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 _____	**08/21/2020**

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 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 observation, interview, and record review, the facility failed to immediately inform the residents representative and consult with the physician when there was a change in condition for 1 of 8 Residents (Resident#1) reviewed for notification of changes. -The facility failed to notify Resident #1's representative and consult with his physician when Resident #1's right eye was found swollen and red. This failure placed all Residents at risk for a violation of their rights and of physician and family/responsible party not being informed of a change in condition. Findings Include: Record review of the face sheet for Resident #1 revealed he was an [AGE] year-old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #1's progress notes dated 12/16/19 written by RN C revealed a note that read, his right eye is swollen and reddened. Informed np. Waiting for reply.plz follow up. Further review of Resident #1's progress notes revealed no other documentation related to this note. Further review of Resident #1's progress notes revealed no documentation of any follow up regarding his eyes by RN C. Phone Interview with RN C on 5/28/20 at 12:21 pm, she said she was a full time RN at the facility. When asked if she remembered Resident #1, she said she did. Surveyor read the note dated 12/16/19 to her and asked if she remembered writing that note or anything about Resident #1 during that time frame. She said, No I am sorry, it was so long time ago I can't remember anything. She said she did recall Resident #1 being on an eye drop but could not remember which one it was. She apologized for not being able to remember anything else. When asked if she thought she did any follow up after this note, she said she could not remember and if she did not document then that probably meant she did not. She said they were supposed to notify the RP and follow up with the physician in situations like this note. Record review of Resident #1's care plan initiated on 4/22/20 read in part, the resident has impaired visual function .interventions .arrange and follow up with eye care practitioner as required .monitor/document/report any s/sx of acute eye problems . There was no care plan to address his visual function prior to 4/22/20. Record review of Resident #1's significant change in status MDS assessment dated [DATE] revealed his BIMS was 9 out of 15 indicating that he was moderately impaired. Further review of the section for vision revealed that he was coded as moderately impaired in vision. Observation of Resident #1 on 8/21/20 at 12:15 pm, revealed Resident #1 in the Barrington unit. He was well groomed and sitting in his wheelchair. He parked his wheelchair, stood up to put his sweater and hat on and sat back down. Surveyor waved to him saying hi resident waved back and smiled at surveyor. His right eye was shut. There was no visible scaring or bruising around his eye. Interview with DON and ADON on 8/11/20 at 11:15 am, when asked regarding the note on 12/16/19 the DON said, there should have been a follow up, it should have been addressed. The DON said the family should have been notified and there should have been more documentation regarding the issue. It should not have been left like that, some type of follow up should have been made. They agreed that since there was no further documentation, they could not tell if anything was done regarding the issue. Record review of the facility's policy for change in condition communication revised on 06/19 read in part, .notify the physician of the change in medical condition .the nurse will document all assessments and change in the .resident's condition on the medical record .if the physician does not respond within an acceptable time frame, the Medical Director and Director of Nursing will be notified .The Medical Director will provide medical orders as necessary to treat the patient's condition .residents family member will be notified of any change in condition .
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of eight residents reviewed for quality of care. -The facility failed to assess and treat Resident #1's right eye when it was found swollen and red. -The facility failed to follow Resident #1's antibiotic order for his right eye as prescribed by his ophthalmologist in April 2020. Resident #1 had surgery on 4/16/20 for enucleation (removal) of right eye. These failures could affect all residents and place them at risk of decreaased quality of care and negative outcomes. Findings Include: Record review of the face sheet for Resident #1 revealed an [AGE] year-old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Observation of Resident #1 on 8/21/20 at 12:15 pm, revealed Resident #1 in the Barrington unit. He was well groomed and sitting in his wheelchair. He parked his wheelchair, stood up to put his sweater and hat on and sat back down. Surveyor waved to him saying hi resident waved back and smiled at surveyor. His right eye was shut. There was no visible scaring or bruising around his eye. Record review of Resident #1's progress notes dated 12/16/19 written by RN C revealed a note that read, his right eye is swollen and reddened. Informed np. Waiting for reply.plz follow up. Further review of Resident #1's progress notes revealed no other documentation related to this note. Further review of Resident #1's progress notes dated 04/12/20 written by LVN A revealed a note that read in part, .Resident was observed with swelling, bloody and pus like drainage from the (R) eye .NP ordered to be transferred to .hospital . Record review of the SBAR for Resident #1 dated 04/12/20 completed by LVN A read in part, .swelling, bloody and pus like drainage was observed from the R eye .NP was notified .911 was called . Record review of Resident #1's hospital, after visit summary dated 04/12/20 read in part, [DIAGNOSES REDACTED].abrasion of right cornea .medications .Moxifloxacin 0.5% ophthalmic solution (used to treat eye infections), administer 1 drop to the right eye 4 times a day for 7 days . Record review of Resident #1's physician order [REDACTED].patient given a prescription for Moxifloxacin ophthalmic solution to be used (1 drop into R eye every hour) . Record review of Resident #1's physician orders [REDACTED]. Record review of Resident #1's MAR/TAR for April 2020 revealed he was given Moxifloxacin 0.5% ophthalmic solution, administer 1 drop to the right eye 4 times a day on 4/13/20 and 4/14/20 (he was in the hospital after that date). Record review of Resident #1's progress notes for April 2020 revealed no documentation to reflect any communication with the physician or Local Eye Specialist to verify orders for his Moxifloxacin. Record review of Resident #1's medical file revealed that he was sent to the hospital on [DATE] and returned to the facility on the same day (4/12/20). Record review of Resident #1's hospital records dated 4/16/20 read in part, .[DIAGNOSES REDACTED].acute bacterial [MEDICAL CONDITION] of right eye .right endophthalmia (inflammation in the tissue within the eye ball) .plan enucleation right eye .in our best medical judgement, this surgery is emergent/urgent .there is significant medical risk of patient deterioration if this surgery is not urgently performed .the patient and family voiced understanding and gave their consent to proceed . Further review of the hospital records, did not reveal a discharge summary. Record review of Resident #1's care plan initiated on 4/22/20 read in part, 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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) resident has impaired visual function .interventions .arrange and follow up with eye care practitioner as required .monitor/document/report any s/sx of acute eye problems . There was no care plan to address his visual function prior to 4/22/20. Record review of Resident #1's significant change in status MDS assessment dated [DATE] revealed his BIMS was 9 indicating that he was moderately impaired. Further review of the section for vision revealed that he was coded as moderately impaired in vision. Phone Interview with RN C on 5/28/20 at 12:21 pm, she said she was a full time RN at the facility. When asked if she remembered Resident #1, she said she did. Surveyor read the note dated 12/16/19 to her and asked if she remembered writing that note or anything about Resident #1 during that time frame. She said, No I am sorry, it was so long time ago I can't remember anything. She said she did recall Resident #1 being on an eye drop but could not remember which one it was. She apologized for not being able to remember anything else. When asked if she thought she did any follow up after this note, she said she could not remember and if she did not document then that probably meant she did not. She said they were supposed to notify the RP and follow up with the physician in situations like this note. Interview with DON and ADON on 8/11/20 at 11:15 am, when asked regarding the note on 12/16/19 the DON said, there should have been a follow up, it should have been addressed. They said the family should have been notified and there should have been more documentation regarding the issue. It should not have been left like that, some type of follow up should have been made. They agreed that since there was no further documentation, they could not tell if anything was done regarding the issue. When asked about the Moxifloaxin, the DON said the facility should have called and got clarification on the order. When there are 2 different orders like that, we need to get clarification. DON was asked if anything was mentioned on the 24 hour log regarding the resident's eyes, she said that she would check but does not believe there was. Phone interview with the Clinical Consultant with the Local Eye Specialist on 8/11/20 at 1:00 pm, when asked about the order that was written for Resident #1 on 04/12/20 by the Ophthalmologist, she said based on the pictures that the family member of Resident #1 had sent to them and concerns from the facility the Doctor did want for Resident #1 to be on Moxifloxacin drops and for those drops to be put in every hour until seen by his primary Ophthalmologist. She said this was communicated to the facility verbally and she also sent the email stating this to the facility. She said she had communicated everything with the facility. She said she even let the NP know because the NP had called her to confirm the drops Resident #1 needed to be on before and after his surgery. Phone interview with NP on 8/12/20 at 1:15 pm, she said the only time she could remember the facility calling her regarding Resident #1's eyes was in April. She said when they notified her of the eye issues, she gave order to send him out to the hospital. She said that was the only time they had ever contacted her regarding his eyes. She said she did not recall communicating with the Local Eye Specialist regarding his eye drops but the facility should follow whatever order is given by the Resident's Ophthalmologist because he was the specialist. Record review of the facility's policy for change in condition communication revised on 06/19 read in part, .notify the physician of the change in medical condition .the nurse will document all assessments and change in the .resident's condition on the medical record .if the physician does not respond within an acceptable time frame, the Medical Director and Director of Nursing will be notified .The Medical Director will provide medical orders as necessary to treat the patient's condition .residents family member will be notified of any change in condition . Record review of the facility's policy for Physician orders [REDACTED].the qualified licensed nurse reviews orders from the transfer record from an acute care hospital or other entity .a call is placed to the physician to confirm the orders and request any additional orders as needed .
F 0740 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 1 of 5 residents (Resident #2) reviewed for behavioral health. -Facility failed to have appropriate monitoring in place for Resident #2's inappropriate sexual behaviors that could place female residents at the facility at risk of sexual abuse. This failure could affect all residents and place them at risk of not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being. Findings Include: Resident #2 Record review of Resident#2's face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident#2's comprehensive MDS assessment dated [DATE] revealed a BIMS of 09 out of 15 indicating moderately impaired cognitively. He required extensive assistance from staff for toilet use, transfer, bed mobility, dressing and personal hygiene. Resident #2 was always incontinent of bowel and bladder. Further review of Section E Behavioral Symptoms revealed Resident #2's behavior not exhibited for A. physical behavioral symptoms directed towards others (e.g., grabbing, abusing other sexually) C. other behavioral symptoms not directed towards others (e.g., physical symptoms such as rummaging, public sexual acts). Record review of Resident #2's care plan initiated 2/28/20 and revised on 8/10/20 revealed the following care plan: Focus: The resident has a behavior problem (touching female resident in appropriate (sic) Goal: The resident will have fewer episodes of (touching female resident) (daily) by review date. Interventions: 8/10/20 one on one care monitoring with resident for behavior. 2/28/20 Administer medications as ordered. Monitor/document for side effects and effectives. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation. Record review of complaint intake # 6 dated 8/9/20 read in part: . I stood behind the double doors of the COVID unit in order to observe the PPE practices. I noticed a male resident on a wheelchair next to a female resident. She was standing near him and he grabbed her hand and his other hand was grabbing her crotch area. I could tell that the female resident had some form of dementia so I immediately told [MEDICATION NAME] First Colony administration about what I observed. They were a few feet away from me and came to tell the nurse who was already inside of the unit to have the male resident go back to his room. [MEDICATION NAME] First Colony Administration then continued to discuss my findings of the Infection Control Audit. but I kept focusing my attention on the hallway as I noticed that the male resident was still grabbing the female resident, now with his hand going inside of her shirt and touching her chest area. I escalated this immediately to [MEDICATION NAME] First Colony Administration and they told the nurse to place him in his room. No one from [MEDICATION NAME] First Colony Administration would go into the COVID unit to help the nurse with the patient. I noticed that the male resident still hadn't gone to his room and that he was still grabbing the female resident. This is when I began to say: I do not feel comfortable with this situation, she is being harassed. I am concerned that nothing is being done to protect this female patient and that she is constantly being sexually assaulted by the male resident. I am concerned that the staff at [MEDICATION NAME] First Colony are allowing this behavior to persist and are not ensuring the safety of all of their residents . Record review of incident # 5 dated 8/7/2020 read in part: .during rounds the staff from the health dept. witnessed through the window resident #2 feeling resident #3's breasts in the hallway. There were no adverse effects as she has dementia and did not recall the incident. Social worker is working on discharge planning for resident #2. The police were called and attempted an interview with resident #3 but she did not want to participate. families were called . Record review of facility's provider investigation report dated 8/13/20 Investigation Summary revealed read in part: .The administrator included multiple members of the leadership team, instructed to begin 1:1 monitoring, and to begin the process of discharging the male resident to a more appropriate facility. All was done to provide safety to all femal residents. Administrator requested a number of in-services be conducted including: 1)ANE, 2) Notice of Transfer, 3) Resident to Resident Altercation, 4) Ambassador Rounds, and 5) Who to contact about incidents and accidents. Adminstrator and Social Workers are continuing to communicate with the family and Ombudsman about transfer from Ocean's Behavioral to another, more appropriate long-term facility . Record review of Resident #2's nurses note dated 1/7/20 read in part: .attempted to kiss Resident #3 . Record review of Resident #2's nurses note dated 2/28/20 read in part: .attempted to kiss Resident . Record review of Resident #2's psych consult dated 3/13/20 written by PMHNP read in part: .indicates reasons for seeing is due to patient touching female clients inappropriately increase [MEDICATION NAME] medication . Record review of Resident #2's psych consult dated 4/15/20 written by PMHNP read in part: .patient advised to maintain distance from all other clients and staff . Record review of Resident #2's nurses note dated 4/17/20 read in part: .moved to another unit due to sexual behaviors . Record review of Resident #2's psych consult written by PMHNP dated 5/14/20 read in part: .there is disinhibition behavior of touching females, however behavior has been less . Record review of Resident #2's nurses note dated 5/24/20 read in part: . Resident #2 observed pulling up a female's blouse, grabbing her arms . Record review of

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F 0740 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Resident #2's nurses note dated 5/27/20 read in part: .ongoing sexual behaviors-attempting to touch females . Record review of Resident #2's nurses note dated 5/28/20 read in part: . increase [MEDICATION NAME] medication . Record review of Resident #2's nurses note dated 6/3/20 read in part: .changed medication to [MEDICATION NAME] 10 mg TID . Record review of Resident #2's nurses note dated 6/10/20 read in part: .increase [MEDICATION NAME] medication . Record review of Resident #2's psych consult written by PMHNP dated 6/20/20 read in part: .keep away from female residents. If behaviors persist will need to sent to Oceans . Record review of Resident #2's nurses note dated 7/4/20 read in part: .pulled up shirt of Resident #3. Resident #3 was saying NO at the time. Note states continue to monitor . Record review of Resident #2's nurses note dated 8/7/2020 read in part: . i saw resident was grabbing other female resident hand , putting his hand under the shirt and trying to hold breast. i immediately went there and separated both of them. educated it is a inappropriate behavior you should stop it and do not repeat it. called family ,np, admin,don.resident is now under one on one observation by CNA to prevent further incidents in future . Record review of Resident #2's nurses note dated 8/8/2020 read in part: . SW received notification of resident fondling a fell ow resident (initials) while on the covid unit. This is not the first incident of this kind on several previous occasions attempts have been made to address the behavior via hospitalization or relocation to a different facility. The resident has a history of this type of behavior based on his persistency hospitalization is warranted. The residents RP has been apprised of his behavior along with the continuity of care plan. The resident is presently being monitored on a one to one basis to ensure the safety of the other residents . The resident information was forwarded to Oceans behavioral . Record review of Resident #2's nurses note dated 8/8/2020 read in part: . Administrator discussed self report with both family members. They had many questions and asked about the next steps. Administrator was very open and forth right as to plans to discharge resident. Until such discharge occurs, the resident will be monitored 1:1 with a staff member to provide adequate supervision in an attempt to mitigate a recurrence. Family Members understand SW is working on finding a facility and they too will look for a facility . Record review of Resident #2's nurses note dated 8/10/2020 read in part: . Resident was monitored during evening shift until 10pm,after 10pm night shift continued to monitor resident.Resident slept all night stayed in his room,no problems,stable and VS within normal limits.Call light is within reach . Record review of Resident #2's nurses note dated 8/10/2020 read in part: .Follow up resident continues to remain on one to one monitoring. other have been no other reported incidents. The resident that he was witness groping (RS) has been moved to the Barrington unit. SW will attempt to obtain alternative placement . Record review of Resident #2's nurses notes for the month of May, June and July 2020 revealed the physician and RP were not notified each time. Record review of Resident #2's nurses note dated 8/10/2020 read in part: . Resident has been accepted in Oceans Behavioral Hospital Katy. Per RP states that she was informed by the ombudsman that she must be given a 30 day discharge. RP was informed based on the residents behavior he represents a safety threat to the other female residents. This represents the second time that an incident has occurred with the same resident whether she is his target or it is just a matter of opportunity is unknown however this behavior has reached a threshold in which transfer is necessary for the safety of fell ow residents and himself. RP was informed that the resident will be discharged to Oceans Behavioral of Katy and upon discharge will not be accepted back into the facility . Record review of Resident #2's MAR and TAR for the month of June 2020 revealed there was no sexual behavior monitoring or interventions in place to monitor Resident #2's sexual behavior. There was no MD's order to do behavior monitoring. Record review of Resident #2's consolidated orders for the month of June 2020 revealed there were no MD orders for monitoirng behaviors, supervision. In an interview on 8/11/20 at 12:05 pm with the Administrator and DON, the Administrator said during rounds on 8/7/2020 the staff from the health department witnessed, through the window, Resident #2 feeling Resident #3's breasts in the hallway. He said Resident#2 was placed on 1:1 and discharged to Oceans Behaviors for medication evaluation as he had had similar behaviors in the past. Resident #3 was moved back to the memory care unit. In an interview on 8/12/20 at 11:23 am with the Social Worker, he said the Resident #2 was receiving psych services. When made aware of this incident, the resident was separated, placed on 1:1 and discharged to Oceans Behaviors. He said the facility was not going to take the resident back. He said the resident's family was not happy with this decision and stated that could possibly be the other person initiating things with the resident first. The social worker said that since this was not new behavior, they were trying to address it properly this time. In an interview on 8/12/20 at 1:13 pm with Resident #2's family member, she said she received a call from the Administrator that they have discharged Resident #2 to Oceans Behaviors and they will not be accepting him back. She said due to the pandemic and with an accusation like sexual behavior, no facility was going to accept the resident. She said she also called the Ombudsman who notified her that the facility needed to give a 30 day discharge notice first. She said she was Resident#2's responsible party and she was not aware of Resident #2's sexual behaviors. In an interview on 8//12/20 at 1:41 pm with the Administrator, he said he discharged Resident#2 because he did not want Resident #2 continuously abusing the females in the memory care unit. He said after he witnessed the incident on 8/7/20 he looked back in Resident#2's chart and that made him decide he couldn't keep Resident #2 in this building any longer. He said the social worker was willing to help the family find more suitable placement since Resident #2 puts female residents and staff at risk at the facility. He said this pattern should have been addressed properly. In an interview on 8/13/20 at 11:20 am with LVN A, he said there were 14 males and 15 females residing in the memory care unit. He said Resident #2 had extreme sexual behaviors which started to be more noticeable about 2 to 3 months ago when he began to get close to the female residents. He said the staff working on this unit were aware of his behaviors and would remove him quickly away from the females and take him to his room. LVN A said they would try to distract Resident #2 by offering him snacks or have him listen to music on YouTube. LVN A said there was no 1:1 staff assigned to Resident #2 for sexual behaviors and only general monitoring was in place like it was for all the residents in the memory care unit. In an interview on 8/13/20 at 11:25 am with CNA A, she said Resident #2 would touch women. She said staff would tell him to stay away and not touch others in an inappropriate way. She said Resident #2 enjoyed eating and staying in his room most of the time. She said Resident #2 did not have sexual behavior all the time but did have them quite a few times. She said it started 2 to 3 months ago. In an interview on 8/13/20 at 11:46 am with Medication Aide A, she said Resident #2 exhibited sexual behaviors. She said he would try to touch female residents inappropriately. When staff saw him doing that, they would separate the resident and attempt to redirect him. She said there were no other residents in the memory care that displayed any sexual behaviors at this time. In an interview on 8/13/20 at 12:14 pm with the DON, she said she was employed since July 7, 2020. She said after this incident on 8/7/20 staff started coming forward and talking about it. She said she was not aware that Resident #2 had any sexual behaviors toward female residents and thought it was just female staff members. She said interventions should have been put in place when staff was made aware of his sexual behaviors. Record review of facility's Behavior Management policy (revised 6/2019) read in part: .it is the policy of this facility that the staff will incorporate behavior management techniques to improve the resident's quality of life. Behaviors are a form of communication; behavior management is the attempt to understand that communication and meet the need of the patient/residents. Procedure: All behavior management must begin with a comprehensive assessment. Only then can team develop effective and appropriate intervention. Every resident/patient will have an initial assessment for any mood or behavior need. Staff should be familiar with resident/patients to readily recognize any change in baseline mood and behaviors. The assessment process is ongoing and should change with any new needs identified: 2. Document and track mood and behaviors and document non-pharmacological attempts to intervene with mood or behavior issues on the behavior monitoring forms as they occur per facility guidelines. Ensure you have identified the target mood or behavior on the behavior monitoring forms not just the diagnosis. 3. Review your behavior documentation including behavior interventions monthly flow record for accuracy and patterns. Time of day, week or month behaviors occurs, what task was being performed, or staff member or another patient/ resident involved when behavior occurs .
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs for 1 of 2 residents (CR#1) reviewed for pharmacy services in that: -CR#1 was not administered medications on 6/27/20 and 6/28/20 as ordered by the physician. This failure could place all residents at risk for not receiving the therapeutic benefits of their medications. Findings Include: CR#1 Record review of CR#1's face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE] and was discharged on [DATE]. Her [DIAGNOSES

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F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) REDACTED]. Record review of CR#1's comprehensive MDS assessment dated [DATE] revealed a BIMS of 15 out of 15 indicating intact cognition. She required total dependence from staff for toilet use and transfer. She required extensive assistance from staff for bed mobility, dressing and personal hygiene. CR#1 was always incontinent of bowel and bladder. Record review of CR#1's care plan initiated on 12/19/2006 and revised on 6/26/2020 revealed the following care plan: Focus: Resident at risk for allergic reaction r/t allergies to the following: [MEDICATION NAME], PCN, [MEDICATION NAME] Goal: Resident will not have an allergic reaction for the next 90 days. Interventions: 1. Review listed allergies prior to giving new medications. 2. Give MD list of all allergies when receiving orders for new medications. Record review of CR#1's hospital's medication orders dated 6/26/20 revealed orders for [MEDICATION NAME] (corticosteroid to treat inflammation) Tablet 6 MG Give 1 tablet by mouth daily for 10 days and [MEDICATION NAME] Capsule (antibiotic) 300 MG Give 1 capsule by mouth two times a day for 4 Days. Record review of CR#1's MAR for the month of June 2020 revealed Resident was not administered [MEDICATION NAME] capsule 300 mg at 8:00am and 4:00pm on 6/27/20 and 6/28/20. Record review of CR#1's MAR for the month of June 2020 revealed Resident was not administered [MEDICATION NAME] tablet 6 mg on 6/28/20 at 9:00am. Record review of CR#1's Nurses notes written by RN Z dated 6/27/20 at 6:38pm revealed read in part: .Late Entry: Note Text: Consult with charge nurse whom states Resident has two ABX that she noted in the discharge papers that have not been delivered by pharmacy. When asked if she had faxed the scripts charge nurse states she has not faxed them at this time. Teaching provided to charge nurse to always fax all scripts that come in with discharge paper work immediately on their receipt. Per charge nurse I was not sure what y'all was doing so I did not fax them yet. Scripts for ABX [MEDICATION NAME] 300 mg and [MEDICATION NAME] 6 mg faxed to pharmacy by writer. Pharmacy contacted and states to pull medications from pixis . Record review of CR#1's nurses notes written by RN Z dated 6/27/20 at 6:55pm revealed read in part: .Late Entry: Note Text: NP contacted and made aware that Resident returns to facility with [MEDICATION NAME] 6 mg Q day x 10 days and [MEDICATION NAME] 300 mg BID x 4 days r/t pneumonia. Further made aware of drug interactions with Aspirin 81 mg and Magnesium [MEDICATION NAME] 400 MG. Order received to hold aspirin 81 mg and Magnesium [MEDICATION NAME] until ABX is completed. Aspirin and Magnesium [MEDICATION NAME] placed on hold as instructed . Record review of CR#1's nurses notes written by RN Z dated 6/27/20 at 6:56pm revealed read in part: .Physician order [REDACTED]. Record review of CR#1's nurses notes written by RN Z dated 6/27/20 at 7:15pm read in part: . Late Entry: Note Text: Per on call pharmacist to deliver [MEDICATION NAME] 6 mg and [MEDICATION NAME] 300 mg today between 2-4 hrs . Record review of CR#1's nurses notes written by RN Z dated 6/27/20 at 7:15pm read in part: .Late Entry: Note Text: [MEDICATION NAME] 300 mg capsule noted not in pixis. Pharmacy contacted and made aware and to stat [MEDICATION NAME] 300 mg to facility tonight . Record review of CR#1's nurses notes written by RN Z dated 6/27/20 at 7:15pm read in part: .Late Entry: Note Text: on call Pharmacist made aware that [MEDICATION NAME] 1 mg in pyxis has been exhausted after pulling initial dose . Record review of CR#1's nurses notes written by RN Z dated 6/27/20 at 7:16pm read in part: .Late Entry: Note Text: Charge Nurse to administer [MEDICATION NAME] 300 MG on arrival from pharmacy . Record review of CR#1's nurses notes written by RN Z dated 6/27/20 at 7:20pm read in part: . Late Entry: Note Text: Per charge nurse she is unable to locate Residents medication on either of the med carts. Writer asked if she had checked Carlisle unit for Residents medications and nurse states no that the off going nurse stated she had reordered Residents medications from the pharmacy and expected delivery tonight. Carlisle unit checked by writer and medications not on unit. Writer asked off going med aide and nurse why they had not informed me that Residents medications were not on the cart before now. Charge nurse states she was awaiting delivery from pharmacy and had not clicked any medications out. Teaching provided to charge nurses and med aide to always notify me when Residents meds are pending delivery from pharmacy. When asked why medications had not been pulled from pyxis, both charge nurses state they do not have access to the pyxis . Record review of CR#1's nurses notes written by LVN B dated 6/28/2020 at 2:22pm read in part: .Note Text: Called pharmacy at 2:20 to enquire about resident medication the ABT ([MEDICATION NAME]) prescription she received from the hospital. Pharmacy representative stated that since the resident is allergic to [MEDICATION NAME] she can not send the ABT for the resident . Record review of CR#1's nurses notes written by LVN B dated 6/28/2020 at 2:41pm read in part: .Note Text: Attempted 3 times to call the NP to be notify about resident antibiotic that pharmacy said can not deliver medication since resident is allergic to the ABT ([MEDICATION NAME]) 300 mg, but NP can not be reached . Record review of CR#1's nurses notes written by LVN B dated 6/28/2020 at 3:14pm read in part: .Note Text: [MEDICATION NAME] Capsule 300 MG Give 1 capsule by mouth two times a day for pneumonia for 4 Days waiting for supply . Record review of CR#1's nurses notes written by LVN B dated 6/28/2020 at 3:15pm read in part: .Note Text: [MEDICATION NAME] Tablet 6 MG Give 1 tablet by mouth one time a day for pneumonia Awaiting for supply . Record review of CR#1's nurses notes written by LVN B dated 6/28/2020 at 6:31pm read in part: .Note Text: [MEDICATION NAME] Capsule 300 MG Give 1 capsule by mouth two times a day for pneumonia for 4 Days Awaiting for supply . Record review of CR#1's nurses notes written by RN Z dated 6/28/2020 at 10:34pm read in part: .Late Entry: Note Text: Writer working remote and noted this nurses note. NP contacted and notified of pharmacy's reason for not sending Resident ABT medications. Awaiting response. Charge nurse contacted and asked to continue to try to reach NP and notify RP accordingly . Record review of CR#1's nurses notes written by RN Z dated 6/29/2020 at 8:38am read in part: .Late Entry: Note Text: Response received from NP regarding ABT [MEDICATION NAME] 300 MG. Orders received to Administer [MEDICATION NAME] 500 MG PO QD x 10 days. Order entered into PCC and pharmacy contacted and asked to STAT medication. PER pharmacy medication to arrive between 2-4 hrs. Charge nurse made aware and asked to notify RP . Record review of CR #1's physician's orders [REDACTED]. Record review of CR #1's physician's orders [REDACTED]. Record review of CR#1's nurses notes written by RN Y dated 6/29/2020 at 1:13pm read in part: .Note Text: [MEDICATION NAME] Capsule 300 MG Give 1 capsule by mouth two times a day for pneumonia for 4 Days waiting for supply ,phoned Np to inform resident is having allergy towards the medication no call back . Record review of CR#1's nurses notes written by RN Y dated 6/29/2020 at 6:33pm read in part: .Note Text: Attempted 2 times to call the NP to be notify about resident antibiotic that pharmacy said can not deliver medication since resident is allergic to the ABT ([MEDICATION NAME]) 300 mg, left the voice message, no response informed DON, unit manager . In an interview on 8/12/20 at 12:55 pm with LVN B, she said CR#1 returned to the facility with new orders for antibiotics from the hospital. She said she was scheduled to work on the COVID unit on June 28, 2020. She said around 6 am the unit manager called her on the phone and asked her to pick up CR#1's meds from the nurse's station when the medications arrived from the pharmacy and administer them to CR#1. LVN B said the pharmacy made two runs, one in the morning before 11 am and the other in the later afternoon. She said around 11 am when the pharmacy did not bring CR#1's medication she called the pharmacy and the pharmacist told her that CR#1's meds could not be dispensed due to her allergies. LVN B said she tried to notify the NP of CR#1's allergies and to get an order for [REDACTED]. She said the protocol was to notify the unit manager if nurses could not get a hold of the NP. She said she did not feel the need to call the unit manager because the unit manager could not do anything for the resident either because the unit manager was a nurse as well only NP could order alternative medications. In an interview on 8/12/20 at 1:17 pm with the DON, this surveyor reviewed CR#1's physician's orders [REDACTED]. She said the nurses and the unit manager that worked with CR#1 mentioned in notes nurses no longer worked at this facility. The DON said the physician should have been notified of the allergy. She said if the nurse could not get a hold of the physician or NP then the nurse should have called the Medical Director. The nurse should have also notified the unit manager and the DON to assist. The DON said her expectation for the nurses is that they should not wait more than 24 hours to administer residents medications. She said this delay caused the resident to not receive her antibiotic to treat her pneumonia. Record review of facility's Ordering and Receiving Non-Controlled Medications policy (not dated) read in part: .5. New admission/re-admission orders [REDACTED]. 6. Receiving medications from the pharmacy a licensed nurse: d) immediately delivers the medications to the appropriate secure storage area or a designee under the direct supervision on the licensed nurse. e) Assures medications are incorporated into the resident's specific allocation prior to the next medication pass .
F 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide food that was palatable, and at a safe and appetizing temperature for residents who ate foods prepared by the facility's only kitchen in that: -2 confidential Resident's complained of food being cold. This failure could affect all residents and place them at risk for reduced meal satisfaction and diminished nutritional value which could result in weight loss and decreased quality of life. Findings include: Record review of the menu for lunch on [DATE] revealed the following items on the menu: roast turkey, candied sweet potatoes, braised cabbage, cornbread. Interview with 2 confidential Resident's on [DATE] between 10:30 am and 11:30 am, they said the food was served cold. Observation and testing of a hall tray for Barrington unit with the Dietary Manager on [DATE] at 12:30 pm revealed the following temperature: Roast turkey with gravy- 120 Degrees Interview with the Dietary

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	455812	A. BUILDING _____ B. WING _____	**08/21/2020**

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.

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F 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) Manager at this time, he said he has not had any complaints about food being cold. He said when they were cooking and on the steam table the turkey was much higher temp. He said that they have been using disposable Styrofoam containers since June. He said if a resident complained about food being cold then they would warm it up or make them a new plate. He said the turkey should have been higher than 120. Interview with CNA C on [DATE] at 9:00am, she said she has been working at the facility for about 6 months. When asked if residents complain about anything, she said they complain about the food being cold. She said when they complain of food being cold, she brings it back to the kitchen so they can warm it up or bring them a new plate. Interview with RN B on [DATE] at 9:36am, When asked if residents complain about anything, he said they complain about the food being cold sometimes. Record review of the facility's policy for safe food temperatures (undated) read in part, .it is the policy of this facility that food temperatures will be maintained at acceptable levels during food .serving .hold hot foods at 140 F or higher during meal service .
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 5 residents (CR #1) reviewed for clinical records in that: -The facility did not document on CR#1's MAR when the resident received medications. This deficient practice could affect all residents that received medications and place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. Findings include: CR#1 Record review of CR#1's face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE] and was discharged on [DATE]. Her [DIAGNOSES REDACTED]. Record review of CR#1's comprehensive MDS assessment dated [DATE] revealed a BIMS of 15 out of 15 indicating intact cognition. She required total dependence from staff for toilet use and transfer. She required extensive assistance from staff for bed mobility, dressing and personal hygiene. CR#1 was always incontinent of bowel and bladder. Record review of CR#1's physician orders [REDACTED]. 2) [MEDICATION NAME] tablet 10 mg ([MEDICATION NAME] oxalate) give 10 mg by mouth one time a day related to major [MEDICAL CONDITION], recurrent, mild 3) Magnesium [MEDICATION NAME] Suspension 400 mg/ml give 30 ml by mouth one time a day for constipation/upset stomach 4) Senna-[MEDICATION NAME] sodium tablet 8.6-50 mg (sennosides-[MEDICATION NAME] sodium) give 2 tablet by mouth at bedtime related to other constipation 5) Tamsulosin HCL capsule 0.4 mg give 1 capsule by mouth at bedtime related to unspecified symptoms and signs involving the [MEDICAL CONDITION] system 6) Vitamin C tablet ([MEDICATION NAME] acid) give 500 mg by mouth one time a day for supplement 7) [MEDICATION NAME] tablet 20 mg give 20 mg by mouth every 8 hours related to Gulliain-barre syndrome 8) [MEDICATION NAME] solution 10 gm/15 ml give 20 ml by mouth three times a day for constipation Record review of CR#1's MAR for June 2020 revealed there were blank spaces for CR#1's medication administration for the following: [MEDICATION NAME] tablet 0.25 mg give 1 tablet by mouth at bedtime for anxiety on 6/28/20 at 8:00 PM. [MEDICATION NAME] tablet 10 mg ([MEDICATION NAME] oxalate) give 10 mg by mouth one time a day related to major [MEDICAL CONDITION], recurrent, mild on 6/26/20 and 6/27/20 at 09:00 a.m. Magnesium [MEDICATION NAME] Suspension 400 mg/ml give 30 ml by mouth one time a day for constipation/upset stomach on 6/26/20 and 6/27/20 at 08:00 a.m. Senna-[MEDICATION NAME] sodium tablet 8.6-50 mg (sennosides-[MEDICATION NAME] sodium) give 2 tablet by mouth at bedtime related to other constipation on 6/28/20 at 9:00 PM. Tamsulosin HCL capsule 0.4 mg give 1 capsule by mouth at bedtime related to unspecified symptoms and signs involving the [MEDICAL CONDITION] system on 6/28/20 at 9:00 PM. Vitamin C tablet ([MEDICATION NAME] acid) give 500 mg by mouth one time a day for supplement on 6/27/20 at 08:00 a.m. [MEDICATION NAME] tablet 20 mg give 20 mg by mouth every 8 hours related to Gulliain-barre syndrome on 6/27/20 at 07:00 a.m. [MEDICATION NAME] solution 10 gm/15 ml give 20 ml by mouth three times a day for constipation on 6/27/20 at 08:00 a.m. and 12:00 p.m. Record review of CR#1's nurses notes for the month of June 2020 revealed there was no documentation CR#1 refusal of taking medications. There was no documentation why the scheduled medication were withheld or not given as ordered. The nurse/MA did not document or list the reason for the resident not receiving the prescribed medications. The attending physician or NP was not notified. In an interview on 8/12/20 at 1:17 pm with the DON, she said she was new to the facility. This surveyor reviewed CR#1's MAR with the DON. The DON confirmed that the nurse or MA did not document on the medication administration record after giving medications in June 2020. She said there should not be any open spaces in the MAR and that if it is not documented it means it was not given. She said she was responsible to monitor and review the MARS/TARs to ensure meds are being given and documented. In an interview on 8/12/20 at 1:39 pm with the Administrator, he said there should not be any blanks in the MARs. He said the DON was in charge of looking at MAR/TARS and making sure there were no gaps/holes and to counsel the nurses. Record review of facility's Documentation-Licensed Nurse policy (revised 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. Medication 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. 2) If a scheduled medication is withheld or not given as ordered, the nurse documents this and lists the reason for the resident not receiving the medication. The attending physician or physician extender must be notified. Route of administration must be charted .

F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for all residents in that: -Customer Service Director failed to have full PPE (N95, gown, gloves, facesheild) in the COVID positive unit. This failure could affect residents dependent upon care and place them at risk for healthcare associated cross-contamination and infections. Findings Include: Observation on 8/7/20 at 11:06 am revealed the Customer Services Director walking into the COVID positive unit with an N95 mask on and three pairs of clothes (two pairs of jeans and a blouse) in her hands. The CSD was stopped by RN B before going into room [ROOM NUMBER] and was told to wear full PPE. The CSD looked at RN B and this Surveyor and said, Give me a minute, and left the covid unit from the clean donning area instead of the doffing exit door. In an interview on 8/7/20 at 11:08 am with RN B, he said full PPE was required to enter the COVID positive unit. RN B said there was also a sign posted outside the COVID hall to notify staff and visitors. In an interview on 8/7/20 at 11: 32 am with Unit Manager A, she said she was at the nurse's station when she observed the CSD walk past her in the COVID positive hall. She said she tried to yell her name to get her attention to stop her and to tell her to don full PPE. She said a few minutes later the CSD came out of the COVID positive hall from the clean side in turn contaminating the clean donning area. In an interview on 8/7/20 at 11:57 am with the Customer Service Director, she said she was the liaison between the residents inside the facility and the family on the outside. She said she was in serviced when entering into the COVID positive unit to wear full PPE such as N95 mask, face shield, gown and gloves. She said she came to the COVID unit to see if room [ROOM NUMBER] was clean as they were expecting a new COVID positive resident from the hospital. She said she heard the unit manager call her name, so she turned back around to speak to her. She said, I was not thinking straight and did not think to put on full PPE. She said the clothes she was carrying with her into the COVID unit belonged to one of the negative residents. She said after she left the COVID unit she went straight to that negative resident's room. She said the risk of not wearing full PPE was spreading infections to herself and other residents. In an interview on 8/7/20 at 11:02 am with the DON, she said full PPE (gown, gloves, N95 and face shield) were required in the COVID unit to protect staff, residents and family. She said the CSD should not have taken a negative resident's clothes to the COVID unit as it was increasing the risk of spreading the infection. She said the CSD has been positive, so she needed to be more careful. She said she would counsel her. The DON also said, We will take every precaution because we have been in the news. Record review of facility's Personal Protective Equipment policy (not dated) read in part: .4. PPE required for transmission based precautions is maintained outside and inside the resident's room, as needed. 5. Training on the proper donning, use and disposal of PPE is provided upon orientation and at regular intervals. 6. Employees who fail to use personal protective equipment when indicated may be disciplined in accordance with personnel policies . Record review of facility's COVID-19 Infection Control policy (revised 8/7/20) read in part: .d. educate staff on proper use of personal protective equipment and application of standard,

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) contact, droplet, and airborne precaution, including eye protection. e. All staff must wear facemasks while in the facility. staff who are caring for COVID-19 positive residents and those caring for residents with unknown COVID-19 must wear an N95, isolation gown, goggles or face shield. F. promote easy and correct use of personal protective equipment (PPE) by: i. Posting signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE. ii. Make PPE, including facemask, eye protection, gowns and gloves, available immediately outside of the resident's room. 6.(j) staff will be required to wear N95 masks and eye shield suspected or active cases of COVID-19 is in the facility. 8.(b) staff to wear appropriate PPE, based on the cohort with which they work . Record review of facility's Infection control program policy (revised 6/2019) read in part: .to provide a healthy living environment with respect for the health and well-being of each resident, staff member and visitors. Goals: a. decrease the risk of infections and communicable diseases to residents, employees, volunteers and visitors. d. maintain compliance with state and federal regulations relating to infection prevention and control .
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation, record review, and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public in that: There was trash on the ground outside of the dumpster. This failure could affect all residents and place them at risk of infection, injuries and health hazards. Findings include: Observation of the dumpster outside on 8/7/20 at 11:43 am revealed approximately 3 white trash bags filled with trash on the ground next to the big dumpster. The green dumpster was also over flowing with trash bags. Observation of the dumpster outside on 8/12/20 at 11:15 am revealed approximately 9 white trash bags filled with trash and approximately 4 cardboard boxes on the ground next to the big dumpster. The green dumpster was also over flowing with cardboard boxes. Interview with Maintenance Director on 8/12/20 at 11:43 am, he said he was responsible for housekeeping and laundry department. He said the floor tech was responsible for taking the trash out. He said they take it out in the morning and after lunch. Interview with the Administrator on 8/12/20 at 2:10 pm, he agreed trash should not be on the ground. He said the problem was that the dumpster lid was on the top and it was hard for some of the ladies to reach so they just put the trash on the ground. He said he was working on getting a dumpster with the side doors so that it would be easier to open and close. Record review of the facility's policy for Waste disposal revised on June 2019 read in part, .waste will be disposed of in a manner to prevent transmission of disease, nuisance .dispose of waste in closed trash bags .remove trash frequently enough to prevent overflow .cover waste containers and close dumpsters at all times .keep area around dumpsters clean .