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 _____	**07/24/2020**

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 0559 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a written notice of room change was received, incluidng the reason the room was changed, for 1 of 1 residents (CR #1) reviewed for notification of room change. -The facility failed to provide evidence that CR #1's RP was given a written notice of a room change before the resident was moved. This failure could place all residents at risk for being displaced without notice and/or reason, to accommodate other individuals. Findings Include: Record review of CR #1's Admission Record, dated [DATE], revealed CR #1 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED].#1's Quarterly MDS assessment, dated [DATE], revealed CR #1 had a BIMS of 00 indicating severly impaired cognitive skills. Record review of CR #1's care plan dated [DATE] revealed CR #1 had impaired cognitive function. Record review of CR #1's clinical record revealed there was no documentation that the family/Responsible Party of CR #1 had been notified the resident's room had been changed due to resident testing positive for COVID-19. This record review revealed the facility learned of CR #1's positive status on [DATE] and the resident passed away on [DATE]. Interview on [DATE] at 10:58 a.m. with a family member of CR #1 she said the facility told her CR #1 was being tested for COVID but no one notified her or her other family member that CR #1 tested positive or that her room was changed. She said she was notified by the police that CR #1 was deceased , and if they come to the facility to identify the body. She said when she got to the facility the door was propped open and so she entered the facility and went to CR #1's room only to be redirected by staff to the COVID unit. She said the nurse finally came out and told them to come on the unit. She said she asked the nurse when the residents room was changed and when was resident diagnosed with [REDACTED]. Interview on [DATE] at 4:10 p.m. the Administrator he said to be honest they have not been doing a real good job at contacting family. He said the facility communication with family was not good, but he was working on that. Interview on [DATE] at 12:00 p.m. the Social Worker said he has been helping nursing to make calls to the family to report COVID positive results. He said in that call he would let the family know the room would be changed. He said there was no protocol per se when they get a positive result who will call the family. He said each staff person would take a stack of results and call the families. He said he would document in the chart the families that he contacted. He looked at his list and said CR #1's family was not one that he notified. Interview on [DATE] at 2:04 p.m. with LVN A she said the family of CR #1 came to the facility to identify the body at the police request. She said when the family got to the facility they were on the isolation hall. She said the family told her they did not know CR #1 had been moved to the COVID hall. LVN A did not know when the resident was moved to the COVID unit. Record review of the facility policy titled Dignity Resident's Rights for dated ,[DATE] read in part, .notify the resident/legal representative or interested family member before there is a room change .
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately inform the residents representative when there was a change in condition for 1 of 10 Residents (CR# 2) reviewed for notification of changes. -The facility failed to notify CR #2's representative when CR#2 was sent to the hospital. This failure affected one former resident and placed all Residents at risk for violation of their rights. Findings Include: Record review of the face sheet for CR#2 revealed an [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE]. His [DIAGNOSES REDACTED]. CR#2 was discharged to the hospital on [DATE]. There were two responsible parties listed on the face sheet. Record review of the quarterly MDS assessment for CR#2 revealed he had a BIMS of 5 out of 15 indicating that he had severe cognitive impairment. Record review of CR#2's care plan (undated) read in part, .FULL CODE .Responsible party requests full code status . Monitor for decline in change of condition .report to M.D. and responsible party . Record review of CR#2's progress notes dated 06/15/20 written by LVN B, read in part, .Resident looks lethargy (sic), not eating well, and spit anything that is put in his mouth. Vital signs: BP 108/65, HR 110 .primary care provider responded with .send resident to the hospital for further evaluation . Record review of CR#2's SBAR communication form dated 06/15/20 completed by LVN B under section name of family/health care agent notified it said attempted three to call family, but no respond. Date 06/15/20 at 2:00 pm. Phone Interview with family member on 6/16/20 at 2:30 pm, she said the facility did not notify them of CR#2 being sent to the hospital. She said they found out CR#2 was in the hospital by a family friend who happened to be at the hospital. She said she was not one of the persons listed as Responsible Party, but said the person who was listed was also not contacted. Phone interview with LVN B on 6/16/20 at 3:17 pm, she said she was the nurse assigned to CR#2 on 06/15/20. She said she checked his vitals and heart rate was tachy ([MEDICAL CONDITION]-fast heart rate) and his normal vital sign it was normal but when she went back to check it was low and he did not look good to her. She said the NP saw CR#2 during rounds with phone, and NP said lets send him out because blood pressure was low and he didn't look well. She said she called family 3 times and it was not working. She said it seemed like the phone was off the hook. She said the first time, it said phone disconnected, 2nd time it was same thing. When asked if she tried to call again at a later time or check to see if there was another number listed, she said she could not remember. When asked what she was supposed to do if they were unable to get ahold of the RP, she said they were supposed to continue trying. Interview with Interim DON on 6/16/20 at 3:35 pm, he provided surveyor with copy of in-service they did for notification of family. Surveyor asked why they did this in-service. He said that because there was concern that nurses were not notifying family of changes. He said yesterday there were issues with T-Mobile so several lines were not working and today a family member called and said they were not notified of resident being sent to the hospital. He said he spoke with LVN B and she said she tried to call but it would not go through. He said that Responsible Parties should be notified of any changes including when resident is sent to the hospital. She said staff were supposed to continue to make attempts to contact the family. Record review of the facility's policy for change in condition communication revised on 06/19 read in part, .the patient/resident and patient's/resident's family member .will be notified of any changes in medical condition or treatment plan .will be notified of any change in condition requiring an emergent transfer to the hospital .all attempts to notify .family members .will be thoroughly documented in the resident's medical record .

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.