STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455812	A. BUILDING _____ B. WING _____	**10/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FIRST COLONY HEALTH AND REHABILITATION CENTER	**4710 LEXINGTON BLVD MISSOURI CITY, TX 77459**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan for each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Resident #1) reviewed for care plan implementation. -The facility failed to follow physician orders [REDACTED].#1. This failure could place all residents receiving stoma care at risk of not receiving the care and services needed to meet their needs. Findings include: Record review of Resident #1's face sheet revealed a [AGE] year-old male who was initially admitted on [DATE] and readmitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed the resident had a BIMS of 9 out of 15 indicating the resident's cognitive function was moderately impaired. He required limited assistance with one person for bed mobility and transfer. He required extensive assistance with one person for dressing, toilet use and personal hygiene. He required supervision with set up only for locomotion on and off unit and eating. Record review of Resident's #1's care plan initiated on 1/1/20 and revised on 9/4/20 revealed the following: Focus: Resident #1 has laryngeal CA and has stoma and uses prosthesis, and he has impaired cognition, and impaired vision, and require monitoring and care of affected site and requires close monitoring and reorientation to ensure his daily needs are met. Goal: Resident #1 and staff will have sufficient communication, and the stoma site and the prosthesis will be cared as ordered on daily basis through next review date. Intervention: Monitor and provide care to stoma site as ordered. Record review of Resident #1's physician orders [REDACTED]. Record review of Resident #1's TAR/MAR dated 7/1/20 to 7/31/20 for cleanse stoma with normal saline twice daily and PRN revealed X marks twice at 6:00 am and 10:00 pm for dates 7/1/20 to 7/20/20 indicating the treatment did not occur. Record review of Resident #1's TAR/MAR dated 7/1/20 to 7/31/20 for [MEDICAL CONDITION] site for s/s of infection every shift: excessive secretions, redness, purulent drainage had blanks on the TAR indicating the treatment did not occur on 8/8/20 at 5:00 pm and 9:00 pm; 8/11/20 at 1:00 pm; and 8/12/20 at 1:00 pm. Record review of Resident #1's TAR/MAR dated 8/1/20 to 8/30/20 for [MEDICAL CONDITION] site for s/s of infection every shift: excessive secretions, redness, purulent drainage had blanks on the TAR indicating the treatment did not occur on 7/7/20 at 1:00 pm; 7/15/20 at 5:00 pm; 7/25/20 at 2:00 pm and 9:00 pm. Observation on 9/12/20 at 3:37 pm of Resident #1 in Barrington unit revealed he was not in his room. His bed was positioned in the lowest position. His bed was made. There was a manual wheelchair in his room facing the wall next to his end table. Observation and interview on 9/12/20 at 3:39 pm of Resident #1 revealed him sitting in his wheelchair in the community area with other residents. He had a 2 X 2 patch and/or covering over his voice box. He said he was doing fine and raised his hands in prayer and said, Thanks to God. He tried to communicate additional information, but he could not be understood. Head to toe visual assessment revealed no marks and/or bruises. He was not wearing his eye patch. Observation and interview on 10/2/20 at 8:45 am revealed Resident #1 sitting in the community living space. He had food stains on his pants. He had mucus in his stoma area. The mucus was clinging to his collarless shirt. He said he was doing fine. He said he had not had his pants changed in two days. He said he would like to have his pants changed. Observation and interview on 10/2/20 at 12:51 pm accompanied by the DON revealed Resident #1 eating lunch, ground beef and mashed potatoes and had a red drink. He had on clean khaki pants and his stoma area was cleaned and free of mucus/secretions. He clapped his hands together and said thank you when this Surveyor told him he looked very nice. In an interview on 9/12/20 at 4:51 pm with CNA B, she said she had worked at the facility for five or six months. She said she was more dedicated to memory care unit but, sometimes floated to other units. She said Resident #1 was a one person assist with dressing, bed mobility, transfers. She said he required limited assistance with toileting and personal hygiene. She said he was independent for eating. She said resident refuses care sometimes especially with changing his clothes. She said he wanders to other resident rooms and unplug their call lights. She said he was redirected each time he pulled call lights out. In an interview on 10/2/20 at 9:40 am with LVN, he said the RP told the nursing staff not to cover Resident #1's stoma so the secretions could come out. He said initially there was a physician's orders [REDACTED]. He said after the RP requested the nursing staff not cover Resident #1's stoma, the nursing staff called to update physician orders [REDACTED].#1 had physician orders [REDACTED]. This Surveyor told RN that Resident #1 had mucus secretion on his stoma site. He said he would clean Resident #1's stoma. He said it was important to keep Resident #1's stoma clean to prevent infection/bacteria. He could not recall the last time he was in-serviced for following physician orders. He acknowledged Resident #1's pants had food stains. He said Resident #1 refused to have them change his clothes at times. This Surveyor asked him if nursing staff had documented his refusal and he said no. In an interview on 10/2/20 at 11:53 am with DON, she said she started employment with the facility about two weeks ago. She said blanks in the MAR meant that it didn't happen. She said she always told staff, if it was not documented, it didn't happen and that's the standard. The DON confirmed physician orders [REDACTED]. She said the risk for the TAR/MAR not accurate was infection/bacteria. She said it was important that physician orders [REDACTED]. She said there was a potential for stoma care not being done because it wasn't documented. She said she did not know how long it had been since nursing staff were trained on accurate clinical documentation or following physician orders [REDACTED]. She said she was aware Resident #1 had pants with food stains and that his stoma had mucus secretion because the LVN brought it to her attention after Surveyor intervention. Record review of the facility's policy titled: Nursing Policies and Procedures revised 6/2019 read in part . Policy: The qualified nurse will perform a monthly recapitulation of all physician orders [REDACTED]. Qualified Nurse: is the nurse designated to review and correct physician orders. Items needed: 1. Resident medical record including previous month's physician orders [REDACTED]. Previous month's MARs/TARs. Procedures: A. Compare the previous and upcoming months' physician orders [REDACTED]. Check each and every physician order. 5. Once the upcoming month's physician orders [REDACTED]. Place the physician's orders [REDACTED].
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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** Based on observation, interview, and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for resident records. -The facility failed to maintain an accurate TAR/MAR record for stoma care/treatment for [REDACTED]. -The facility failed to transcribe Resident #1's diabetes medication per physician orders [REDACTED]. Findings include: Record review of Resident #1's face sheet revealed a [AGE] year-old male who was initially admitted on [DATE] and

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

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.

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) readmitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed the resident had a BIMS of 9 out of 15 indicating the resident's cognitive function was moderately impaired. He required limited assistance with one person for bed mobility and transfer. He required extensive assistance with one person for dressing, toilet use and personal hygiene. He required supervision with set up only for locomotion on and off unit and eating. Record review of Resident #1's care plan initiated 7/19/20 revealed the following: Focus: Resident #1 has Diabetes Mellitus Date Initiated: 08/07/2019 Revision: 09/04/20. Goal: Resident #1 will have no complications related to diabetes through the review date. Date initiated: 08/07/2019 Revision: 09/04/20. Interventions: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness; and dietary consult for nutritional regimen and ongoing monitoring. Date initiated: 08/07/19. Upon further review of Resident's #1's care plan initiated on 1/1/20 and revised on 9/4/20 revealed the following: Focus: Resident #1 has laryngeal CA and [MEDICATION NAME] uses prosthesis, and he has impaired cognition, and impaired vision, and require monitoring and care of affected site and requires close monitoring and reorientation to ensure his daily needs are met. Goal: Resident #1 and staff will have sufficient communication, and the stoma site and the prosthesis will be cared as ordered on daily basis through next review date. Intervention: Monitor and provide care to stoma site as ordered. Observation and interview on 9/12/20 at 3:39 pm of Resident #1 revealed him sitting in his wheelchair in the community area with other residents. He was wearing a plaid shirt with a collar; khaki pants and a baseball cap. He had a 2 X 2 patch covering stoma on his neck. He said he was doing fine and raised his hands in prayer and said, thanks to GOD. He tried to communicate additional information, but he could not be understood. Head to toe visual assessment revealed no marks and/or bruises. He was not wearing his eye patch. Record review of Resident #1's physician orders [REDACTED]. Record review of Resident #1's physician orders [REDACTED]. Record review of Resident #1's TAR/MAR dated 7/1/20 to 7/31/20 for cleanse stoma with normal saline twice daily and PRN revealed X marks twice at 6:00 am and 10:00 pm for dates 7/1/20 to 7/20/20 indicating the treatment did not occur. Record review of Resident #1's TAR/MAR dated 7/1/20 to 7/31/20 for [MEDICAL CONDITION] site for s/s of infection every shift: excessive secretions, redness, purulent drainage had blanks on the TAR indicating the treatment did not occur on 8/8/20 at 5:00 pm and 9:00 pm; 8/11/20 at 1:00 pm; and 8/12/20 at 1:00 pm. Record review of Resident #1's TAR/MAR dated 8/1/20 to 8/30/20 for [MEDICAL CONDITION] site for s/s of infection every shift: excessive secretions, redness, purulent drainage had blanks on the TAR/MAR indicating the treatment did not occur on 7/7/20 at 1:00 pm; 7/15/20 at 5:00 pm; 7/25/20 at 2:00 pm and 9:00 pm. Record review of Resident #1's MAR dated 7/1/20 to 7/31/20 for Glimepiride tablet 1 mg by mouth one time a day related to Type 2 Diabetes Mellitus was not transcribed to the MAR. Record review of Resident #1's MAR dated 8/1/20 to 8/30/20 for Glimepiride tablet 1 mg by mouth one time a day related to Type 2 Diabetes Mellitus was not transcribed to the MAR. Record review of Resident #1's MAR dated 9/1/20 to 9/30/20 for Glimepiride tablet 1 mg by mouth one time a day related to Type 2 Diabetes Mellitus was not transcribed to the MAR. Observation on 10/2/20 at 8:45 am revealed Resident #1 sitting in the community living space. He had food stains on his pants. He had mucus in his stoma area. The mucus was clinging to his collarless shirt. He said he was doing fine. He said he had not had his pants changed in two days. He said he would like to have his pants changed. Observation and interview on 10/2/20 at 12:51 pm accompanied by DON revealed Resident #1 eating lunch, ground beef and mashed potatoes and had a red drink. He had on clean khaki pants and his stoma area was cleaned and free of mucus/secretion. He clapped his hands together and said thank you when this Surveyor told him he looked very nice. In an interview on 9/12/20 at 4:51 pm with CNA B, she said she had worked at the facility for five or six months. She said she was more dedicated to memory care unit but, sometimes floated to other units. She said Resident #1 was a one person assist with dressing, bed mobility, transfers. She said he required limited assistance with toileting and personal hygiene. She said he was independent for eating. She said resident refuses care sometimes especially with changing his clothes. She said he wanders to other resident rooms and unplug their call lights. She said he was redirected each time he pulled call lights out. In an interview on 9/12/20 at 4:58 pm with MA, she said she had worked at the facility for 3 years. She said she administered medications to resident. She said she only gave resident one medication; it was a tablet. She confirmed there was no orders documented on the MAR for diabetes's (Glimepiride) medication. She said the resident was taking [MEDICATION NAME] (Doneparil) 1 tablet in the evening. She said she did not give insulin that was the nurse's role. She said she goes to the medication administration record to find out what medication to give to the residents and how much. In an interview on 9/12/20 at 5:16 pm with RN, she said she had worked at the facility for two months. She said he was taking Glimepiride for diabetes before but, he was no longer taking it. She said it was discontinued yesterday. She said he went for a doctor's appointment yesterday and that was when the doctor discontinued Glimepiride. She said resident was not on insulin and has never been on insulin. She said she monitored visually for signs and symptoms of [MEDICAL CONDITION] and [DIAGNOSES REDACTED]. She said she did not record and/or document her assessments. She said in [DIAGNOSES REDACTED], she looked for signs of clammy hands, sweating, shaking and trembling. She said in [MEDICAL CONDITION], she looked for signs of thirst, compulsive eating or weight loss. She said Resident #1 had never shown any signs and symptoms of hyper or [DIAGNOSES REDACTED] during her shift. She said the charge nurse was responsible for making sure the TAR/MAR were accurate. She said she did reconciliation of TAR/MAR and physician orders [REDACTED]. In an interview on 9/12/20 at 5:45 pm with LVN Supervisor, she said she had been at the facility only a few months. She said she was familiar with Resident #1. She said he had never been on insulin. She said his diabetes medication (Glimepiride) was discontinue late yesterday and she was in the process of updating his care plan. She said the nursing staff monitored for signs and symptoms, but documentation was only required for episodes. In an interview on 10/2/20 at 9:40 am with LVN, he said the RP told the nursing staff not to cover Resident #1's stoma so the secretion could come out. He said initially there was a physician's orders [REDACTED]. He said after the RP requested the nursing staff not cover Resident #1's stoma, the nursing staff called to update physician orders [REDACTED].#1 had physician orders [REDACTED]. He said he would clean Resident #1's stoma after Surveyor intervention. He acknowledged Resident #1's pants had food stains. He said Resident #1 refused to have them change his clothes at times. This Surveyor asked him if nursing staff had documented his refusal and he said no. He said nurses were responsible for ensuring resident's physician orders [REDACTED]. In an interview on 10/2/20 at 11:42 am with DON, she said Resident #1 was diagnosed with [REDACTED]. She said the resident went to the hospital on [DATE] for eye surgery and he returned on 4/17/20. She said the facility was responsible for obtaining a medication list from the hospital. She said diabetes medication was on his discharged medication list. She said the facility was responsible for notifying the RP on same day of admission of the resident's medication list. She confirmed the MAR had blanks for administering diabetes medication. She said if it was not documented then it meant that either physician orders [REDACTED]. She said it was important to be transcribed to the MAR because nursing staff used the MAR as a basis to follow physician orders. In a follow-up interview on 10/2/20 at 11:53 am with DON, she said she started employment with the facility about two weeks ago. She said blanks in the MAR meant that it didn't happen. She said she always told staff, if it was not documented, it didn't happen and that's the standard. The DON confirmed physician orders [REDACTED]. She said the risk for the MAR not be accurate was infection/bacteria. She said it was important to be transcribed to the MAR because nursing staff used the MAR as a basis to follow physician orders. She said there was a potential for stoma care not being done because it wasn't documented. She said she did not know how long it had been since nursing staff were trained on accurate clinical documentation or following physician orders [REDACTED]. She said she was aware Resident #1 had pants with food stains and that his stoma had mucus secretion because the LVN brought it to her attention after Surveyor intervention. In an interview on 10/2/20 at 2:21 pm with Administrator, he said he was aware the facility had issues with clinical documentation. He said the facility was amidst of an in-house correction plan that emerged out of QAPI. He said in PCC he was reviewing POC and EMAR documentation and ran a report called, missed medication audit report and brought discoveries to morning meetings. He said the DON got the medication issues and delegated to her nursing staff for corrections. He said the POC through the DON goes back to the staffing coordinator and the staffing coordinator got with the CNA's to make corrections. He said additionally every clinical meeting the facility reviewed every physician order, all new admissions/readmits assessments, all discharges, all changes in condition, and risk or incident/accidents, falls, skins, weights so by the time the meeting is concluded they had a good picture of what was going on with resident's health status/condition. He said they documented to do list and at the end of day, staff reported whether it got done. He said if it didn't get done, staff had to communicate why and provide reason for it not getting done. He said every Wednesday they did triple check (nursing, medical records and business, MDS, social services and therapy) to ensure they completed tasks on PCC for past week. He said once the system indicated they were completed with a green indicator, he as the Administrator locked the system to account for the past week. He said if there were blanks on the EMAR that meant that medications were missed or given but not documented. He said, either way, it's bad. Record review of the facility's policy titled, Nursing Policies and Procedures

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) revised on 6/2019 read in part . Policy: It is the policy of this facility that documentation pertaining to the resident will be recorded in accordance with regulatory requirements. Procedures: 1) The nursing staff will be responsible for recording care and treatment, observations and assessments and other appropriate entries in the resident clinical record. Medications and Treatments: 1) The qualified nursing staff notes the time, date and dosage of all medications and treatments at the time they are administered and initials the note on the medication and/or treatment record .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility did not maintain an infection prevention program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections in that: -Facility stored clean flat bed sheets in the soiled side of the laundry room. -CNA A failed to demonstrate proper hand hygiene and donning and doffing of PPE. These failures placed all residents at risk of cross contamination and infection. Findings include: Laundry Observation and interview on 10/2/20 at 2:45 pm, accompanied by the Administrator and Laundry Aide, revealed the soiled side of the laundry room had approximately 30 flat bed sheets green in color that were stored uncovered on a three-layered rack. The Laundry Aide said the facility did not use them any longer. The Administrator said the laundry staff used them as rags for cleaning. The Administrator said he would move them to the maintenance storage room. In an interview on 10/2/20 at 3:02 pm with the Administrator, he said the laundry room had two shifts: one from 6 am to 2 pm and 12:30 pm to 8:30 pm. He said the laundry staff were responsible for keeping their area clean. He said the laundry room had not had a supervisor for several months prior to him arriving at the facility. Record review of the facility's undated policy and procedure for infection control revealed it did not address storing clean linen. Observation on 09/29/20 at 3:42 p.m. during the demonstration of donning and doffing of PPE CNA A washed her hands, dried her hands with a paper towel, and used the same wet paper towel turn off the water faucet. Thereby contaminated her hand, and she proceeded to don on PPE. Upon demonstration of PPE removal, CNA A used the contaminated gloved hand to untie the non- disposable gown behind the neck and waist. Then she hung it up to be reused. Interview on 09/29/20 at 3:51 p.m., with CNA A, and she said she forgot to remove the glove the before she untied the grown and hanged it up. She said she contaminated the gown by not removing the dirty glove before untying the gown. CNA A said she contaminated her hand using the wet paper towel to turn off the water faucet. She should have used a dry paper towel. Interview on 09/29/20 at 4:00 p.m. with DON, and she said CNA A should have used a dry paper towel to turn off the water faucet to prevent contaminating her clean hands. By using the wet paper towel, she contaminated her hands and the PPE. DON also said CNA A contaminated the gown when she did not remove her dirty glove before untying the strings of the gown. She should have placed the gown in the trash bag instead of hanging it up to be reused. Record review of the facility in-service on proper donning and doffing and hand washing dated 08/28/20 revealed that CNA A's name was on the list for staff in-serviced. Record review of the facility COVID-19 infection control policy revealed, policy explanation and compliance guidelines; no 5d: educate staff on proper use of personal protective equipment protection.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a safe, sanitary environment for staff in 1 of 1 laundry rooms in that: -The facility failed to keep the laundry room clean and equipment/machinery clean. This failure placed residents whose items are laundered at the facility at risk of contamination which could result in illness. Findings Include: Observation and interview on 10/2/20 at 2:45 pm, accompanied by the Administrator and Laundry Aide, revealed the soiled side of the laundry room was dirty. The ceiling fan had a layer of dust; 2 of 2 washing machines had a caked film of spilled powder detergent surrounding the base of the washing machines which encompassed an area about 96 X 80 inches of space. The area next to the two facility's washing machines had a pallet approximately 48 X 40 inches of space that had layers of spilled powder detergent that covered the entire pallet; there was three containers of laundry chemicals (softener, suds and [MEDICATION NAME]) that sat on top of the pallet. The Administrator confirmed the layers of spilled powder detergent had been there for an extend period. He confirmed there was a caked film of laundry detergent surrounding the two facility's washers. He confirmed the new facility washer's lint cover was caked with lint/dust. He said he would get the ceiling fan cleaned to get the layer of dust off the fan guard. The sink in the clean linen area had a caked film of dirt with buildup calcium that encompassed the entire sink. The Administrator confirmed the sink located in the clean linen area had a caked film of dirt and calcium buildup that covered the entire handwashing sink. The lint trap filter on the middle dryer (1 of 3 dryers) was not attached to the bottom of the dryer because it was broken; it laid on the floor. Same dryer had the lint trap filter covered with lint indicating it had not been cleaned in an extend period. The Administrator confirmed the dryer vent to the middle dryer was covered with lint indicating the filter had not been changed. The laundry aide said it was supposed to be cleaned out after two dries'. The laundry aide said the laundry room was supposed to be cleaned after every shift. In an interview on 10/2/20 at 3:02 pm with the Administrator, he said the laundry room had two shifts: one from 6 am to 2 pm and 12:30 pm to 8:30 pm. He said the laundry staff were responsible for keeping their area clean. He said it was not an excuse to have the soiled area dirty because it was the soiled side of the laundry room. He said the laundry room had not had a supervisor for several months prior to him arriving at the facility. He said it was apparent that the laundry room had been dirty for a long while. He said the laundry aide resigned this Monday. He said he was already documenting her for poor performance. He said he was going to make sure the laundry area got cleaned up. He said he was going to in-service staff. He said the facility used an accountability system called TELS which was part of direct supply. He said he would be adding the laundry room to the system for cleaning and detailing tasks. When he saw the kind of situation that the laundry room was in, he said, so apparently the clothes getting back to the residents were not cleaned.