

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455631	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Colonial Manor Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2035 N Granbury St Cleburne, TX 76031	

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (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
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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents had the right to and the facility promoted and facilitated resident self-determination through support of resident choice, which included but not limited to the right to make choices about aspects of his or her life in the facility that were significant to the resident for 1 of 4 residents (Resident #1) reviewed for self-determination. 1. The facility failed to ensure Resident #1's brief was changed when soiled when staff insisted she use the commode instead of her brief. This failure could place residents at risk for being denied the opportunity to exercise his or her autonomy regarding things that were important in their life and a decrease in their quality of life. Findings included: Review of Resident #1 face sheet reflected a [AGE] year-old female admitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (neurological conditions that result from a stroke), transient cerebral ischemic attack (temporary interruption of blood flow or stroke), bipolar disorder (mood swings ranging from depressive lows to manic highs), schizoaffective disorder (mental health condition that combines symptoms of schizophrenia and depression or bipolar disorder), muscle weakness, unspecified lack of coordination, muscle wasting and atrophy right lower leg (loss of muscle mass and strengths), muscle wasting and atrophy left lower leg (loss of muscle mass and strength), and unsteadiness on feet. Review of Resident #1 quarterly MDS dated [DATE] reflected a BIMS of 15 (no cognitive impairment). Further review reflected that resident did not reject any evaluation or care such as ADL assistance. Resident #1 had functional limitation in range of motion with upper extremity impairment on both sides of her body. Review reflected a urinary toileting program had not been trialed with Resident #1 which included scheduled toileting, prompted voiding or bladder training. Review of urinary and bowel continence reflected Resident #1 was frequently incontinent for both. Review reflected Resident #1 was at risk of developing pressure ulcers but had no pressure ulcers. Review reflected Resident #1 had no skin conditions. Review of Resident #1 care plan dated 07/02/2021 reflected Resident #1 had an ADL self-care deficit and was at risk for not having her needs met in a timely manner with a goal for Resident #1 to maintain a sense of dignity by being clean, dry, odor free and well-groomed through 11/19/2025. Review reflected Resident #1 was frequently incontinent of bowel/bladder related to disease process and physical limitations and needed encouragement to get up and use her toilet with date of 06/25/2025. Goal included that resident will be clean and odor free through the next review date of 11/19/2025. Interventions included to check frequently of wetness and soiling and change as needed, use briefs or incontinent products as needed for protections, and assist to the toilet as needed. Review of care plan dated 08/03/2021 reflected Resident #1 was at risk for development of pressure ulcers with interventions to check frequently for soiling or wetness and provide incontinence care as needed, and briefs of adult incontinence products as needed for protections. Review of Resident #1 visual or bedside Kardex (electronic health record) report as of 09/04/2025 reflected under bowel and bladder Resident #1 was incontinent and to check frequently for wetness and soiling and change as needed. Review of Resident #1 bowel and bladder program screener dated 02/12/2025 reflected Resident #1 was not continent of bladder or bowel function which has remained the same since the last three months. Resident #1 was not on a toileting plan and had not been evaluated or found appropriate for a trial toileting plan. Review of bowel and bladder program screener dated 08/14/2025 reflected Resident #1 was continent of bladder and bowel function. Review of bladder continent POC (point of care or electronic health record) response history for 14 days reflected Resident #1 had a continent episode on 08/22/2025, two episodes on 08/31/2025, two episodes on 09/01/2025 and a continent episode on 09/03/2025. Further review reflected resident had 2 incontinent episodes on 08/22/2025, three on 08/23/2025, three on 08/24/2025, two on 08/25/2025, three on 08/26/2025, two on 08/27/2025, two on 08/28/2025, one on 08/30/2025, one on 08/31/2025, one on 09/01/2025, three on 09/02/2025 and one on 09/03/2025. Review of bowel continent POC response history for 14 days reflected Resident #1 had one continent episode on 08/22/2025, one on 08/28/2025, two on 08/30/2025, two on 09/01/2025 and one on 09/03/2025. Further review reflected Resident #1 had one incontinent episode on 08/22/2025, two on 08/24/2025, one on 08/25/2025, three on 08/26/2025, one on 08/27/2025, one on 08/28/2025, one on 08/31/2025, one on 09/01/2025, two on 09/02/2025 and one on 09/03/2025. Review of care plan conference notes dated 07/15/2025 reflected meeting was held on 07/14/2025 at 11:00 AM. Nursing summary reflected there were no concerns, issues or changes and discussed resident's independence. Social services</p>		