STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor Care Center	821 US Hwy 81 W New Braunfels, TX 78130

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observation, interview and record review, the facility failed to ensure the right to be free from abuse for 6 of 11 residents (Residents #4, #5, #7, #8, #10, and #11) reviewed for abuse as evidenced by: 1. Facility failed to address that Resident #3 sexually assaulted Resident #4 on [DATE]. 2. Facility failed to address that Resident #3 physically assaulted Resident #5 on [DATE]. 3. Facility failed to address that Resident #7 reported to CNA B that Resident #3 was sexual inappropriate with Resident #7 on [DATE]. 4. Facility failed to address that Resident #3 was sexually inappropriate with Resident #10 and reported to Social Worker A on [DATE]. 5. Facility failed to address that Resident #11 reported to Social Worker A that Resident #3 was being sexually inappropriate and moved out of Resident #3's room on [DATE]. 6. Facility failed to address that Resident #3 was sexually inappropriate with Resident #8 during the week of [DATE] - [DATE]. An Immediate Jeopardy (IJ) was identified on [DATE] at 5:10 p.m. The IJ template was provided to the facility on [DATE] at 7:24 p.m. While the IJ was removed on [DATE] at 3:18 p.m., the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy and a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of its plan of Removal (POR). This failure could place residents in the facility at risk for abuse or harm from other residents exhibiting aggressive behaviors. The findings were: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/22/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Record review of Resident #3's undated face sheet revealed he was a [AGE] year-old male who admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included Vascular Dementia (a general term for impaired ability to remember, think, or make decisions), Type 2 Diabetes (a chronic condition that happens when your body can't use insulin properly), Schizoaffective Disorder, Bipolar Type (a chronic mental illness involving symptoms of schizophrenia and bipolar disorder and characterized by symptoms such as delusions, hallucinations, depression, and high-energy mood), Anxiety Disorder (a feeling of worry, nervousness, or unease) and Depression (a mood disorder that causes persistent feelings of sadness and loss of interest). Record review of Resident #3's quarterly MDS assessment, dated [DATE], revealed Resident #3 had a BIMS score of 14, indicating no cognitive impairment. Record review of Resident #3's comprehensive care plan revealed the following care plans: 1) [Resident #3] has behaviors in the dining area, during meals, that agitates other residents' r/t he uses vulgar language, racial slurs and talks loudly, start date [DATE]. 2) [Resident # wants to express himself sexually and is cognitively intact to choose to have a sexual relationship(s), start date [DATE]. 3) [Resident #3] has behaviors while outside smoking that agitates other residents' r/t he uses vulgar language, racial slurs, and talks loudly, start date [DATE]. 4) Resident has physically abusive behavioral symptoms of physical aggression directed toward another resident, start date [DATE], end date [DATE]. 5) Resident has been heard calling his roommate 'my lover', which upsets the roommate. He stated he calls him that because he believes it to be funny, but he does not consider his roommate to be his lover, start date [DATE]. 6) Resident has socially inappropriate/disruptive behavioral symptoms as evidenced by [Resident #3] talks in a loud voice and says inappropriate things to staff and other residents. [Resident #3] tells untrue stories such as the Administrator will buy him gifts. [Resident #3] stated his cigarettes were marijuana. [Resident #3] makes false allegations against staff, start date [DATE]. 7) Resident has socially inappropriate/disruptive behavioral symptoms as evidenced by recent behaviors reported by nursing staff: argumentative, refusing to come inside late at night, yelling and cursing at staff, singing and talking loudly in the dining area during meal services, start date [DATE]. 8) [Resident #3] was observed engaging in a sexual act with another male resident, start date [DATE]. 9) Resident has potential for socially inappropriate/disruptive behavioral symptoms r/t bipolar disorder and anxiety, start date [DATE]. Record review of Resident #3's December MAR revealed Resident #3 had the following orders: 1) Clonazepam 1mg, 1 tablet, scheduled for 8:00 a.m. and 8:00 p.m. daily for bipolar disorder with a start date of [DATE]. 2) Benztropine 1mg, 1 tablet, scheduled for 8:00 a.m. daily for schizoaffective disorder with a start date of [DATE]. 3) Cymbalta delayed release 60mg, 1 capsule, scheduled for 7 a.m.-10 a.m. daily for major depression disorder with a start date of [DATE]. 4) Gabapentin 400mg, 2 tablets to equal 800 mg scheduled for 8:00 a.m., 2:00 p.m., and 8:00 p.m. for neuropathy pain with a start date of [DATE]. 5) Lyrica 50mg, 1 capsule scheduled for 8:00 a.m.-10:00 a.m. and 8:00 p.m.- 10:00 p.m. for pain with a start date of [DATE]. 6) Trazadone 150mg, ,d+[DATE] tab scheduled for 8:00 p.m. for insomnia. Record review of Resident #3 progress note, [DATE] at 11:50 a.m. by LVN A, stated, told in report that DON was not reached. Pt has been very argumentative with staff and other patients all day. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3's progress note, [DATE] at 11:21 a.m. by LVN C, stated, Enter this shift this morning and observed resident very talkative, speaking with other residents and staff loudly, sometimes 15 minutes with kisses and hugs. Administered all medications including PRN Ativan 0.5mg. STAT labs CBC. CMP, UA with C&S. Resident attempted to go outside and sit on the porch but was redirected back inside. Resident required redirection to eat breakfast, sat down to eat 30 minutes later after food was placed on the table. While in dining room [Resident #3] called another resident a bitch because [Resident #3] says the other resident called him a prostitute. [Resident #3] was redirected and continued to eat his breakfast. After resident ate breakfast, he went to his room and laid down. Police here to speak with resident due to an incident that occurred yesterday. Resident is 1:1[supervision] until further notice. Record review of Resident #3 prescription order revealed an ordered received by LVN C on [DATE] for Ativan .5mg, 1 tablet, PRN. Record review of Resident #3's progress note, [DATE] at 11:53 a.m. by LVN C stated, [lab company] here to do STAT labs, resident refused blood draw d/t police here questioning him on complaint made by another resident. At this time resident is very upset and doesn't want to be bothered. UA was collected earlier today and was sent with tech. Attempted to do a skin assessment, resident refused that as well. Record review of Resident #3's progress note, [DATE] at 11:58 a.m. by Agency LVN L stated, This nurse observed resident arguing with another resident. This nurse did not hear what they were saying. This nurse redirected residents successfully. Record review of Resident #3's progress note, [DATE] at 1:15 p.m. by LVN C, stated, This nurse was informed resident threatened to kill 'whoever call the police on him.' This nurse called on call for [Resident #3 physician] and spoke with [Nurse Practitioner] and gave orders to send resident to psych hospital. Call placed to [hospital name] to give report, ER nurse made me aware that if resident doesn't meet criteria he will be sent right back. Call placed to EMS requesting resident to be sent out for a psych eval and treat. EMS dispatcher made me aware that since this is a psych transport police will come out first. The police came back inside and stated since resident didn't verbally name someone then they can't do much about it because the person would have to press charges. Record review of Resident #3's progress note, [DATE] at 1:36 p.m. by LVN C stated, Resident was sitting outside and came inside once he saw the other resident [representative] enter the building. As the [representative] was leaving with the resident for a oop stay, [Resident #3] began cursing at the resident and [resident representative] while they were leaving and tried walking toward them. Resident was blocked from trying to get the other resident. [Resident representative] exchanged words as well. Resident then proceeds to walk towards the dining room and states to another resident what are the fuck are you looking at mother fucker and hits him. The other resident gets up and attempt to hit him back but almost lost his balance. Residents were separated immediately. Call placed to the police. Record review of Resident #3's progress note, [DATE] at 2:55 p.m. by LVN C stated, Resident arrested due to physical assault to another resident and sent to [County Name], [case number]. Police informed this nurse its a Emergency protective order that last for 72 hours if judge approves. Call placed to [resident representative], message left requesting call back, NP on call, Administrator, ADON and DON was notified. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a facility document titled 24-hour resident monitoring form used to document the 1:1 supervision for Resident #3, dated [DATE], listed 3 columns for each shift with column 1 -time, column 2-location/room, column 3- staff initials. The form revealed Resident #3 was documented as out front at 12:00 p.m., 12:blank, 12:blank and initialed with CNA A's initials. Resident #3 was documented DR (number) at 12: blank, 1:00 p.m., 1:blank, 1:blank, 1:blank, 2:00 p.m., 2:15, 2:30, 2:45 and initialed with CNA A's initials. Record review of a facility document titled Event Report for Resident #3, completion date [DATE] at 2:31 p. m. by LVN C, described the behavior exhibited by Resident #3 as, Resident was sitting outside and came inside once he saw the other resident [representative] enter the building. As the [representative] was leaving the resident for a oop stay [Resident #3] began cursing at the resident and [resident representative] while they were leaving and tried walking toward them. Resident then proceeds to walk towards the dining room and states another resident what are the fuck are you looking at mother fucker and hits him. The other resident gets up and attempt to hit him back but almost lost his balance. Residents were separated immediately. Call placed to the police. The event report revealed Resident #3 exhibited 'anger' and a 'desire to harm others'. The event report section titled Behavioral Symptoms stated Resident #3 exhibited physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) 4 to 6 days, but less than daily. The event report section of behavioral symptoms stated Resident #3 exhibited verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others), 1 to 3 days in the last 7 days. The event report section of behavioral symptoms stated Resident #3 exhibited other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds, 1 to 3 days in the last 7 days. The event report stated Resident #3's behaviors put the resident at risk for significant risk for physical illness or injury, significantly interfered with resident care, put others at significant risk for physical injury, significantly intruded on the privacy and activities of others and significantly disrupted the care or living environment. The event report section for interventions for Resident #3 revealed medications were ineffective and non-pharmacological measures taken were redirection and 1:1. The outcome of the non-pharmacological measures used was coded as 'interventions ineffective'. 2. Record review of Resident #5's undated face sheet revealed he was an [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included Conversion Disorder with Seizures (a functional disorder that causes abnormal sensory experiences and movement problems during periods of high psychological stress), Congenital Malformations of Corpus Callosum-Birth Defect (a condition present at birth when parts of the nerve fibers that connect the right and left sides of the brain are missing), Dementia (a mood disorder that causes persistent feelings of sadness and loss of interest), Unspecified Intellectual Disabilities (a diagnosis for individuals when assessment of the degree of the intellectual disability by means of locally available procedures, is difficult or impossible because of sensory or physical impairments). Record review of Resident #5's MDS assessment, dated [DATE], revealed Resident #5 was coded as rarely/never understood on Section B- Hearing, Speech and Vision. Section C- Cognitive Patterns revealed Resident #5 had short term memory problems and Resident #5's cognitive skills for daily decision making were moderately impaired, defined on the MDS as decisions poor, cues/supervision required. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #5's comprehensive care plan revealed the following care plans, 1) [Resident #5] has been identified as having IDD PASRR positive status related to unspecified intellectual disabilities and conversion disorder, start date [DATE]. 2) Resident has difficulty understanding others R/T impaired cognition, start date [DATE]. 3) Resident has impaired cognition R/T Dementia and Congenital malformations of corpus callosum, start date [DATE]. Record review of Resident #5's progress note, [DATE] at 2:50 p.m. by Agency LVN L stated, Another resident [Resident #3] walked by [Resident #5] and said what the F*** are you looking at and hit [Resident #5] in the left forearm. This was Witness by [MA A]. Record review of Resident #5's progress note, [DATE] at 3:22 p.m. by Agency LVN L stated, [Physician name] returned call and was notified. Stat x-ray ordered. Record review of Resident #5's progress notes revealed a skin assessment was completed on [DATE] at 3:27 p.m. by Agency LVN L and there were no alterations in skin integrity noted. Record review of Resident #5's progress note, [DATE] at 9:14 p.m. by LVN F stated, x-ray came to take x-ray at 7:30 p.m. Resident is resting in his room. Record review of a document titled event report for Resident #5, completion date [DATE] at 2:59 p.m. by Agency LVN L, revealed Resident #5 was hit in the left forearm by Resident #3. The event report was checked 'yes' to a question of if the incident was witnessed. The location of the incident was marked as 'dining room'. Injury was described as no injury noted. Resident has a small dark green bruise. Treatment was marked 'x-ray ordered'. Action taken was marked 'police notified'. Immediate intervention to prevent reoccurrence stated keep [Resident #3] away from resident. The report revealed Resident #5's resident representative, physician and NP were notified of the incident. Record review of Resident #5's x-ray report, date of service [DATE] and faxed date [DATE], revealed no evidence of acute fracture or dislocation in forearm. 3. Record review of Resident #4's undated face sheet revealed he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included Schizophrenia (a chronic mental illness characterized by delusions, hallucinations and disorganized thinking), End stage renal disease, and Conversion disorder with seizures (a functional disorder that causes abnormal sensory experiences and movement problems during periods of high psychological stress). Record review of Resident #4's quarterly MDS assessment, dated [DATE], revealed Resident #4 had a BIMS score of 15, indicating no cognitive impairment. Record review of Resident #4's progress notes, [DATE] at 11:50 a.m. by Agency LVN L stated, Residents [representative] called this morning asking to speak with someone about a grievance. This nurse stated that [Admission Coordinator name] the manager on duty was at lunch, that this nurse could take her number and have [Admission Coordinator name] call her back. This nurse stated that I was [Resident #4's] nurse today and if I could help her. [Resident representative] then stated that [Resident #4] was sexually assaulted last night. that [Resident #3 first name] asked [Resident #4] to come look at his Christmas tree last night and when [Resident #4] entered the room [Resident #3] shut the door and took his clothes off and started rubbing on [Resident #4]. This nurse took [resident representative] number and stated that [Admission Coordinator] would call her back. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #4's progress notes, [DATE] at 12:01 p.m. by Agency LVN L stated, police have arrived and are getting statements. Record review of Resident #4's progress notes, [DATE] at 2:05 p.m. by Agency LVN L stated, Resident left with [resident representative] for therapeutic leave. Record review of Resident #4's facility document titled event report, completion date [DATE] at 12:22 p.m. by ADON A, described the event as recipient of sexually inappropriate behavior and included a brief description of the incident that stated Resident was invited by another Resident to their room to look at the Christmas tree. Once they were in the room, the other resident then closed the door, pulls his pants down, blocks the entrance to his room door and begins to rub his genitals against [Resident #4]. The event report revealed there were no witnesses to the alleged event and no injuries were noted. Action taken was described as staff re-education, resident re-education, police notified, state notified, Administrator notified, DON notified and listed as immediate intervention implemented that the other resident was placed on 1:1 supervision. Record review of Resident #4's Social Service progress note, [DATE] at 4:38 p.m. by Social Worker A stated, [Resident #4] returned from [resident representative] outing in time to smoke outside. SW spoke to him 4: 38PM and he appeared to be doing well. SW expressed sorrow that [Resident #4] was assaulted in that way and that it was no way his fault. We talked about how shocking it is to be put in that situation. He said he was badly shaken up but going home with his [resident representative] really helped. They fed him well and talked to him and gave him his meds. He said he is not traumatized by it but felt that way when it happened. SW assured him that the Resident was arrested and taken to jail and will not be returning and that we are packing up his belongings. I told him [psychiatry company name] would be here to visit with him and I personally contacted them to be sure they were coming. He thanked me for coming to talk to him. I told him to reach out anytime he needed to talk. I also offered additional counseling if he needed it and he told me he was good. 4. Record review of Resident #7's undated face sheet revealed he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included Myopathy (a muscle disease) and Atherosclerosis of coronary artery bypass graft (surgical operation to bypass arteries in the heart). Record review of Resident #7's MDS assessment, dated [DATE], revealed Resident #7 had a BIMS score of 15, indicating no cognitive impairment. 5. Record review of Resident #8's undated face sheet revealed he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included Pulmonary Fibrosis (a disease in which the lungs become scarred and damaged causing difficulty in breathing), Anxiety (a feeling of worry, nervousness, or unease) and Depression (a mood disorder that causes persistent feelings of sadness and loss of interest). Record review of Resident #8's MDS assessment, dated [DATE], revealed Resident #8 had a BIMS score of 12, indicating moderate cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. Record review of Resident #10's undated face sheet revealed he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included Hemiplegia (paralysis of one side of the body), Anxiety (a feeling of worry, nervousness, or unease), Depression (a mood disorder that causes persistent feelings of sadness and loss of interest), Schizoaffective Disorder, Bipolar Type (a chronic mental illness involving symptoms of schizophrenia and bipolar disorder and characterized by symptoms such as delusions, hallucinations, depression, and high-energy mood), and Chronic Post-Traumatic Stress Disorder (a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress and anxiety). Record review of Resident #10's MDS assessment, dated [DATE], revealed Resident #10 had a BIMS score of 15, indicating no cognitive impairment. Record review of a facility document titled Safe Survey for Resident #10, dated [DATE] by Social Worker A, revealed a question Has any staff/resident approached you in a way that made you feel uncomfortable? Social Worker A wrote Friday-[Resident #3] came to my room the other day. He said he has a 'female part' down there (he pointed to his penis). He said his 'asshole is his pussy'. He told me I would like him better than [girl's name]. [Resident#10] told him 'I'm not doing that shit'. He bent over and showed me his butthole. He told me if I told anyone he has rights and the right to be gay. Last Monday he tried to give me a kiss (he walked into my room). That's sexual harassment. He is gay and he can be gay all he wants. He uses his gayness as a crutch. He ate all my cookies, he sat there and ate them. He offered my money. Can you keep him away from me? 7. Record review of Resident #11's undated face sheet revealed he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes (a chronic condition that happens when your body can't use insulin properly) and Mild Intellectual Disabilities (a neurodevelopmental condition that affects adaptive and cognitive potential). Record review of Resident #11's MDS assessment, dated [DATE], revealed Resident #11 had a BIMS score of 13, indicating no cognitive impairment. Record review of a facility document titled Safe Survey for Resident #11, dated [DATE] by Social Worker B, revealed a question Has any staff/resident approached you in a way that made you feel uncomfortable? Social Worker B wrote yes but I don't know if he is no longer here, from what I heard. Resident #11 told the head nurse/reported it when it happened. The survey also revealed a question has any staff/resident approached you about any sexual advances or remarks or anything that would cause you concern? and Social Worker B wrote yes, same as above. Happened last week then they moved me to a different room and then I heard he wet to jail. He told the head nurse when it happened. It was his former roommate, [Resident #3]. During an interview with the Administrator, [DATE] at 10:40 a.m., the Administrator stated Resident #3 and Resident #4 were not in the facility. The Administrator stated Resident #4 was out on pass with his resident representative and Resident #3 was in jail because Resident #3's behavior continued to escalate and there was another incident that resulted in Resident #3 being arrested. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with the Administrator, [DATE] at 11:00 a.m., the Administrator stated he was notified on the morning of [DATE] around 9 a.m. by the Admissions Coordinator that Resident #4 reported to the Admissions Coordinator that Resident #3 allegedly asked Resident #4 to go to Resident #3's room to look at his Christmas tree on [DATE] at approximately 5 p.m. to 6 p.m. Resident #4 reported that he went to Resident #3's room and when he entered the room, Resident #3 closed the door to the room, dropped his pants, rubbed his bare bottom on him and made him uncomfortable and attempted to kiss him. The Administrator stated, when he was notified of the allegation, he began an investigation and reported the incident to HHSC and the police were notified by Resident #4's resident representative before the Administrator had a chance to contact them. The Administrator stated the police arrived around 10:14 a.m. on [DATE] to interview Resident #3 and Resident #4 and after the interviews, Resident #4's family took him out on pass from the facility. The Administrator stated after Resident #3 was interviewed by the officers, Resident #3 came out of his room and started threatening to beat people's asses and wanted to know who called the police on him and then looked at another resident and said, 'what are you looking at' and then hit the other resident. The Administrator stated the police were still outside at the time and came back in the facility and arrested Resident #3 and took him to jail. The Administrator also stated the police took an article of clothing from Resident #4 to see if there was any DNA from Resident #3. The Administrator stated Resident #3 had exhibited behaviors in the past and had a couple of reportable incidents after he admitted to the facility. The Administrator stated Resident #3 had a sexual encounter with a resident that was reported but both residents were consenting and after we investigated it, it was unsubstantiated. The Administrator stated Resident #3 had a resident-to-resident physical altercation right after he admitted last year, but there were no injuries. The Administrator stated Resident #3 had been on hospice services and was declining for part of the year but had recently improved and graduated off of hospice and said Resident #3 was on psychiatric services and his medication had been effective. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with the Admissions Coordinator, [DATE] at 11:40 a.m., the Admissions Coordinator stated she arrived at the facility for manager of duty around 6:30 a.m. on [DATE]. The Admissions Coordinator stated Resident #3 asked her to go see his room and his decorations when she arrived and she went down to his room. Upon noticing that Resident #3 had decorated the whole room, the Admissions Coordinator stated she made a comment to him about how nice the room looked but if he gets assigned a roommate, he would have to take down the decorations on the other side of the room. The Admissions Coordinator said he got upset and poked me on the right upper arm and said 'no, you have to give me thirty days' notice first' in a real agitated voice. The Admissions Coordinator displayed a round dime size bruise on her right upper arm and stated that the bruise was from Resident #3. The Admissions Coordinator stated she tried to redirect Resident #3 to go to breakfast but he stated he was just going to stay in his room. The Admission Coordinator stated she took residents who smoke outside on a smoke break around 7 a.m. and Resident #4 was late to the smoke break and appeared tired and upset. The Admissions Coordinator stated she asked Resident #4 if he was ok and he stated he was tired and could not sleep the night before and agreed to go to her office to talk to her after the smoke break. The Admissions Coordinator stated around 8 a.m., Resident #4 went to her office and told her Resident #3, on [DATE] around 5 p.m., asked Resident #4 to go see his room and how he decorated it and to see his Christmas tree. Resident #4 said Resident #3 then shut the door behind him, dropped his pants, rubbed his naked ass on him and then tried kissing on him as he was trying to get out the door. Resident #4 said Resident #3 told Resident #4 that since Resident #4's family member had died 3 months ago, he did not need to be heterosexual. The Admissions Coordinator stated Resident #4 said he was able to get around Resident #3 and leave the room and stated he told a nurse what happened but could not describe the nurse and stated he did not know who it was. The Admissions Coordinator stated the 2 nurses that work the shift are his favorites so I don't know how he could not remember who it was, I think his times could be off because he knows the nurses. The Admissions Coordinator stated she notified the Administrator of the allegations made by Resident #4. The Admissions Coordinator stated between the hours of 8 a.m. and 9 a.m. on [DATE], Resident #3 was observed being agitated and being rude to residents and staff in the dining room, insulting people, and calling people fat. The Admissions Coordinator stated staff continued to redirect Resident #3 and he returned to his room and then the police arrived around 10:15 a.m. to talk to Resident #3 and Resident #4. The Admissions Coordinator stated 2 officers went to talk to Resident #3 and she could hear Resident #3 screaming and yelling in the room. Other officers went to talk to Resident #4 for about 30 minutes and took some articles of clothing. The Admissions Coordinator stated she asked an Officer what was going to happen once they leave from Resident #3's room because he was agitated, and they said they would investigate to see if they would issue a warrant for sexual assault. When the officers exited from Resident #3's room, the Admissions Coordinator witnessed Resident #3 walking behind the officers and yelling fuck you, you pigs. I used to be a male prostitute, I know my rights, I'm getting a lawyer. The Admissions Coordinator stated a CNA was assigned to sit with Resident #3 1:1. Resident #4's resident representative called and said they would be coming up to the facility to take Resident #4 out on pass and the nurse was notified and then Resident #3 was overheard yelling I will fucking kill whoever called the police on me at the nurses station. The Admissions Coordinator stated she notified the Administrator of the behavior and notified the police who were still outside of the facility. The police reentered the facility and told the Admissions Coordinator that Resident #3 could not be arrested for the statement since it was not directed toward a specific named individual. The Admissions Coordinator stated she told the CNA who was providing 1:1 with Resident #3 around 1:30 p.m. to take Resident #3 out front to get some air while the Admissions Coordinator was going to take the residents, including Resident #4, outside on the smoking patio for a smoke break. The Admissions Coordinator stated she was outside with the residents on a smoke break for about 5 - 10 minutes and was notified that Resident #3 physically hit Resident #5. The Admissions Coordinator stated she was told by a nurse that Resident #4's resident representative entered the facility and Resident #3 started calling Resident #4's representative a faggot or gay and Resident #5 laughed so Resident #3 hit him on the forearm. The Admissions Coordinator stated she notified the Administrator of the physical altercation; police were notified and she had to leave the facility for a personal appointment before the police arrived and arrested Resident #3. The Admissions Coordinator stated she was unsure how Resident #3 was able to physically assault Resident #5 while he

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor Care Center	821 US Hwy 81 W New Braunfels, TX 78130

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview with Resident #5, [DATE] at 3:00 p.m., revealed Resident #5 sitting in a wheelchair in the dining room. Resident #5 smiled when greeted and was able to nod yes and no to basic questions. Resident #5 lifted the sleeve of his sweatshirt on his left forearm revealing a dime size bruise when asked if he felt safe at the facility. Resident #5 made a punching gesture with his right fist into his left forearm when asked what happened to cause the bruise. Resident #5 indicated he was not scared of anyone and that he was not in pain by nodding his head no. [TRUNCATED]

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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** 48753 Based on interview and record review, the facility failed to provide pharmaceutical services including procedures that assured accurate administering of all drugs to meet the needs of residents for 1 of 11 residents (Resident #3) reviewed for pharmaceutical services, in that: 1. MA A administered Resident #9's Gabapentin to Resident #3 when Resident #3 did not have the medication available on 12/14/2024. 2. The facility did not reorder Resident #3's Lyrica, Gabapentin and Clonazepam timely, resulting in Resident #3 missing 3 doses of Lyrica, 5 doses of Gabapentin and 2 doses of Clonazepam. 3. LVN A received an Ativan prn order from NP A on 12/14/2024 for Resident #3 and did not add the medication to Resident #3's physician orders or order the medication from the pharmacy. 4. LVN C documented LVN C administered an Ativan prn to Resident #3 on 12/15/2024 that had not been administered. These failures could place residents who receive medications administered by the facility at risk of not receiving the intended therapeutic benefit of their medication. The findings included: Record review of Resident #3's undated face sheet revealed he was a [AGE] year-old male who admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included Vascular Dementia (a general term for impaired ability to remember, think, or make decisions), Type 2 Diabetes (a chronic condition that happens when your body can't use insulin properly), Schizoaffective Disorder, Bipolar Type (a chronic mental illness involving symptoms of schizophrenia and bipolar disorder and characterized by symptoms such as delusions, hallucinations, depression, and high-energy mood), Anxiety Disorder (a feeling of worry, nervousness, or unease) and Depression (a mood disorder that causes persistent feelings of sadness and loss of interest). Record review of Resident #3's quarterly MDS assessment, dated 10/09/2024, revealed Resident #3 had a BIMS score of 14, indicating no cognitive impairment. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's comprehensive care plan revealed the following care plans: 1) [Resident #3] has behaviors in the dining area, during meals, that agitates other residents' r/t he uses vulgar language, racial slurs and talks loudly, start date 11/11/2023. 2) [Resident #3 wants to express himself sexually and is cognitively intact to choose to have a sexual relationship(s), start date 11/13/2023. 3) [Resident #3] has behaviors while outside smoking that agitates other residents' r/t he uses vulgar language, racial slurs, and talks loudly, start date 11/13/2023. 4) Resident has physically abusive behavioral symptoms of physical aggression directed toward another resident, start date 11/11/2023, end date 02/11/2024. 5) Resident has been heard calling his roommate 'my lover', which upsets the roommate. He stated he calls him that because he believes it to be funny, but he does not consider his roommate to be his lover, start date 11/07/2023. 6) Resident has socially inappropriate/disruptive behavioral symptoms as evidenced by [Resident #3] talks in a loud voice and says inappropriate things to staff and other residents. [Resident #3] tells untrue stories such as the Administrator will buy him gifts. [Resident #3] stated his cigarettes were marijuana. [Resident #3] makes false allegations against staff, start date 11/05/2024. 7) Resident has socially inappropriate/disruptive behavioral symptoms as evidenced by recent behaviors reported by nursing staff: argumentative, refusing to come inside late at night, yelling and cursing at staff, singing and talking loudly in the dining area during meal services, start date 10/17/2023. 8) [Resident #3] was observed engaging in a sexual act with another male resident, start date 10/12/2023. 9) Resident has potential for socially inappropriate/disruptive behavioral symptoms r/t bipolar disorder and anxiety, start date 10/12/2023. Record review of Resident #3's December MAR revealed Resident #3 had the following orders: 1. Clonazepam 1mg, 1 tablet, scheduled for 8:00 a.m. and 8:00 p.m. daily for bipolar disorder with a start date of 05/13/2024. The MAR reflected the medication was not administered on 12/13/2024 at 8:00 a.m., the reason documented was unavailable. 12/13/2024 at 8:00 p.m. the medication was not administered; the reason documented was pending delivery. 12/14/2024 at 8:00 a.m. the medication was not administered; the reason documented was unavailable. 2. Benztropine 1mg, 1 tablet, scheduled for 8:00 a.m. daily for schizoaffective disorder with a start date of 12/15/2024. The MAR reflected the medication was administered on 12/15/2024 at 8:00 a.m. 3. Cymbalta delayed release 60mg, 1 capsule, scheduled for 7 a.m.-10 a.m. daily for major depression disorder with a start date of 05/06/2024. The MAR reflected the medication was administered daily as ordered. 4. Gabapentin 400mg, 2 tablets to equal 800 mg scheduled for 8:00 a.m., 2:00 p.m., and 8:00 p.m. for neuropathy pain with a start date of 10/12/2023. The MAR reflected the medication was not administered 12/10/2024 2:00 p.m., the reason documented was pending delivery. 12/12/2024 at 8:00 a.m. and 2:00 p.m. the medication was not administered, and the reason documented was the medication was on order. 12/13/2024 at 8:00 a.m. the medication was not administered, and the reason documented was not available. 12/13/2024 at 8:00pm the medication as not administered, and the reason documented was pending delivery. 12/14/2024 the medication was not administered, and the reason documented was unavailable. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Lyrica 50mg, 1 capsule scheduled for 8:00 a.m.-10:00 a.m. and 8:00 p.m.- 10:00 p.m. for pain with a start date of 05/06/2024. The MAR reflected the medication was not administered 12/13/2024 8:00 a.m.-10:00 a.m., the reason documented was unavailable. 12/13/2024 8:00 p.m. -10:00 p.m. the medication was not administered, and the reason documented was pending delivery. 12/14/2024 8:00 a.m. -10:00 a.m. the medication was not administered, and the reason documented was unavailable. 6) Trazadone 150mg, 1/2 tab scheduled for 8:00 p.m. for insomnia. The MAR reflected the medication was not administered on 12/10/2024 at 8:00 p.m. and the reason documented was pending delivery. Record review of Resident #3's progress note by LVN C, recorded as late entry on 12/15/2024 at 2:03 p.m. and dated 12/12/2024 at 9:55 a.m. stated, Call placed to [pharmacy name] requesting the status of Clonazepam, Lyrica, Gabapentin and Trazodone due to not being filled, [pharmacy] states it's an issue with his insurance since he came off hospice services. Medicaid is listed as his secondary and not primary, Pharmacy is unable to bill for medications. BOM aware. Will continue to follow up. Record review of Resident #3's progress note by LVN A, 12/13/2024 at 2:49 p.m., stated asked BOM to update insurance information so that pharmacy may send medications. done and verified with [pharmacy name] that they received form. Meds should be delivered this evening. Record review of Resident #3's progress note by LVN A, recorded as late entry on 12/14/2024 at 11:50 a.m. and dated 12/13/2024 at 4:40 p.m., stated, Pharmacy called and stated would not send meds because Medicaid is calling themselves secondary payor. Medicaid needs to be called on Monday to get to change. Passed on in report for nurse to call the DON to get approval for meds for the weekend to be sent until situation resolved. Record review of Resident #3's progress note, 12/14/2024 at 11:50 a.m. by LVN A, stated, told in report that DON was not reached. Pt has been very argumentative with staff and other patients all day. Pharmacy called and dose of Clonazepam removed from the ER kit [Emergency Kit]. Pharmacist aware there are only 3 doses left in ER kit and pt takes BID. Lyrica dose is 50 mg and ER kit only has 150 mg capsules. DON contacted and explained situation. She then in turn contacted the pharmacy and meds to be delivered this evening. Difficult to get pt to take the Clonazepam due to being resistant to care and being argumentative. After 15 minutes, pt final took the meds. NP called and informed and gave N.O. for Ativan 0.5mg Q6 PRN. Record review of Resident #3's progress note by Agency LVN B, 12/15/2024 at 1:38 a.m., 14-day supply of Lyrica and Clonazepam delivered. Gabapentin/Benztropine still pending delivery. Record review of Resident #3's progress note by LVN C, 12/15/2024 at 11:21 a.m., stated, Enter this shift this morning and observed resident very talkative, speaking with other residents and staff loudly, sometimes 15 minutes with kisses and hugs. Administered all medications including PRN Ativan 0.5mg. STAT labs CBC. CMP, UA with C&S. Record review of Resident #3's prescription order revealed an ordered received by LVN C on 12/15/2024 for Ativan .5mg, 1 tablet, PRN. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's progress note by the DON, 12/16/2024 at 11:55 a.m., stated Identified in a progress note dated 12/14/2024 at 11:50 a.m. that am floor nurse informed to PRN floor nurse to contact DON regarding delivery of a medication from pharmacy. No contact attempted from pm floor nurse. No missed calls, no missed emails, and no missed text messages identified. Floor nurse for am shift instructed to not endorse the need to DON. When needed, please contact DON immediately. Record review of Resident #3's progress note by the ADON, 12/16/2024 at 4:11 p.m., stated notification received from med aide that she attempted to pull Clonazepam 1mg, Lyrica 50 mg and Gabapentin 400 mg, but was unsuccessful due to a billing issue. Floor nurse notified; NP notified via floor nurse. During an interview with the DON, 12/17/2024 at 9:37 a.m., the DON stated she was notified by LVN A on 12/14/2024 that Resident #3 was out of Clonazepam, Lyrica and Gabapentin and the pharmacy was not sending the medication due to a billing issue. The DON said when she was notified, she immediately called the pharmacy and approved for the medications to be billed to the facility and the medications were delivered the same day. The DON said medications should be reordered at least 24-48 hours prior to a resident reaching the last available dose of their medication and the DON stated she should have been notified by staff immediately, when the facility staff became aware that the pharmacy was not approving the medication so the DON could approve the medication so there would be no disruption in the availability for Resident #3's medications. The DON stated Resident #3 did miss 2 doses of his Clonazepam on 12/13/2024 but received his 8:00 a.m. dose from the E-kit on 12/14/2024 and the 8:00 p.m. dose arrived from the pharmacy. The DON stated the medication aides and charge nurses are responsible for reordering resident medications and the expectation for billing concerns or undelivered medications was for the ADON or DON to have been notified immediately. The DON stated the importance of administering medications per the physician orders and reordering medications timely was to potentially avoid adverse outcomes. The DON stated medication doses should not be missed in order to ensure therapeutic blood levels of the medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with MA A, 12/17/2024 at 10:49 a.m., MA A stated she was the medication aide for Resident #3 and stated she notified a hospice representative around 11/25/2024 that Resident #3 needed a refill on Clonazepam and Lyrica. MA A stated Resident #3 was still on hospice at that time and Resident #3 still had a 14-day supply of the medication when she made the notification. MA A stated, on 12/04/2024 MA A noticed Resident #3 was running low on the medications and called the pharmacy and asked them if they got the reorder prescriptions. MA A stated the pharmacy said Resident #3 was no longer on hospice and needed new billing information and could not send the medication until the billing information was updated. MA A stated she reported this information to LVN A and to the ADON. MA A stated Resident #3's behavior was changing so MA A took a Gabapentin from Resident #9 and administered it to Resident #3 on 12/13/2024 at 2 p.m. MA A stated Resident #9 had enough so I pulled from one of her extra blister packs. Even if she were to run out, I would have enough time to order more for her. She gets 4 or 5 blister packets at a time. MA A said she did not document anything on Resident #9's chart regarding MA A taking one of Resident #9's Gabapentin pills from Resident #9's blister pack. MA A stated she had been educated on not taking administering or borrowing medications from other residents and MA A said, I know we are not supposed to do that. MA A stated staff know when to reorder medications based on the medication blister packet. MA A stated the blister packet has four columns with medications and the 4th column is blue. MA A stated staff are trained to reorder medication when staff reach the blue column and stated staff reorder 7-10 days prior getting to the end of the blister packet. MA A stated the medication aides or nurses can order the medications and if the medication aides have an issue when ordering a medication, the medication aide is required to notify the charge nurse and ADON. The MA A stated, if a medication is not available for a resident, MA would pull it from the E-kit and if it is not available in the E-kit, MA A stated, I will borrow from other residents if they need it. I know we are not supposed to do that, and I don't want to get in trouble, but I would do that. Now, if it was a narcotic, I would not do that, but other meds I would borrow. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LVN A, 12/17/2024 at 12:30 p.m., LVN A stated MA A reported to her on Monday or Tuesday that Resident #3 was low on some medications, and she was trying to reorder his medications. LVN A stated LVM A printed Resident #3's physician orders and faxed them to the pharmacy. LVN A stated when she returned to work on Friday, 12/13/2024, MA A told her Resident #3 was out of Clonazepam, Gabapentin and Lyrica. LVN A stated, I asked her what she did while I was off, and she said she told the ADON. LVN A said she called the pharmacy and was told the face sheet needed to be updated. LVN A went to the BOM and got the face sheet updated and then faxed it to the pharmacy. LVN A stated around 4:40 p.m. the pharmacy called and said they could not send the medication because Medicaid was not aware they were the primary payor source. LVN A stated she called the Medicaid office and sat on hold but by that time it was after 5 p.m. on a Friday so LVN A called NP A and told NP A there was a billing issue with Resident #3's medications and the facility would have to follow up on Monday. LVN A stated NP A was notified that LVN A would pull the medications from the E-kit or would see if the facility could pay for the medication for a few days. LVN A stated she notified Agency LVN B at shift change of the medication concern and LVN A stated she asked Agency LVN B to call the DON and ask her to call the pharmacy to send at least a 3 day supply of the meds since we can't call Medicaid until Monday LVN A stated Agency LVN B asked if Agency LVN B should call the DON that night and LVN A said yes, it's 6 p.m. and still early. LVN A stated when LVN A returned to the facility on [DATE] at 6 a.m. for her shift, Agency LVN B gave report and Agency LVN B stated the DON was not called and notified about the medication and stated Agency LVN B stated she called the pharmacy instead and was told the facility needed to contact Medicaid on Monday. LVN A said LVN A called the DON immediately and notified her Resident #3 did not have his medications and the DON called the pharmacy, covered the cost of the medications and the medications were delivered later that day. LVN A stated LVN A notified NP A on 12/14/2024 that Resident #3's Lyrica dose was different than what was available in the E-kit and NP A gave an order for Ativan prn but LVN A did not administer the medication because Resident #3 said he did not want to take it. LVN A stated Resident #3 was alert and oriented and able to verbal pain and did not verbalize any pain or exhibit pain symptoms related to the missing doses of Gabapentin and Lyrica. LVN A stated the medication aides and charge nurses are responsible for reordering medications and reorder based on the blister pack. LVN A stated medication are usually reordered when a resident has less that a 5-day supply and if a resident does not have a medication available, staff can pull the medication from the e-kit. LVN A stated the charge nurses are responsible for following up on medications that have not arrived from pharmacy and nurses are trained to notify the ADON or DON if a medication was not available. LVN A stated the DON will approve medications to be billed to the facility until funding concerns can be resolved so residents do not miss doses of medications. During an interview with LVN C, 12/17/2024 at 1:09 p.m., LVN C stated the pharmacy informed LVN C on 12/12/2024 Resident #3's Clonazepam, Lyrica and Gabapentin were not covered due to a billing issue. LVN C notified the ADON and the ADON told LVN C to notify the BOM. LVN C stated she then notified the BOM and she said she would look into it. LVN C said she did not work on 12/13/2024 or 12/14/2024. LVN C stated she was notified by the medication aide on 12/15/2024 that Resident #3's Clonazepam and Lyrica had arrived, but the Gabapentin had not and said, we gave him a prn Ativan since we knew he did not have all of his medications in his system. LVN C if there was an issue with reordering resident medication, LVN C usually gets approval to have the facility pay for the medication. LVN C stated she thought the billing issue was being addressed since the BOM said she was taking care of it. I thought it was being taken care of and then I was not here. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Pharmacist, 12/17/2024 at 2:02 p.m., the Pharmacist stated Resident #3 missing a few doses of Clonazepam would not send a resident into a psychotic situation, especially if they are taking other medications as well because the Clonazepam stays in the system for a while. During an interview with Resident #3's Psychiatrist, 12/17/2024 at 2:33 p.m., the Psychiatrist stated when Resident #3 admitted to the facility, Resident #3 exhibited sexually inappropriate, agitated, and disruptive behaviors including delusions related to his diagnoses of Schizoaffective of bipolar types, depression and anxiety. The Psychiatrist stated Resident #3 settled down and was doing well and then had a health decline and was admitted to hospice in April 2024. The Psychiatrist stated, approximately 2 months ago, Resident #3 began showing significant improvement in health and was discharged from hospice services and had been less anxious and agitated and there were no reports of sexual behaviors until this weekend. The Psychiatrist stated Resident #3 was seen weekly and stated Resident #3's behaviors were not the result of Resident #3 missing some doses of his Clonazepam and Lyrica. The Psychiatrist stated Resident #3 was on other psychotropic medications to control mood and behavior and stated Resident #3 is Bipolar and has a history of behaviors and anything could have triggered his bipolar behaviors. During an interview with Agency LVN B, 12/18/2024 at 10:34 a.m., Agency LVN B stated LVN A never told me to call the DON. She edited to say she passed it on to me, but she did not pass it on to me. No one has called to question me or ask me a question about it. Agency LVN B stated she called the pharmacy on the night of 12/13/2024 and they said Medicaid was closed over the weekend and there was nothing that could be done. I notified the ADON the following morning. Agency LVN B stated Resident #3's medications were available on her shift on 12/14/2024. Agency LVN B stated she had been educated to notify the ADON if a medication was not available or not delivered by the pharmacy. During an interview with ADON A, 12/18/2024 at 12:06 p.m., ADON A stated she was notified by LVN A on 12/13/2024 that the pharmacy needed updated billing information from the BOM. ADON A stated she was not aware Resident #3 was completely out of the medication and thought the BOM was addressing it. ADON A stated a medication aide informed her 3 days earlier that Resident #3 only had 3 pills left of his Clonazepam, gabapentin and Lyrica and ADON A said she spoke to the pharmacy and was told the medications would be delivered. ADON A stated, Friday 12/13/2024, all of a sudden, the pharmacy would not send due to an insurance issue. The BOM updated it and sent it over and then the pharmacy called late in the day and said Medicaid says they are a secondary insurance and would not approve so LVN A was trying to call Medicaid. LVN C called me on the morning of 12/14/2024 and I told her to pull the medications from the E-kit and then the DON was contacted and approved for the facility to pay for the medications, and they were delivered the same day. During an interview with NP A, 12/18/2024 12:21 p.m., NP A stated he observed Resident #3 on 12/13/2024 walking around in the hall and he seemed ok. NP A stated Resident #3 had been really great over the last several months. NP A stated he was notified by LVN A on 12/14/2024 that Resident #3 was being verbally aggressive toward people and cursing at other residents. LVN A stated Resident #3's Clonazepam was out of stock and LVN A was getting the medication out of the E-kit and NP A stated he gave her an order for prn Ativan. NP A stated the on-call NP was notified on Sunday that Resident #3 was having disruptive behaviors and ordered a UA, C&S, CBC and CMP. NP A stated he did not think the missing doses of Clonazepam would have contributed to his behavior stating he was also on Cymbalta and Trazadone that are both mood stabilizers as well and Clonazepam stays in the body awhile. If you missed it for a week or more, you could see changes in behavior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/22/2024
NAME OF PROVIDER OR SUPPLIER: Colonial Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 821 US Hwy 81 W New Braunfels, TX 78130	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the BOM, 12/18/2024 at 12:16 p.m., the BOM stated she was notified by LVN C on 12/12/2024 that nursing was having a hard time reordering Resident #3's medication from the pharmacy. I looked into it and realized his payor source had not been updated by hospice in TMHP when he was discharged from hospice services on 12/01/2024. The BOM stated she corrected his face sheet and faxed the information over to the pharmacy as requested on 12/13/2024. During an interview with the DON, 12/18/2024 at 2:12 p.m., the DON stated nursing staff have received education on not administering medications that have been borrowed from other residents or are not prescribed to the resident. The DON stated administering medications to a resident that had been borrowed from another resident could increase the chance for a medication error stating, a med can look similar but not be the same, the doses could be different. They are not trained enough in pharmacology, and we are not pharmacists The DON stated a resident who has medication removed from their blister pack and administered to another resident had the potential to miss doses of their medications if they ran out of the medication before the medication could be reordered. During an interview with LVN A, 12/19/2024 at 7:03 p.m., LVN A stated LVN A received an order from NP A for Resident #3 on 12/14/2024 around noon for Ativan prn. LVN A stated she never administered the medication to Resident #3 and LVN A did not enter the PRN Ativan into Resident #3's consolidated orders or send the order to the pharmacy. LVN A stated well, I guess I missed it and did not put the order in the system. During an interview with LVN C, 12/20/2024 at 1:33 p.m., LVN C stated she did not administered Ativan to Resident #3 on 12/15/2024. LVN C stated she received the order from the on-call NP and entered the order on the order summary but did not pull the medication from the E-kit because Resident #3 was already wired up at that point and was not going to take anything. LVN C said, I must have pre-documented that I gave it thinking I was going to give it but I did not give it. LVN C stated medications should not be documented as administered until after administration, had received training on accurate documentation and stated medication administration should be documented on the MAR. During an interview with the DON, 12/20/2024 at 1:43 p.m., the DON stated medication administration should not be documented until a resident takes the medication because a resident could decline the medication or spit the medication out and should ideally be documented in the resident MAR. The DON stated it was important to document medication administration after the medication is administered to ensure the medication was consumed. During a telephone interview, 12/21/2024 at 10:38 a.m., Agency MA D stated she could not remember if she did or did not administered Resident #3 his 8 AM doses of Gabapentin and Lyrica on 12/14/2024. Agency MA D said if a medication was not available, she would inform the nurse so the nurse could obtain the medication from the E-kit. MA D stated she could not remember who the nurse was that worked on 12/14/2024 and did not remember if she told the nurse if the medications were not available. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Colonial Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 821 US Hwy 81 W New Braunfels, TX 78130	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview, 12/21/2024 at 11:27 a.m., the Medical Director, who was Resident #3's primary physician, stated he thought his NP A was notified that Resident #3 did not receive Gabapentin medication on 12/10/2024, 12/12/2024, 12/13/2024, and 12/14/2024, did not receive Lyrica mediation on 12/13/2024 and 12/14/2024. The Medical Director said the facility's protocol was to notify the physician/primary care provider when a resident did not receive a medication. The Medical Director stated he did not think there would be any harm from not receiving a couple of doses of Gabapentin or Lyrica. The Medical Director stated it was unpredictable if Resident #3 had received the prn dose of Ativan if it would have affected the resident's decomposition or not, and the physician did not think the prn Ativan would have curbed his aggression. The Medical Director said Ativan was to treat anxiety, it was effective with low levels of anxiety, but the effectiveness of the medication was unpredictable in individuals with bipolar [disorder] or schizophrenia diagnoses. During a telephone interview, 12/21/2024 at 11:54 a.m., Resident #3's NP A stated he was not notified that Resident #3 did not receive the Gabapentin medication on 12/10/2024, 12/12/2024, 12/13/24 and 12/14/2024; and he was not notified Resident #3 did not receive the Lyrica medication on 12/13/2024 and 12/14/2024. NP A said there would not have been any harm to Resident #3 when he missed his medication Gabapentin, he could have had .some peripheral [extremities] pain in his feet and legs . and the resident would have to miss a weeks' worth of the medication before it would affect the resident. NP A stated the harm of not receiving the medication Lyrica could result in some pain since it was used to treat Resident #3's neuropathy. NP A stated he gave a verbal order to a nurse over the phone for prn Ativan every 6 hours, he was not informed the resident refused the medication or did not receive the medication. NP A stated had he known Resident #3 refused the Ativan, he would have asked for a more detailed assessment from the nurse such as what medications the resident took that day, what medications the resident had refused, and might have asked for a psychiatric consult sooner or had the resident placed on 1:1 sooner if the resident was agitated. The NP A stated he did not think the missed doses of PRN Ativan could have caused his outburst and had Resident #3 received the Ativan, the resident probably would have mellowed out and not reached the level of aggression that he did, but unfortunately we can't force our patients [residents] to take the medications. During a telephone interview, 12/21/2024 at 12:09 p.m., MA A stated she did not administer Resident #3 his 8 AM doses of Gabapentin and Lyrica on 12/13/2024 because the medications were not available. MA A stated she informed the nurse the medications were not available and thought the nurse she told was LVN A. MA A stated the week before Resident #3 ran out of the medications Gabapentin and Lyrica she had informed the nurses he would be out of the medications in the following week. During an interview, 12/22/2024 at 11:35 a.m., ADON A stated nobody communicated to me that Resident #3 did not receive his Gabapentin medication . on 12/10/2024, 12/12/2024, 12/13/2024 and 12/14/2024. ADON A said if she had been informed Resident #3 had not received his Gabapentin medication, she would have contacted his physician or nurse practitioner, would have contacted the pharmacy to see if the resident needed a new order or if there was a problem with his insurance. ADON A stated the harm of Resident #3 not receiving his Gabapentin medication could cause him to have increased pain, but he did not exhibit or express that he was in pain when she spoke to him, and she spoke to him daily, and he did not communicate that he was in pain. ADON A stated LVN A informed her on 12/13/2024 that Resident #3 had a billing issue for his medication Lyrica because he just came off hospice, the pharmacy was showing the resident was still under hospice and his Medicaid was pending. ADON A stated when she left for the day on 12/13/2024, LVN A was working on this issue. ADON A said she informed LVN A to write a note that there was a billing issue in Resident #3's chart, to contact his physician, and the ADON was not certain if she had communicated this to the DON or not. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/22/2024 at 1:27 p.m., ADON A stated she contacted their pharmacy to find out when Resident #3's prn Ativan was delivered to the facility, and the pharmacy had never received the order, so it was not delivered to the facility. ADON A stated she had checked the medications carts and verified Resident #3 did not have any Ativan in the medication carts. During an interview on 12/22/2024 at 1:30 p.m., the DON stated the procedure for ordering medications was for the nurse to enter the order into the resident's clinical record immediately after it was received. Once the order was entered into the computer and saved, the order would be transmitted to the pharmacy to be filled. The DON stated the pharmacy would not fill a medication order if the order was not in the computer and the nurse cannot pull a medication from the E-kit if the order for the medication was not in the resident's electronic clinical record. The DON said she was not informed Resident #3 had not received his Gabapentin medication on 12/10/2024, 12/12/2024, 12/13/2024 and on 12/14/2024, and Lyrica medication 12/13/2024 and 12/14/2024. The DON stated she was only informed via text message from LVN A on 12/14/2024at 10:55 AM that Resident #3's medications Gabapentin, Clonazepam, and Lyrica needed her approval so they could be refilled, which she did immediately. The DON said had she known Resident #3 had missed doses of his medications Gabapentin, Clonazepam, and Lyrica, she would have contacted the resident's physician or nurse practitioner. Record review of a facility policy titled, PREPARATION AND GENERAL GUIDELINES. IIA2: Medication Administration-General Guidelines (Pharmacy: NPS Care LLC, a [pharmacy name] Pharmacy Services, LLC company, Effective 06/01/2022) stated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. Section B. Administration 15) Medications supplied for one resident are never administered to another resident. Section D. Documentation (including electronic) 1) The individual who administers the medication dose records the administration on the resident's MAR/eMAR direc [TRUNCATED]