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 _____	03/13/2020

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 interview and record review, the facility failed to implement a comprehensive person-centered care plan for 1 of 8 residents (CR#1) reviewed for comprehensive care plans. -The facility failed to perform CR #1's blood sugar testing before meals as ordered by the physician. -The facility failed to administer [MEDICATION NAME] to CR#1 as ordered by his physician. These failures could potentially affect all residents with care plans. Findings include: Record review of CR#1's face sheet revealed he was a [AGE] year-old male who was admitted to the facility on [DATE] and was discharged on [DATE]. His [DIAGNOSES REDACTED]., pneumonia, [MEDICAL CONDITION] in [MEDICAL CONDITION], and [MEDICAL CONDITION]. Record review of CR#1's admission assessment notes dated [DATE] at 10:13 pm revealed his vital signs were blood pressure 140/79, respiration 18 with no skin issues. Right foot amputated, [MED]gen 3 liters on nasal cannula. Aspiration precaution should be taken. [MEDICAL TREATMENT] Monday, Wednesday and Friday, site on right chest. [DEVICE] present but it is clamped. Food and medications can be taken by mouth-crushed. He has peripheral vision only. Record review of CR#1's baseline care plan dated [DATE] revealed the resident needed one person's physical assistance for hygiene, dressing, bathing, bed mobility and transfer. Record review of CR #1's hospital Discharge orders dated 3/5/20 section entitled, Special Treatment and Procedures revealed in part, Other: Monitor blood sugar levels and blood pressure . both run on high end. Treat as directed. Record review of CR#1's physician's orders [REDACTED].= 0 units 151-200 = 3 units 201-250 = 5 units 251-300 = 7 units 301-350 = 9 units 351-400 = 11 units 401 + =13 units >401 give 13 units and call MD Subcutaneously every 6 hours as needed for diabetes sliding scale AC and HS (Active) Record review of CR#1's blood sugar check documentation revealed one check was done on [DATE] at 7:45 pm and it was 357. Insulin was given. Record review of CR #1's blood sugar check documentation revealed blood sugar check was done on 3/7/2020 at 10:42 am and it was 427 and insulin was given. The blood pressure was 154/72. Further record review revealed no documentation that the morning accucheck was done prior to breakfast on 3/7/2020. There was also no documentation the doctor was notified when the blood sugar was 427. Record review of CR#1's MAR indicated [REDACTED]. In an interview on 3/11/2020 at 8:15AM with CR#1's family member she said CR#1 was not given his medications and his blood pressure was high. He was sent to the hospital where they had to intubate him. She further stated when his blood pressure runs high he has nose bleed. In an interview on [DATE] at 2:58 PM with RN A revealed on 3/05/2020 she admitted CR#1 to the facility. She said on admission she assessed the resident. She said she then called the doctor to review the medication. The doctor instructed her to continue with the orders from the hospital. She said she checked the E-kit to see what medications were available and then called the pharmacy stat. She said she thought she had transcribed all the orders from the hospital to the nursing home records. In an interview on [DATE] at 3:30 PM with LVN A said she was called in to the facility to work and she got there about 9:00 AM. She said she did not know if the blood sugar was done before she got there. However, CR#1 family was in the room assisting him with eating and they requested for his blood sugar to be checked. She said she checked the blood sugar and it was 457 and she gave him 13 units of insulin and called the doctor. She said at that time CR#1's was having problems breathing and was having nose bleed. When the doctor did not answer she called 911 and the resident was sent to the hospital. In an interview on 3/13/2020 at 11:00 AM with LVN B who worked the 10:00 PM - 6:00 AM said she did not check CR#1's blood sugar (on 3/7/20) because the morning nurse usually did the blood sugar check. She said when she left that morning one of the day nurse was there and she counted her medications (narcotics) off with her. She said she did not know that the other nurse was late because no one told her she was going to be late. Record review of CR#1's Clinical Notes dated 3/07/2020, revealed no documentation the accucheck was done that morning before breakfast as ordered on [DATE]. Record review of the hospital notes for CR#1 revealed the resident was admitted to the hospital on [DATE] for shortness of breath and [MEDICAL CONDITION]. Further record review of the hospital laboratory result done on 3/7/2020 at 2:53 PM revealed a glucose level of 333 and a blood pressure of 191/92. In an interview with the DON on [DATE] at 3:00 PM regarding documentations for CR#1 she said she was new. She further stated that in nursing if it was not documented it was not done. Record review of the facility's Nursing Policies and Procedures read in part, .Subject: Physician order [REDACTED]. Procedures: Admission: 1) The qualified licensed nurse reviews orders from the transfer record from an acute care hospital or other entity. 2) A call is placed to the physician to confirm the orders and request any additional orders as needed. In the event the physician writing the transfer order is not credentialed by the facility, the designated attending physician is contacted to confirm the transfer orders and request any additional orders. Medication/treatment 2. Transcribe the order into the Medication Administration Record [REDACTED]. Subject: Blood Glucose Monitoring Policy: Bedside blood glucose monitoring will be performed by qualified medical personnel with a physician's orders [REDACTED]. Only medical personnel may perform a glucose test. All test will be recorded in the resident's medical record. Procedures; 16. Write the results of the test in the resident's medical record 17. Notify the physician if the result is out of the specific range. .
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in that: Cook A did not change gloves or use tongs to pick up ready to eat food. Sanitizing solution and red bucket was not accesable to wipe counter tops. Equipment was not clean. Food was not at the correct holding temperature. Missing base board at the walk-in-freezer. These failures affected all residents who ate food prepared by the facility's kitchen by placing them at risk of foodborne illness. Findings include: Observation 03/13/2020 beginning at 12:30 PM during lunch service revealed the following: A tray with cooked chicken on the counter and not on the steam table with a temperature of 102 degrees. Potato Salad in a pan of cold water with no ice in the pan with a temperature of 67 degrees. Cook A wore the same gloves to pick up plates, open microwave pick up rolls and put them on resident's plate. In an interview with Cook A on 3/13/2020 at 12:35 PM she said the facility did not have any more holding pans and that was why the chicken was on the counter. She said they had ordered more pans but had not received them yet. She said she was doing the best with what she had. During an interview on 3/13/2020 at 12:40 PM the Dietary Manager said she was new to the facility and was in the process of addressing issues in the kitchen. She said she was going to work on getting more holding pans for the kitchen. At that point she instructed Cook A to reheat the chicken and dispose of the potato salad and serve mashed potatoes instead. Further observation of the Kitchen on 3/13/2020 beginning at 12:40 PM revealed the following: The convection oven with an accumulation of grease and burnt food particles. The inside of the

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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) oven was black and the oven doors had a yellow greasy substance on them. There were wipe cloths on the preparation table and there was no red bucket with sanitizing solution available. There was a missing base board at the walk-in-freezer. In an interview on 3/13/2020 at 12:45 PM the Dietary Manager said she was going to have staff clean the oven. She then instructed the staff to get a red bucket with sanitizing solution to put the wipe cloth in. Record review of the Nutrition Services Policy and Procedures revised 6-2019 read in parts . Subject: Safe Food Preparation Policy: During food production process, food will be handled by methods to minimize contamination and bacterial growth to prevent food borne illness. Procedures: 1. Prepare foods in a sanitary manner with minimal handling. When feasible, foods are prepared the same day as service and as close to the time of service as possible . 3. Time/Temperature control for safety (TCS) foods shall be in the temperature zone (41-140) no more than four hours throughout the entire food handling process . 10. Avoid touching ready to eat foods that are no subsequently cooked with bare hands. Use tongs (or other utensils) or gloves instead. When gloves are worn they are clean, without tears, and changed between task and whenever you leave the kitchen. They are also changed after sneezing, coughing, or touching hair or face . Subject: Sanitation & Food Safety in Food Service The Nutrition/Culinary Service Director (NSD) will assume responsibility for food safety and sanitation of nutrition Culinary Department. Procedures: 1. Infection control and sanitation practices are followed to minimize the risk of contamination of food and prevent food borne illness. Should a foodborne illness outbreak occur, the local health department is notified . 3. The NSD develops, implements and monitors a cleaning schedule that assigns specific cleaning responsibilities to specific individuals. Cleaning tasks are initialed as they are completed . 7. The NSD provides written cleaning instructions for each area and piece of equipment in the kitchen .
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 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 8 residents (CR #1) reviewed for clinical records in that: CR #1's clinical record did not completely and accurately reflect the course of treatment of [REDACTED].#1's physician's transfer order did not include the monitoring of high blood sugar and blood pressure. CR #1's physician's transfer order did not include feeding tube care, or [MEDICAL TREATMENT] left AVG and right Quinton cath care. CR #1's physician's transfer order did not include all of his medications. These failures placed all residents at risk for incomplete and inaccurately documented medical records. Findings include: CR#1 Record review of CR#1's face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE] and was discharged on [DATE]. His [DIAGNOSES REDACTED]. Record review of CR #1's hospital discharge order dated 3/5/20 revealed Special treatment and Procedures Feeding Tube Care: Wash with soap and water: peg tube clamped/not in use [MEDICAL TREATMENT]: Left AVG and Right Quiton Cath. Ipratropin [MEDICATION NAME]/[MEDICATION NAME] 3 ml inhalation med nebulizar solution q6h prn for shortness of breath, wheezing. [MEDICATION NAME] 40 mg po, tab daily, first dose 03/06/20 at 09:00 [MEDICATION NAME] 20 mg po, tab daily, first dose 0[DATE] at 09:00 [MEDICATION NAME] 10 mg po tab daily, first dose 03/12/20 at 09:00 physician's orders [REDACTED].#1's MAR for March 2019 revealed no documentation that the feeding tube care and [MEDICAL TREATMENT] left AVG and right Quinton Cath was done. There was no documentation that an accucheck was done at AC on 3/7/3020. Further record review of the transfer order revealed that [MEDICATION NAME]/[MEDICATION NAME] 3 ml inhalation med nebulizar solution q6h prn for shortness of breath, wheezing. [MEDICATION NAME] 40 mg po, tab daily , first dose 03/06/20 at 9:00 [MEDICATION NAME] 20 mg po, tab daily first dose on 03 /10/20 at 09:00, [MEDICATION NAME] 10 mg po tab daily first dose 3/12/20 at 9:00 was not documented in CR#1's clinical records. In an interview on [DATE] at 2:58 PM with RN A revealed that on 3/05/2020 she admitted CR#1 to the facility. She said on admission she assessed the resident, then called the doctor to review the medications. The doctor instructed her to continue with the orders from the hospital. She said, she check the E-kit to see what medications were available and called the pharmacy stat. She said she thought she had transcribed all the orders from the hospital to the nursing home but said it was really busy so she must have missed the other orders. In an interview on 3/12/20 at 3:00 PM with the DON, she said she was new. She said she would have to have a nurse in charge of admissions to ensure admission orders [REDACTED]. Record review of the facility's Nursing Policies and Procedures read in part, .Subject: Physician order [REDACTED]. Procedures: Admission: 1) The qualified licensed nurse reviews orders from the transfer record from an acute care hospital or other entity. 2) A call is placed to the physician to confirm the orders and request any additional orders as needed. In the event the physician writing the transfer order is not credentialed by the facility, the designated attending physician is contacted to confirm the transfer orders and request any additional orders. .