medications as prescribed by the physician. The discharge instructions set forth above have been explained to me. I understand all instructions and the importance of following them as specified. I absolve the nursing facility from all responsibility from any variance from these instructions. A box was checked indicating a handwritten signature was obtained from the patient, with instructions to see the miscellaneous tab of the resident's chart for a scanned copy. Further review of the form revealed no list of reconciled medications.Record review of CR #1's electronic record's miscellaneous tab on [DATE] revealed no scanned copy of signed discharge instruction form.Record review of CR #1's [DATE] MAR revealed medications she was currently taking at time of discharge on [DATE] included, in part:Insulin Glargine Subcutaneous (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Solution 100 UNIT/ML (Insulin Glargine) Inject 40 unit subcutaneously at bedtime (8pm) related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS started on [DATE] and last administered [DATE].Lidocaine External Patch 4 % (Lidocaine) Apply to BOTH KNEE topically in the morning (8am) for BILATERAL (affecting two sides) KNEE PAIN started on [DATE] and last administered on [DATE].Biofreeze Cool The Pain External Gel 4 % (Menthol (Topical Analgesic) Apply to BOTH ANKLES topically three times (8am, 12pm, 8pm) a day for BILATERAL ANKLE PAIN started on [DATE] and last administered on [DATE] at 12:00pm.HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 61 - 150 = 0; 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10, subcutaneously before meals (6:30am, 11:30am, 4:30pm) for Diabetes started on [DATE] and last administered on [DATE] at 4:30pm.AZO Cranberry Urinary Tract Oral Capsule 250-60 MG (Cranberry-Vitamin C) Give 1 capsule by mouth one time a day (8am) for UTI PREVENTION started on [DATE] and last administered on [DATE].Losartan Potassium Oral Tablet 50MG (Losartan Potassium) Give 50 mg by mouth one time a day (8AM) related to ESSENTIAL (PRIMARY) HYPERTENSION Hold for SBP less than 110, DBP less than60, and/or HR less than 60 started on [DATE] and last administered on [DATE] due to outside of parameters to administer on [DATE] and [DATE].Baclofen Oral Tablet 10 MG (Baclofen) Give 10 mg by mouth three times a day (8am, 12pm, 8pm) for Muscles Spams started on [DATE] and last administered on [DATE] at 8pm.Lyrica Oral Capsule 100 MG (Pregabalin) Give 1 capsule by mouth three times a day (8am, 12pm, 8pm) related to POLYNEUROPATHY, [Per MD orders do not change times on this medication] started on [DATE] and last administered at 8pm on [DATE].oxyCODONE HCl Oral Tablet 10MG (Oxycodone HCl) Give 1 tablet by mouth every 8 hours related to POLYNEUROPATHY, for 2 Weeks [[DATE] - [DATE] at 12AM, 8AM, and 4PM], last administered on [DATE] at 4pm with pain rating of 6/10.Phone interview on [DATE] at 10:50am revealed CR #1 stated she was discharged from the facility on [DATE] and had attempted to coordinate with the facility to obtain her discharge paperwork so a wheelchair could be delivered to her home. During the call, CR #1 included a [NAME] Specialist from the wheelchair company. The [NAME] Specialist confirmed difficulty coordinating with the facility to obtain discharge paperwork needed to process delivery of CR #1's wheelchair. The [NAME] Specialist stated residents were typically provided discharge documentation upon discharge, which would have allowed the company to proceed with delivery; however, CR #1 reported she did not receive any discharge paperwork from the facility. CR #1 further stated she did not receive any items from the facility at the time of discharge, including discharge paperwork or medications. She reported the facility arranged a ride share for approximately 7:00pm on [DATE], and when the ride arrived, the facility did not have her belongings or medications prepared but proceeded with discharging her. CR #1 stated she asked the nurse about her medications prior to leaving and was informed she could not take them home because they were narcotics.Interview on [DATE] at 3:45pm revealed the Discharge Planner stated she completed the top portion of the discharge instruction form, and the nurse was responsible for reviewing the form with the resident and obtaining the resident's signature prior to discharge. The Discharge Planner stated she was unaware of the process for handling the signed form after completion and indicated the nurse would need to be consulted for further information.Interview on [DATE] at 3:50pm revealed RN B stated she recalled CR #1 and her discharge. RN B stated the discharge instruction form was printed and reviewed with CR #1, and she reported CR #1 signed the form. RN B stated she placed the signed form in the box at the nurses station for medical records to scan into the resident's chart. RN B stated that if the form was not present in CR #1's record, medical records would need to be consulted. RN B further stated that residents were not provided a copy of the signed discharge instruction form at discharge; however, they were provided a discharge summary report, a medication order summary report, and their medications, along with a list of medications returned to them at discharge. RN B stated the items were provided to CR #1.Interview on [DATE] at 5:10pm revealed the Administrator stated she had consulted with Medical Records and confirmed CR #1's signed discharge instruction form was not (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	present in the resident's chart. The Administrator stated that if the form had been received, it would have been scanned into the record. The Administrator further stated Medical Records staff were diligent in retrieving documents from the nurses station box and scanning them into the chart. She indicated the absence of the document suggested the form may not have been placed in the designated box at the nurses station and clarified medical records did not have the form.Interview on [DATE] at 5:29pm revealed the Unit Manager stated that when a resident was discharged home, the nurse was responsible for providing discharge instructions, a discharge summary, and the resident's medications. The Unit Manager stated that, in most cases, all remaining medications were provided to the resident at discharge, including narcotics. The Unit Manager stated that in some situations, depending on the quantity of narcotics remaining, the physician might limit the amount sent home; however, residents were not discharged without receiving any of their prescribed narcotic medications. The Unit Manager provided an example that if a resident had a 30-day supply remaining, the physician might elect to send only a 14-day supply home. The Unit Manager stated she was not familiar with CR #1 specifically but indicated there should have been a reconciled medication list that reflected the medications provided to the resident at discharge.Interview on [DATE] at 5:58pm revealed CR #1 stated she had been informed a few days prior to [DATE] that she would be discharged from the facility on that date. She reported staff were aware of her discharge, as nurses and CNA staff made comments on [DATE] regarding her leaving that day. CR #1 stated the Discharge Planner informed her on [DATE] that there were issues arranging transportation. She reported the Discharge Planner paid for a ride share out of pocket and scheduled pick-up for 7:00pm. CR #1 stated when the ride arrived, the facility had not prepared her belongings, medications, or discharge paperwork. CR #1 stated she contacted the Discharge Planner to report the situation and was instructed to proceed with the ride to avoid being charged. She reported that as she entered the ride, a nurse she believed to be RN B approached the vehicle and asked her to sign a paper. CR #1 stated she was told it was just something to sign due to her leaving and denied the document was explained as discharge paperwork. CR #1 further denied receiving discharge instructions or any documentation prior to leaving the facility. CR #1 stated she was discharged without medications and reported she went the remainder of the evening and the following morning without her prescribed medications, including pain medications. She stated the Discharge Planner delivered medications to her home on [DATE] at approximately noon and retrieved the facility wheelchair at that time. CR #1 stated the Discharge Planner left shortly after arrival due to parking concerns. CR #1 further stated that after reviewing the medications provided, she identified that Lyrica and AZO, medications she had brought from home, were not returned to her.Interview and record review on [DATE] at 9:00am revealed the Administrator stated she had additional information regarding the discharge of CR #1. The Administrator stated that at the time of discharge, CR #1's medications were not prepared, and the Discharge Planner delivered them to CR #1's home the following morning. The Administrator provided a copy of a text message log. Review of the log revealed a message from the Discharge Planner on [DATE] at 4:10pm stating, [CR #1] discharge today. Home Health. Back to Assisted Living. Ride Share pick up for 7pm. A subsequent message dated [DATE] at 9:22am stated, Nurse Manager not responding to my call or text. I'm driving from the north side trying to take [CR #1] her meds because they wasn't ready last night when her ride arrived and I'm heading to take them to her. An additional message stated, The building called me back just now, they are ready for me to pick them up. The Administrator stated a photograph was also taken of the medications provided to CR #1 by the Discharge Planner. Review of the photograph revealed multiple blister packs of medications and a bag containing a sheet of paper with CR #1's name written on it. The photograph did not clearly identify the specific medications or quantities provided. The Administrator stated the facility was unable to produce a reconciled list of medications provided to CR #1 at discharge. She reported a pharmacy sheet was available showing medications dispensed during the resident's stay and suggested it could be compared to the drug destruction log to infer which medications may have been returned. The (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator acknowledged there should have been a documented list of medications provided to the resident; however, such documentation could not be located at the time.Record review of the drug destruction binder revealed no medications were destructed for CR #1 in [DATE].Interview and record review on [DATE] at 11:56am revealed the Discharge Planner stated the facility became aware on [DATE] that CR #1 would be discharged . The Discharge Planner stated CR #1 was informed and agreed to a discharge date of [DATE]. She reported that once a discharge date was established, the resident's name and discharge date were placed on a board in her office for staff awareness and discussed during the next morning meeting to ensure staff were prepared. The Discharge Planner stated she initiated discharge assessments and the discharge instruction form to begin documenting information related to the discharge. She reported that she typically selected a discharge time in advance and communicated it to staff to ensure all preparations were completed. The Discharge Planner stated that on [DATE], CR #1 expressed concern regarding transportation home, stating she did not have a way to leave the facility and could not afford to stay an additional day due to copay requirements. The Discharge Planner stated that at approximately 3:00pm, she obtained approval from the Administrator to arrange transportation through the facility van driver. She provided text messages showing she contacted the van driver on [DATE] at 3:07pm; however, no response was received. The Discharge Planner stated that due to concern about CR #1's ability to return home, she paid out of pocket for a ride share scheduled to arrive at 7:00pm. She reported sending a message to a group chat with nursing management staff on [DATE] at 4:19pm stating, [CR #1] pickup is for 7pm she cannot miss her ride. [RN D] can you make sure the nurse and CNA are aware? A response from RN D at 4:19pm stated, sure. Additional messages showed the Discharge Planner notified the group at 6:55pm that the ride had arrived. The Discharge Planner stated she was at home when the ride arrived and reported CR #1 called her stating the facility did not have her belongings, medications, or paperwork ready. The Discharge Planner stated she attempted to contact the facility and send messages to the management group but received no response. The Discharge Planner stated she learned the following morning that CR #1 had left the facility without her medications. She reported returning to the facility on [DATE] to retrieve the medications from nursing staff. She stated she had a nurse take a photograph of the medications, acknowledging she was not licensed to dispense medications but felt it was necessary to ensure CR #1 received them. The Discharge Planner stated she delivered the medications to CR #1's home at approximately 11:56am on [DATE]. She reported there was a list of medications with administration instructions included in the bag, and although she was not a nurse, she reviewed the instructions with the resident prior to leaving. The Discharge Planner stated she was unsure whether documentation existed regarding the medications delivered and could not confirm whether Lyrica or AZO were included. She reported the only documentation provided to CR #1 at that time was the medication list included in the bag.Interview on [DATE] at 12:45pm revealed RN D stated she was no longer employed at the facility and had ended her employment in [DATE]. RN D stated she did not recall CR #1 or any text messages related to CR #1's discharge. She further stated she did not believe she was working on [DATE], as she recalled being ill with COVID around that time. RN D was informed of text message documentation indicating she responded sure to a message from the Discharge Planner regarding ensuring CR #1 was prepared for discharge. RN D stated she did not recall the message and suggested the response may have been sent as a general acknowledgment. RN D stated nurse managers were not responsible for preparing residents for discharge and indicated that responsibility rested with the floor nurse and Med Aide. She stated staff were typically informed of planned discharges by the Discharge Planner. RN D further stated the group chat used for communication included management staff only and did not include direct care staff responsible for preparing residents for discharge.Interview on [DATE] at 1:00pm, the Administrator said according to their time tracking system RN D was working on [DATE] from 7am - 5pm and her last day of work was [DATE].Record review of the facility Transfer and Discharge policy implemented on [DATE] and date last reviewed/revised on [DATE] revealed in part, .b. A member of (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	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the interdisciplinary team will complete relevant sections of the Discharge Summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to, the following. iii. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter). c. Orientation for transfer or discharge will be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the resident can understand. Depending on the circumstances, this orientation may be provided by various members of the interdisciplinary team. d. Facility will assist with transportation arrangements to the new facility and any other arrangements as needed.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately submit a PASRR Level 1 Screening screening when a resident admitted with a diagnosis of Mental Illness, Intellectual Disability or Developmental Disability for (1 Resident #9) of 4 residents reviewed for PASRR screenings. The facility did not correctly identify Resident #9 as having mental illness in their PASRR Level 1 Screening. This failure could place residents with documented mental illness diagnoses at risk of not receiving needed care and services in the appropriate setting. Findings included:Review of Resident #9's face sheet, dated 5/1/26 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: ileus (a condition in which the bowel does not work correctly), hemiplegia (complete paralysis) and hemiparesis (weakness) following cerebral infarction (a type of ischemic stroke), epilepsy (a brain condition that causes recurring seizures), dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), and schizophrenia (a serious mental health condition that affects how people thing, feel, and behave).Record review of the PASRR level 1 screening dated 3/27/26 revealed he was negative for mental illness, intellectual disability, and developmental disability.Record review of Resident #9's Comprehensive MDS, dated [DATE] revealed a BIMS score of 1 which indicated severe cognitive impairment. Resident #9 had an active diagnosis of schizophrenia and was taking an antipsychotic.Record review of Resident #9's physician's orders with a start date of 4/21/26 indicated he was prescribed Quetiapine Fumarate (atypical antipsychotic) oral tablet 50 mg, via g-tube two times a day.Record review of Resident #9's care plan dated 3/27/26 indicated he had a behavior problem, removing colostomy (an opening in the colon that lets stools pass from the body without going through the anus) bag and throwing it on the floor. Interventions included: anticipate and meet the resident's needs, assist the resident to develop more appropriate methods of coping and interacting, encourage the resident to express feelings appropriately, caregivers to provide opportunity for positive interaction/attention, stop and talk with him as passing by.During an interview and observation of Resident #9 on 4/28/26 at 8:20 a.m. revealed he was lying in bed wearing a hospital gown and watching tv. When questioned about the food Resident #9 repeated I'm alright or It's alright.During an interview with the MDS Coordinator on 5/1/26 at 10:55 a.m., she said she would upload the PASSR Level 1 in system within 72 hours. She said she did not check if the PASRR Level 1 was accurate; the Regional MDS Coordinator was responsible for checking the accuracy of the PASRRs. The MDS Coordinator said she was not sure if Resident #9 was referred to a psychiatrist. She said she was from a different state and the current state did things differently. She said she did not know the risk to the resident when an inaccurate PASRR was completed for the resident.Record review of the facility's policy titled Resident Assessment-Coordination with PASRR Program dated 12/20/25 revealed in part . This facility coordinates assessments with the preadmission screening and resident review program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs .

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	676207	A. Building B. Wing	05/01/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who are incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 2 of 10 residents (Residents #33 and #28) reviewed for incontinent care. -Resident #1's Foley catheter bag was observed more than half full and was not emptied as needed during observation on 04/29/2026 at 11:22 a.m.- Resident #2's Foley catheter bag was observed more than half full and was not emptied as needed during observation on 04/30/2026 at 5:00 p.m. This failure could place residents with indwelling Foley catheter at risk of infection, sepsis, hospitalization and death. Findings included: Record review of Resident # 33's face sheet dated 03/02/2026 revealed, she was a [AGE] year-old female admitted on [DATE] with the following diagnoses: Sepsis (Life-threatening medical emergency caused by the body's response to infection that can lead to tissue damage, organ failure, and potential death), acute kidney failure, obstructive and reflux uropathy (blockage of urine flow, causing backflow that can lead to kidney damage and infection). Record review of Resident # 33's quarterly MDS dated [DATE] revealed she had a BIMS score of 13, indicating cognitively intact. Section H0300 urinary continence was coded; always incontinent. Record review of Resident # 33's comprehensive care plan dated 03/02/2026 revealed the following care areas:-The resident had an indwelling Foley catheter due to neurogenic bladder. Goal: The resident will be/remain free from Foley catheter related trauma. The resident will show no sign or symptoms of urinary infection. Interventions: Position Foley catheter bag and tubing below level of the bladder. Record review of Resident # 33's clinical care orders dated 3/19/2026 revealed, urinary Foley catheter care, check for patency (unobstruction) and empty Foley catheter bag every shift. Observation of Resident # 33's Foley catheter bag on 04/29/2026 at 11:22 a.m., revealed, the bag was 1600 cc out of 2000 ml full. In an interview with CNA A on 04/29/2026 at 12:35 p.m., she said she did check Resident # 33's Foley bag at the beginning of her shift, to record the output. She said usually she would empty the foley bag at the end of her shift or when it was full. CNA A said when she checked the foley bag at the beginning of her shift, it showed 200-300 cc. CNA A said failure to empty Resident # 33's Foley bag when it was due could lead to health deterioration. In an interview with LVN A on 04/29/2026 at 12:52 p.m., she said it was the responsibility of the CNAs to empty the Foley bag and report the readings to the nurse. She said Resident # 33 had a Foley catheter because of urinary retention. LVN A said she failed to check Resident # 33's Foley catheter to see if the previous shift had emptied the urine or documented the output. She said the fact that the Foley bag had 1600 cc at 11:22a.m., meant the night shift did not empty the bag. LVN A said if the bag was not emptied, there was a possibility of urine backing up into Resident # 33's bladder which could lead to UTI which might progress to sepsis, thereby causing infection into the blood stream. She said it could have resulted in a negative change in Resident # 33's health. In an interview on 04/29/2026 at 1:11 p.m., CNA B said it was the responsibility of the CNAs to empty the foley bag and then report the amount to the nurses who will document in PCC. She said, the norm was to check and empty the foley bag at least once during each shift. CNA B said, she emptied Resident # 33's foley bag on the night of 04/28/2026 breaking 04/29/2026 but did not remember if she told RN A the urine output amount. She said she was not authorized to document urine output in PCC (software used by the facility to document residents care). In a telephone interview on 04/29/2026 at 4:10 p.m., with RN A, she said it was the responsibility of the CNAs and the nurses to empty the Foley bag, but the responsibility of the nurses to document the output in PCC. RN A said, CNA B told her Resident # 33's output was 500 cc before 5:00 a.m. She said, from 4:00 a.m. to 11:22 a.m., she expected the output to have been 700 cc. She said if the Foley output was 1600 cc at 11:22 a.m., that meant the night shift did not empty the Foley bag. RN A said- Resident # 33 was on fluid restriction. She said if urine had backed up into the (continued on next page)

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	676207	A. Building B. Wing	05/01/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 33's bladder, and that could have resulted in UTI. In an interview with Resident # 33 on 04/29/2026 at 4:32 p.m., she said the Foley catheter was not emptied throughout the night. The facility staff work 8 hours shift-6a.m.-2 p.m., 2 p.m. to 10 p.m., and 10 p.m. to 6 a.m. She said she was depended on staff to help her because she cannot walk. In an interview with RN B on 04/29/2026 at 4:51 p.m., she said Resident # 33 had a Foley catheter due to urinary retention. She said it was the responsibility of the nurses and the CNAs to empty the foley bag. RN B said, I empty the Foley bag at the start of the shift while the CNAs were expected to complete the task at the end of the shift. She said at the end of the shift she recorded both readings. RN B said if there was 1600 cc of urine in Resident # 33's Foley bag, it meant the night shift did not empty the Foley bag. She said if Resident # 33 had a UTI, it might cause sepsis which could result to death. Resident # 28Record review of Resident # 28's face sheet dated 04/19/2026 revealed she was a [AGE] year-old female with the following diagnosis: neurogenic bladder (neurological damage which can result in symptoms such as overflow incontinence, urgency, and retention). Record review of Resident # 28's quarterly MDS dated [DATE] revealed she had a BIMS score of 13 indicating cognitive intactness. Section-H-bladder and bowel revealed she had an indwelling catheter (a flexible, close system tube inserted into the bladder to continuously drain into an external bag). Section I-15000 revealed she was paraplegic (paralysis affecting the lower part of the body). Record review of Resident # 28's care plan dated 4/19/2026 revealed the following areas:-Dependent on indwelling catheter for the management of neurogenic bladder. Goal: The resident will show no signs and symptoms of urinary infection. The resident will be/remain free from catheter related trauma. Intervention: Monitor for signs and symptoms of discomfort on urination and frequency. Monitor/document for pain/ discomfort due to catheter. Monitor/record/ report to MD for signs and symptoms of UTI: pain, blood-tinged urine, cloudiness, no output, foul smelling urine, fever, chills, altered mental status, changes in behavior and change in eating patterns.-Enhanced barrier precautions implemented related to urinary catheter. Goal: The spread of MDRO will be reduced. Intervention: Implement EBP. Monitor for signs and symptoms of infection, offer emotional support as needed related to infection risk of EBP. Record review of Resident # 28's clinical care order dated 01/05/2026 revealed: empty Foley every four hours. Record review of Resident # 28's MAR dated 4/19/2026 stated: Foley care, Foley bag to be emptied every four hours related to frequent urination. Observation of Resident # 28's foley catheter bag on 04/30/2026 at 5:00 p.m., revealed the bag was at 1500 cc out of 2000 cc full. Resident # 28 was not interviewed because she was asleep. In an interview with LVN B on 04/30/2026 at 5: 32 p.m., she said Resident # 28 was admitted with an indwelling foley catheter because she had an accident that resulted to spinal cord injury (damaged nerve with the spinal column which causes permanent paralysis). She said it was the responsibility of the nurses and CNAs to empty the foley bag. LVN B said the CNAs reported the output readings and she documented them in PCC. She said if 1500 cc of urine was observed at 05:00 p.m., in Resident # 28's foley bag, that was evident the 6 a.m.- 2 p.m. staff did not empty the foley bag at the end of their shift. In an interview with LVN C on 04/30/2026 at 06:08 p.m., she said CNA C did not report the output for Resident # 28 on 04/30/2026 at shift change to her. LVN C said it was the responsibility of the CNAs to empty the Foley bag and then report the output readings to the nurse. She said if there was 1500 cc output at 5:00 p.m., it meant the 6 am to 2 p.m. shift did not empty the Foley bag. LVN C said, Resident # 28 would be at risk for sepsis if she is not treated and could possibly lead to death. In an interview on 05/01/2026 at 07:20 a.m., the NM said Resident # 28 had an indwelling catheter due to urinary retention and obstructive uropathy (blockage of urine flow which causes urine to backup into the kidneys). The NM said- she expected the CNAs to empty the Foley bags and report the output to the nurses. She said if Resident # 33 and Resident # 28 had a foley bag of 1600 cc and 1500 cc respectively, they were susceptible to UTI which could lead to sepsis and if not treated could lead to unwanted hospitalization. She assumed the previous shifts did not empty the foley. In an interview on 5/01/2026 at 08:05 a.m., with the ADM, she said Resident # 33 and Resident # 28's foleys were not emptied by the previous shifts. She said that (continued on next page)

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	676207	A. Building B. Wing	05/01/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it could cause UTI and could result in sepsis. The ADM said she expected the staff to empty the foley bags every shift as stated in the residents' clinical orders. In an interview on 05/01/2026 at 12:31 p.m., with CNA C, she said she had emptied Resident # 28's Foley bag once during her shift. She said she did not report the readings to the nurse because she did not know she had to report the reading to the nurse. She acknowledged she was trained on Foley care and how to empty the Foley bag but did not recall what she was told to do after she emptied a Foley bag. On 05/01/2026 at 12:59 p.m., unsuccessful telephone call to LVN D who provided care to Resident # 28 on 04/30/2026 from 6a.m. to 2 p.m. The facility's policy titled Catheter Care revised on 12/01/2025, revealed: It is the policy of the facility to ensure that all residents with indwelling catheters receive appropriate catheter care. Catheter care will be performed every shift. Empty drainage bag routinely. Document care and report and concerns noted to the nurse on duty.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that a resident who needed respiratory care was provided care consistent with professional standard of practice, the comprehensive person-centered care plan, and the residents goals and preferences for 1 of 31 resident (Resident #93) reviewed for respiratory care.The facility failed to ensure Resident #93, who had COPD and required oxygen via nasal cannula, had a functioning oxygen concentrator for approximately 5 hours. Resident #93 was found to have oxygen saturation level below her baseline and complaints of not getting enough air.This failure placed the resident at risk for hypoxia (critical condition where body tissues are deprived of sufficient oxygen), respiratory distress, and deterioration of health. Findings include:Record review of Resident #93 face sheet revealed an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: chronic respiratory failure with hypoxia (long-term condition where the respiratory system cannot adequately oxygenate the blood, resulting in low oxygen levels), shortness of breath, hypertension (high blood pressure), Chronic Obstructive Pulmonary Disease (a progressive, incurable lung disease that obstructs airflow, causing severe breathing difficulties), acidosis (an excess acid buildup in blood or bodily fluids, occurring when the lungs or kidneys cannot maintain a healthy pH balance), and Generalized Anxiety Disorder (persistent, excessive, and uncontrollable worry about everyday matters).Record review of Resident #93's Quarterly MDS dated [DATE] revealed a BIMS score of 11 out of 15, indicating moderate cognitive impairment. Further review of the MDS revealed:a primary medical condition category of Debility, Cardiorespiratory Conditions (a combination of profound physical weakness and dysfunction in the heart or lungs)active diagnoses of respiratory failure and asthma, COPD, or chronic lung diseasea health condition of shortness of breath or difficulty breathing when lying flatspecial treatment that included oxygen therapyrespiratory therapy services provided for at least 15 minutes a day for 7 days within the last 7 daysRecord review of Resident #93's Care Plan revealed:A care area initiated on 5/8/2025 for a diagnosis of COPD. The resident received oxygen therapy related to ineffective gas exchange. Interventions included, in part, giving medications as ordered by MD; monitoring and documenting side effects and effectiveness; and monitoring for signs and symptoms of respiratory distress and reporting to MD PRN, including respirations, pulse oximetry, increased heart rate, restlessness, diaphoresis (sweating), headaches, lethargy, confusion, atelectasis (partial or total collapse of a lung), hemoptysis (coughing up blood or blood-tinged mucus from the respiratory tract), cough, and accessory muscle use (use of muscles other than the diaphragm and intercostals to assist breathing). Interventions also included providing O2 as ordered and providing reassurance to allay anxiety, including ensuring the resident had a method to call for assistance and staying with the resident during episodes of respiratory distress.A care area initiated on 6/1/2025 for COPD. The resident used supplemental O2 and exhibited SOB while lying flat. Interventions included, in part, giving aerosol or bronchodilators (medications that widen airways by relaxing bronchial muscles) as ordered; monitoring and documenting side effects and effectiveness; keeping the head of the bed elevated or placing the resident upright in a chair during episodes of difficulty breathing; and providing O2 as ordered.A care area initiated on 8/5/2025 for altered respiratory status and difficulty breathing. Interventions included, in part, administering medications/puffers as ordered; monitoring for effectiveness and side effects; monitoring and documenting changes in orientation, increased restlessness, anxiety, and air hunger (the distressing sensation of not getting enough air or inability to take a deep breath); and monitoring for signs and symptoms of respiratory distress and reporting to MD PRN, including increased respirations, decreased pulse oximetry, and increased heart rate.Record review of Resident #93's physician orders revealed:Oxygen: Obtain SpO2 (measures the percentage of oxygen-saturated hemoglobin in the blood) every shift, initiated on 5/1/2025.Oxygen: Oxygen was to be titrated to keep O2 at 90-92% for COPD; every shift, oxygen was to be titrated down due to high (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CO2 levels, with monitoring of saturation levels to maintain between 90-92%, initiated on 2/22/2026 and discontinued on 4/29/2026.Ipratropium Bromide Inhalation Solution 0.02% (Ipratropium Bromide) (a bronchodilator used to manage wheezing and breathing difficulties in COPD): 1 inhalation via nebulizer two times a day related to COPD, initiated on 3/18/2026.Oxygen: Oxygen was to be titrated at 3 lpm/nc to keep O2 above 90% for COPD; every shift, oxygen was to be titrated down due to high CO2 levels, with monitoring of saturation levels to keep above 90%, initiated on 4/29/2026.Record review of Resident #93's April 2026 MAR revealed:An order to obtain SpO2 every shift (day 6am-2pm, evening 2pm-10pm, and night 10pm-6am). From 4/1/2026 through 4/30/2026, SpO2 levels ranged from 96%-98%, with no readings below 96%.An order to titrate O2 to maintain levels at 90-92% for COPD; every shift, oxygen was to be titrated down due to high CO2 levels, with monitoring of saturation levels to maintain between 90-92%. From 4/1/2026 through 4/29/2026, the order was completed, and O2 saturation levels ranged from 96%-98%, with no complaints of SOB.An order to titrate O2 at 3 lpm/nc to keep O2 above 90% for COPD; every shift, oxygen was to be titrated down due to high CO2 levels, with monitoring of saturation levels to keep above 90%. From 4/29/2026 through 4/30/2026, the order was completed, and O2 saturation levels ranged from 97%-98%, with no complaints of SOB.An order for Ipratropium Bromide Inhalation Solution 0.02% (Ipratropium Bromide), 1 inhalation via nebulizer two times a day at 8am and 4pm. From 4/1/2026 through 4/30/2026, the treatment was administered, with findings of clear lung sounds and O2 saturation ranging from 96%-98%Record review of Resident #93's vitals log dated from 4/1/2026 through 4/30/2026 revealed that her O2 saturation levels ranged from 96%-98% while on O2 via nasal cannula (a lightweight, flexible tube used to deliver supplemental oxygen to individuals requiring respiratory support).Record review of Resident #93's progress note dated 3/16/2026 at 5:15pm by the RRT revealed, Patient assessed. Respiration regular and unlabored. Patient laying in bed with the head of the bed in a higher [NAME] (60-90 degree, upright, seated position primarily used to treat respiratory distress by maximizing chest expansion). HR 84, RR 17, O2 97% on 2lnc, breath sounds scattered crackles (abnormal popping or bubbling noises heard through a stethoscope during a physical exam) in all lobes of both lungs today. patient is short of breath when laying flat.Record review of Resident #93's progress note dated 3/23/2026 at 11:53am by the RRT revealed, Patient assessed. Patient laying in bed with the head of the bed in a higher [NAME]. Patient is short of breath when laying flat. HR 80, RR 16, O2 96% on 2lnc, breath sound is rhochi (low-pitched, rattling, or snoring-like lung sounds) in all lobes of both lungs today.Record review of Resident #93's follow-up note dated 4/8/2026 by the NP revealed, in part, .03/30/2026: Long-term resident seen in bed, stable and in no distress. Sitting up in bed. No edema (swelling caused by excess fluid trapped in the body's tissues) noted. Continues on oxygen for COPD. Voices chronic shortness of breath, not worse. Lungs with diminished sounds in lower lobes, clear to upper lobes. The History of Present Illness noted, in part, .XXX[AGE] year old female, is seen for SNF follow-up. She is lying in bed, stable and in no acute distress. She remains on oxygen at baseline. She is alert and oriented. Further review of the note revealed Review of Systems noting, in part, .GENERAL- stable, no distress, no fever, no chills, no malaise, no fatigue, no night sweats, no dizziness, on oxygen at baseline, alert and oriented. RESPIRATORY- chronic shortness of breath not worse, on oxygen for COPD, no cough, no wheezing, no chest pain with breathing. The follow up note physical examination revealed, in part, .GENERAL- lying in bed, stable, no acute distress, thin frail appearance, on oxygen at baseline, alert and oriented. RESPIRATORY- on oxygen, diminished lower lobes, clear to upper lobes, equal expansion, no respiratory distress. The NP further noted in the Assessment and Plan, in part, .CHRONIC RESPIRATORY FAILURE WITH HYPOXIA: Stable, no acute changes. Patient remains on baseline oxygen. Lungs with diminished sounds in lower lobes, clear to upper lobes. Alert and oriented. No respiratory distress noted. Continue current oxygen therapy. Monitor oxygen saturation.Record review of Resident #93's progress note dated 4/13/2026 at 11:44am by the RRT revealed, Patient assessed. Patient complained of cough. Patient laying in bed with the head of the bed in a higher [NAME]. Patient is short of breath when laying flat. Patient was (continued on next page)

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	676207	A. Building B. Wing	05/01/2026

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	educated on cough techniques. Patient perform return demonstrated satisfactorily. HR 77, RR17, O2 97% on 2lnc, breath sounds is scattered crackles in all lobes of both lungs today. patient will continue to benefit from breathing treatment at this time.Record review of Resident #93's progress note dated 4/20/2026 at 10:49am by the RRT revealed, Patient assessed. Patient laying in bed with the head of the bed in a higher [NAME]. Patient is short of breath when laying flat. HR 74, RR 16, O2 98% on 2lnc, breath sounds is scattered crackles in all lobes of both lungs today.Observation and interview on 4/28/2026 at 8:48am revealed Resident #93 was lying in bed with the head of the bed elevated and a nasal cannula placed in her nostrils, with tubing around her ears securing it in place. The tubing from the nasal cannula was attached to an oxygen concentrator located to the right of her bed. The oxygen concentrator had a humidifier attached with sterile water inside. The concentrator was making a humming noise; however, a red light was illuminated at the top of the machine next to a wrench symbol. The oxygen flow meter showed the floating ball at the bottom of the tube, indicating no flow rate. Resident #93 stated she felt okay and reported she could hear the O2 concentrator vibrating, so she believed it was on. The surveyor informed Resident #93 that the concentrator had a red light illuminated and was not showing a flow rate. Resident #93 stated she hoped it was working and denied any difficulty breathing at that time. She stated she used oxygen due to COPD and sometimes experienced SOB even while using O2. A nebulizer mask with tubing was observed on the nightstand, and Resident #93 stated she used the mask for breathing treatments. Resident #93 stated she would inform staff if she felt the oxygen was not working.Observation and interview on 4/28/2026 at 2:11pm revealed Resident #93 was lying in bed with the head of the bed elevated and a nasal cannula in place attached to the oxygen concentrator. She was observed fanning herself with a small piece of paper. Observation of the oxygen concentrator revealed a red light illuminated next to a wrench symbol, a humming noise from the machine, a flow rate reading below 0 lpm, and a loud beeping noise. Resident #93 stated she did not know where the beeping noise was coming from but reported it had been beeping for hours. She stated a staff member had entered the room earlier, heard the beeping, and told her they would get the nurse; however, no one had returned. Resident #93 stated, Oh, they don't care that it's beeping. She was unable to identify the staff member but stated it was a female. Resident #93 further stated, I don't feel like I'm getting enough air.Observation and interview on 4/28/2026 at 2:16pm revealed the surveyor approached the nurses station and requested Resident #93's nurse due to concerns regarding her oxygen concentrator. LVN B identified RN C as Resident #93's nurse. RN C was observed sitting at the nurses station typing on a computer. LVN B approached RN C and informed him the surveyor had questions regarding Resident #93's oxygen. RN C remained seated and continued typing until approximately 2:20pm, at which time he stood and stated he believed Resident #93's oxygen flow rate was set at 2 lpm. RN C was asked by the surveyor to assess the oxygen concentrator, as the setting could not be determined and the machine was beeping. RN C entered Resident #93's room with the surveyor and, upon observing the concentrator, stated Oh and adjusted the flow rate dial, after which the metal ball rose to 2 lpm on the flow meter. The oxygen concentrator continued to display a red light and emit a beeping alarm at that time. RN C stated he did not know the cause of the red light and alarm and reported he would need to consult with the respiratory therapist (RRT). The surveyor requested RN C obtain Resident #93's vital signs, as the resident was still fanning herself, although she stated she felt okay when asked by RN C. RN C left the room to retrieve a vital signs machine. While RN C was out of the room, the O2 concentrator light changed to green and the alarm ceased. Resident #93 stated she felt the oxygen was working and that she was starting to get some air. At approximately 2:26pm, RN C returned with the vital signs machine and applied a pulse oximeter to the resident's right index finger. The initial SpO2 reading was 92%. The pulse oximeter remained in place for approximately 1-2 minutes, during which readings fluctuated between 91%-93%. RN C also stated the concentrator light was now green, indicating it was functioning properly and delivering the set amount of oxygen.Observation and interview on 4/28/2026 at 3:08pm revealed Resident #93 was lying in bed, no longer fanning herself, with a nasal cannula in place. The oxygen (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concentrator displayed a green light, and the flow meter was set at 2 lpm. Resident #93 stated she had been fanning herself earlier because, I was trying to get some air. She reported she was now feeling okay and asked who the male staff member was that had entered the room earlier (RN C). The surveyor informed Resident #93 that RN C was her nurse from the morning and asked if she had seen him enter the room prior to adjusting the oxygen concentrator. Resident #93 responded, Maybe this morning.Interview on 4/28/2026 at 3:09pm revealed RN C stated he had entered Resident #93's room at approximately 7:20am and administered a breathing treatment. He stated the oxygen concentrator was functioning properly at that time and her O2 saturation was 98%. RN C was asked if he had returned to Resident #93's room later in the day, as an O2 saturation level had been documented at 2:00pm. RN C denied returning to the room prior to entering with the surveyor and stated the documented time reflected when he entered the information into the chart, not when the assessment occurred. RN C denied hearing any beeping from Resident #93's room and denied observing a red light on the O2 concentrator prior to the surveyor bringing it to his attention.Interview and record review on 4/28/2026 at 3:49pm revealed the Unit Manager stated the DON and ADON were both out sick. She stated she typically worked on the first floor and was not familiar with Resident #93, who resided on the second floor. The Unit Manager stated a resident with COPD should be monitored by assessing the O2 saturation levels and observing for symptoms of exacerbation, including SOB, abnormal breath sounds, or difficulty breathing. The Unit Manager was shown photographs taken by the surveyor on 4/28/2026 at 8:57am of Resident #93's oxygen concentrator, which showed a red light illuminated and no flow rate indicated on the flow meter. After reviewing the photographs, the Unit Manager stated the red light indicated the machine was not functioning properly. The Unit Manager stated if that occurred, the nurse should attempt to troubleshoot the machine and, if it remained nonfunctional, replace it with another unit. She further stated that if the machine displayed a red light or emitted a beeping alarm, staff should notify the nurse, and the nurse should immediately assess both the resident and the equipment. The Unit Manager stated that depending on the resident's baseline, a resident with COPD who required oxygen and went without it for approximately 5 hours could experience respiratory distress or respiratory failure. The Unit Manager was informed that Resident #93's baseline O2 saturation levels ranged from 97%-98% and that after the oxygen concentrator was adjusted by RN C, her O2 saturation levels ranged from 91%-93%. The Unit Manager stated she could not provide further clinical interpretation specific to Resident #93, as she was not familiar with the resident.Phone interview on 4/28/2026 at 7:20pm revealed CNA E stated she had worked the morning shift on 4/28/2026 with Resident #93. CNA E stated during her final rounds, toward the end of her shift, she heard a beeping noise coming from Resident #93's oxygen concentrator. CNA E stated she immediately reported the beeping to RN C. CNA E stated she was unsure what actions were taken after reporting the concern, as she continued with care for other residents. CNA E was unable to recall the exact time she reported the beeping but stated it was likely after 1:00pm. CNA E further stated she had entered Resident #93's room earlier that morning to empty her catheter bag and reported the oxygen concentrator appeared to be functioning at that time. She did not recall observing a red light on the concentrator during that encounter. CNA E was unable to recall the exact time of this observation but stated it occurred after 8:00am.Phone interview on 4/28/2026 at 8:09pm revealed MA A stated she had worked with Resident #93 on the morning of 4/28/2026. MA A stated she woke Resident #93 for her medications at approximately 7:00am, at which time the resident was observed to be without complaints. MA A recalled Resident #93 requested that the air conditioning be adjusted because she was cold. MA A stated she did not recall whether a red light was present on the oxygen concentrator but reported there was no beeping at that time. MA A stated she returned to Resident #93's room at approximately 11:50am to administer a medication shake and reported the resident continued to voice no concerns. She further stated she did not hear any beeping or observe a red light on the oxygen concentrator during that encounter. MA A stated Resident #93 was typically vocal and would use her call light if she felt unwell or was in distress. MA A reported Resident #93 consistently (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	used O2 via nasal cannula and used it 24/7. MA A stated if she had observed the concentrator beeping or displaying a red light, she would have notified the nurse.Phone interview on 4/29/2026 at 7:09am revealed CNA D stated she had worked with Resident #93 on the morning of 4/28/2026. CNA D stated she did not recall hearing any beeping from Resident #93's room and believed the oxygen concentrator was functioning during her observations. However, CNA D stated she did not assess the concentrator light or verify the flow rate setting. CNA D was unable to recall the specific times she checked on Resident #93 but reported she observed the resident throughout her shift. CNA D denied Resident #93 voiced any concerns and denied observing any issues with the oxygen concentrator.Interview on 4/29/2026 at 9:20am revealed RT B stated she was not the usual respiratory therapist for the facility and was serving as a temporary replacement for the RRT. RT B stated the regular RRT might return to the facility later. RT B reviewed Resident #93's physician's orders for oxygen and stated she was unable to clarify the order or determine the appropriate oxygen settings for the resident. RT B stated physician orders typically included a specified oxygen flow rate and reported she was unsure what the appropriate setting should be. RT B stated she would attempt to obtain clarification regarding Resident #93's oxygen therapy requirements.Observation and interview on 4/29/2026 at 9:30am revealed RT B and the surveyor entered Resident #93's room and observed a new oxygen concentrator on the right side of the resident's bed. Resident #93 was observed smiling with a nasal cannula in place and stated she was feeling much better. She reported staff had brought in a new oxygen concentrator on 4/28/2026 shortly after the surveyor left the room. Resident #93 stated she knew something was wrong the previous day because she had been coughing frequently and reported she now felt she was getting enough air following replacement of the oxygen concentrator. RT B was present in the room, and at the surveyor's request, Resident #93's O2 saturation level was assessed and measured at 95%-96% with the nasal cannula in place and oxygen flow rate set at 3 lpm. RT B stated she would consult with the MD to clarify the physician's order regarding the appropriate oxygen flow rate setting.Phone interview on 4/29/2026 at 10:20am revealed the NP stated the facility had contacted her to clarify Resident #93's oxygen therapy order; however, she stated the existing order remained appropriate and did not require a specified oxygen flow rate. The NP stated the intent of the order was to maintain Resident #93's O2 saturation above 90%. She explained that for patients with COPD, baseline O2 saturation levels may be lower than those of individuals without COPD. She further clarified the order indicated a typical range of 90%-92% but did not require maintaining the resident strictly within that range, rather ensuring levels remained above 90%. The NP stated there was no concern with O2 saturation levels exceeding 92% and noted Resident #93's baseline of approximately 98% while on O2 via nasal cannula was appropriate. The NP stated there was no fixed flow rate for Resident #93 and explained that titrate meant adjusting the oxygen flow as needed to maintain O2 saturation above 90%. The surveyor informed the NP of observations indicating the oxygen concentrator had not been functioning for approximately 5 hours. The NP stated she was unable to comment on the situation, as she was not present and could not verify the duration the resident was without oxygen. The NP further stated concern for respiratory distress would arise if the resident was without oxygen for a prolonged period, such as multiple hours or days, but reiterated she could not determine the impact without direct assessment of the resident at that time.Phone interview attempted on 4/29/2026 at 2:29pm with the MD. There was no answer and a voicemail was left requesting a return phone call.Interview on 4/29/2026 at 5:09pm revealed the RRT stated that a red light on an oxygen concentrator indicated a malfunction and the machine should be removed from service for maintenance. The RRT stated that even if the machine resumed functioning after displaying a red maintenance light, it should still be replaced and evaluated to determine the cause of the malfunction. The RRT was informed of the surveyor's observations on 4/28/2026 indicating Resident #93's oxygen concentrator was not functioning for approximately 5 hours. The RRT stated t would not pose a risk to Resident #93 and reported the resident had been observed without O2 previously without issue. The RRT denied knowledge of whether Resident #93 had previously gone (continued on next page)

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