STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455020	A. Building B. Wing	07/10/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that were identified in the comprehensive assessment, and described services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 8 residents (Resident #1) reviewed for care plans. The facility failed to ensure Resident #1's care plan reflected his bowel incontinence and included a care plan regarding how to take care of his bowel incontinence. These deficient practices could place residents at risk for not receiving proper care and services due to inaccurate care plans. The findings included: Record review of Resident #1’s face sheet, dated 07/09/2025, revealed Resident #1 was [AGE] years old male, admitted to the facility on [DATE], and re-admitted to the facility on [DATE] with the diagnosis of major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), urinary tract infection (infection to the bladder), dysuria (discomfort, pain, or burning when urinating), neuromuscular dysfunction of bladder (the nerve that carry messages back and forth between the bladder and the spinal cord and brain do not work the way they should), and paraplegia (inability to voluntarily move the lower parts of the body). Record review of Resident #1’s quarterly MDS, dated [DATE], revealed the resident’s BIMS was 15 out of 15, which indicated the resident’s cognition was intact, and the resident needed to have substantial/maximal assistance (Helper does MORE THAN HALF the effort) to sit to stand and chair to bed transfer, and for toilet transfer, the resident did not attempted due to medical condition or safety concerns. Further record review of the MDS indicated Resident #1 had urinary indwelling catheter and was always bowel incontinent. Record review of Resident #1’s comprehensive care plan, dated 03/10/2025, revealed the resident had the care plan regarding how to care for the resident’s bladder, indwelling catheter, but there was no care plan regarding how to care for the resident’s bowel incontinence. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455020	A. Building B. Wing	07/10/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/10/2025 at 9:05 a.m. revealed two CNAs were providing catheter care and perineal care to Resident #1. Interview on 07/10/2025 at 11:50 a.m. Resident #1 said he could not go to the bathroom for a bowel movement by himself, and he had bowel incontinence. The resident stated the facility staff should clean the resident. Interview on 07/10/2025 at 9:17 a.m. CNA A stated Resident #1 was always incontinent of bowel , and staff should check and clean the resident. Interview on 07/09/2025 at 11:13 a.m. the MDS nurse acknowledged there was no care plan regarding how to care Resident #1’s bowel incontinence. The resident was readmitted recently, and the MDS nurse missed it when developing the resident’s care plan. The MDS nurse stated Resident #1’s care plan should have addressed the resident’s bowel incontinence care because the resident was always bowel incontinent, and staff should clean the resident. Interview on 07/10/2025 at 3:45 p.m. the DON stated Resident #1’s care plan should have addressed the resident’s bowel incontinence care because the resident was always incontinent of the bowel, and staff should clean the resident. No care plans regarding how to care Resident #1’s bowel incontinence might cause improper care because the care plan looked like a blueprint. Record review of the facility policy, titled “Care Plans, Comprehensive Person-Centered,” revised 12/2020, revealed “… 9. Areas of concerns that are identified during the resident assessment will be evaluated before interventions are added to the care plan. 10. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. 11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident’s problem areas and their causes, and relevant clinical decision making. a. When possible, interventions address the underlying sources of the problem areas, not just addressing only symptoms or triggers. b. Care planning individual symptoms in isolation may have little, if any, benefit for the resident. ”

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 2 residents (Resident #1) reviewed for incontinence care. When CNA-A was providing incontinent and bladder indwelling catheter care to Resident #1 on 07/10/2025, CNA-A did not clean the resident's suprapubic area (the area of the abdomen located below the umbilical region), left groin area, right groin area, and scrotum. These failures could place residents who required incontinence care at risk for cross contamination and the development of new or worsening urinary tract infections. The findings included: Record review of Resident #1's face sheet, dated 07/09/2025, revealed Resident #1 was [AGE] years old male, admitted to the facility on [DATE], and re-admitted to the facility on [DATE] with the diagnosis of major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), urinary tract infection (infection to the bladder), dysuria (discomfort, pain, or burning when urinating), neuromuscular dysfunction of bladder (the nerve that carry messages back and forth between the bladder and the spinal cord and brain do not work the way they should), and paraplegia (inability to voluntarily move the lower parts of the body). Record review of Resident #1's quarterly MDS, dated [DATE], revealed the resident's BIMS was 15 out of 15, which indicated the resident's cognition was intact, and the resident needed to have substantial/maximal assistance (Helper does MORE THAN HALF the effort) to sit to stand and chair to bed transfer, and for toilet transfer, the resident did not attempted due to medical condition or safety concerns. Further record review of the MDS indicated Resident #1 had urinary indwelling catheter and was always bowel incontinent. Record review of Resident #1's comprehensive care plan, dated 03/10/2025, revealed the resident had the care plan regarding how to care for the resident's bladder, indwelling catheter, but there was no care plan regarding how to care for the resident's bowel incontinence. Observation on 07/10/2025 at 9:05 a.m. revealed CNA-A washed her hands with water, put on gloves and a gown, opened the old and dirty brief of Resident #1, then cleaned only the resident's penis with a circular motion. CNA-A did not clean the resident's suprapubic area, left groin area, right groin area, and scrotum. CNA-A cleaned Resident #1's indwelling catheter gently, then rolled the resident to the left side and cleaned the resident's rectal and buttock areas. Further observation revealed CNA-A changed her gloves after sanitizing her hands and put a new and clean brief under the resident, then closed the brief. Interview on 07/10/2025 at 9:17 a.m. CNA-A acknowledged she did not clean Resident #1's suprapubic area, left groin area, right groin area, and scrotum, then she cleaned only Resident #1's penis, indwelling catheter, and buttock areas. Further interview revealed CNA-A said she was very nervous, so she forgot to clean Resident #1's suprapubic area, left groin area, right groin area, and scrotum. CNA-A stated she should have cleaned those areas to prevent possible infection. Interview on 07/10/2025 at 3:45 p.m. the DON stated CNA-A should have cleaned Resident #1's suprapubic area, left groin area, right groin area, scrotum per the facility policy to prevent possible infection. Record review of the facility policy, titled Perineal Care, revised 12/2020, revealed 01/20/2023, revealed B. For a male resident: . (6) Continue to clean the perineal area including the penis, scrotum, inner thighs. (12) Clean the rental area thoroughly, including the area under the scrotum, the anus, and the buttocks, change the cleansing wipe as needed.