STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455631	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor Nursing Center	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 0600 Level of Harm - Actual harm Residents Affected - Few	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** Based on interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for three (Residents #2, #3, and #4) of 6 residents reviewed for abuse.On 01/05/2026 the facility failed to protect Resident #1 from hitting Resident #2 resulting in a scratch measuring 0.02x0.4cm to Resident #2's right eye and a scratch measuring 0.01x0.3cm to the bridge of Resident #2's nose. On 01/08/2026 the facility failed to protect Resident #4 from being called a liar by LVN A.On 01/31/2026 the facility failed to protect Resident #3 from being followed by Resident #1 down the hall to initiate a fist fight, residents' arms made contact with no injuries.This failure could place residents at risk of continued abuse and harm. Findings included: Residents #1, #2, and #3 Record review of Resident #1's face sheet, dated 02/12/2026, revealed a sixty-one-year-old male who was admitted to the facility on [DATE]. His admitting diagnoses included alcoholic polyneuropathy (nerve damage caused by chronic, heavy alcohol consumption and associated nutritional deficiencies), vascular dementia (a cognitive decline caused by reduced blood flow to the brain, damaging brain tissue and causing symptoms like memory loss, confusion, and impaired planning) and aphasia (a language disorder that impairs the ability to speak, understand, read, and write, with symptoms ranging from mild word-finding difficulties to total communication loss). Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) dated 01/28/2026 Quarterly Assessment Section C - Cognitive Patterns revealed a score of 0 indicating severe cognitive issues, E0200 - Behavioral Symptom - Presence and Frequency - Physical behavioral symptoms directed toward others Behavior of this type occurred 1 to 3 days. Record review of a care plan dated 12/30/2025 revealed a focus of Resident #1 had a behavioral problem as evidenced by Resident #1 hit another resident with intervention dated 02/03/2026 Resident #1 moved to a private room with a private bathroom and intervention dated 01/06/2026 staff will check on Resident #1 frequently to ensure needs are met. Record review of Resident #2's face sheet, dated 02/12/2026, revealed an eighty-three-year-old male who was admitted to the facility on [DATE] and re-admitted [DATE]. His admitting diagnoses included Alzheimer's disease (the most common form of dementia, a brain disorder that slowly destroys a person's memory and thinking skills), anxiety disorder (mental health conditions characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life), and depressive episodes (a period of at least two weeks featuring persistent, severe low mood or loss of pleasure (anhedonia), along with symptoms like sleep disturbances, fatigue, guilt, and reduced concentration that impair daily functioning). Record review of Resident #2's MDS dated [DATE] Resident Comprehensive and Care Screening Section C - Cognitive Patterns revealed a score of 0 indicating severe cognitive issues, Section C - Cognitive Patterns - Delerium C1310 - signs and symptoms of delirium inattention - did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was (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: 455631	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2026
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F 0600 Level of Harm - Actual harm Residents Affected - Few	being said and disorganized Thinking - was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject) - behavior continuously present, did not fluctuate. Review of Resident #2's care plan dated 11/25/2025 revealed a focus for wandering/exit seeking indicated - Resident #2 wanders related to cognitive impairment and was at risk for injury with a goal dated 11/25/2025 of Resident #2 will wander in a safe environment without occurrence of injury and dignity will be maintained through the next review date of 04/23/2025 with interventions dated 11/25/2025 attempt to determine any pattern or cause of wandering, redirect if Resident #2 enters a restricted area, and distract Resident #2 from wandering by offering pleasant diversions, structured activities, food, conversation etc. Record review of Resident #3's face sheet, dated 02/12/2026, revealed a seventy-five-year-old male who was admitted to the facility on [DATE]. His admitting diagnoses included dementia (a progressive, non-normal aging condition involving a decline in mental abilities severe enough to disrupt daily life), bipolar disorder (chronic mental health condition characterized by extreme shifts between high-energy mania and low-energy depression), and anxiety disorder. Review of Resident #3's care plan revealed a focus dated 11/17/2025 Resident #3 had a behavior problem as evidenced by become agitated when staff attempted to redirect causing aggression toward staff attempted to hit resident punches at the air at times when frustrated with intervention dated 12/17/2025 monitor behavior episodes and attempt to determine underlying cause, assess and anticipate Resident #3's needs, intervention dated 11/17/2025 approach Resident #3 in a calm manner, intervention dated 11/17/2025 when Resident #3 becomes agitated intervene before the agitation escalates by guiding away from source of distress engaging calmly in conversation or attempting to [other] interventions. If response is aggressive then approach at a later time after ensuring the safety of Resident #3 and nearby residents. Record review of Resident #3's MDS (clinical assessment to determine resident's strength and needs) dated 11/16/2025 Resident Comprehensive and Care Screening Section C - Cognitive Patterns revealed a score of 0 indicating severe cognitive issues, Section C - Cognitive Patterns - Delerium C1310 - signs and symptoms of delirium inattention - did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said and disorganized Thinking - was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject) - behavior continuously present, did not fluctuate. Review of Resident #2's Skin Observation Worksheet dated 01/05/2026 by ADON A reflected right eye scratch 0.02x0.4cm and bridge of nose scratch 0.01x0.3cm. Record review of a written statement dated 01/05/2026 by CNA A revealed CNA A and CNA B were outside Residents' room when they heard Resident #2 yelling out, oh, no help me ow! It sounded like Resident #2 was crying. We entered the room. Resident #1 had his hand balled into a fist and pulled back. Resident #2 was leaning over on his side with his hand over his eyes whimpering. Resident #1 walked off and said nothing. CNA A called for nurses. Resident #2 had a visible mark under his right eye and another one across the bridge of his nose. LVN C said to move Resident #1 to another room in the secured unit. Record review of written statement dated 01/05/2026 by CNA C revealed on 01/05/2026 CNA A and CNA B came to the nurse's station and said Resident #1 hit Resident #2 in the face. CNA C went to the room of Resident #1 and Resident #2, and Resident #2 was hunched over holding his face. When Resident #2 removed his hand CNA C saw Residen#2 had a cut on his nose and under his right eye. CNA C said they removed Resident #2 from the room. Record review of a written statement dated 01/05/2026 by CNA B revealed CNA B and CNA A heard someone yell for help. When they went to the room, they saw Resident #1 leaning over Resident #2's bed making a fist to hit him. CNA B and CNA A were able (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	to move Resident #1 away from Resident #2. CNA B and CNA A looked at Resident #2's face and Resident #2 had a scratch on the lower part of the eye and the side of his nose. Record review of written statement dated 01/05/2026 by LVN C revealed a CNA (CNA not identified) came into the hallway calling and the CNA said, Hey, he just punched him. On entering the room Resident #2 was noted in bed covering his face with his hands. After moving Resident #2's hands Resident #2's nose was red with a small opening on the bridge of Resident #2's nose and another small opening under Resident #2's right eye. Resident #2 began asking, why'd he do that? Resident #1 was asked what happened and Resident #1 said he had no idea. Review of Resident #1's progress note dated 01/05/2026 by LVN D reflected Resident #1 was seen by CNA (CNA not identified) with right back arm pulled back with a balled fist. Resident #1 standing over roommate Resident #2. Resident #2 lying on left side curled up with hands covering right eye yelling, help me. Resident #1 went back to his side of the room. Resident #2 said, I don't know what happened. Resident #1 moved to another room without a roommate. Review of Resident #2's progress note dated 01/05/2026 by LVN D reflected Resident #2 was lying in bed yelling Oh no, help me. Resident #1 was standing over Resident #2 when staff walked and saw Resident #1's arm pulled back with hand balled in fist. Resident #2 was lying in bed with hands over his right eye curled up on his left side. Resident #2 repeated I don't know why, I don't know why. I don't know why. Resident #1 and roommate Resident #2 were separated. Noted small open area on bridge on nose 0.2cm x 0.8cm. and a small open area below the right eye 0.2cm x 0.7cm. Review of Resident #1's progress note dated 01/22/2026 by LVN C reflected Resident #1 following another resident into the hall, yelling at him d/t the other resident walking through restroom into his room. resident was redirected back to his room where he has since calmed down Review of Resident #1's progress note dated 01/27/2026 by LVN C reflected Resident #1 noted agitation d/t another male resident wandering into room multiple times. Review of Resident #1's progress note dated 01/27/2026 by LVN C reflected Resident #1 noted agitation d/t another male resident repeatedly coming into his room. he has been redirected by staff and is now calm in room. this behavior repeats each time. Review of Resident #1's progress note dated 01/31/2026 by LVN A reflected Resident #3 entered Resident #1's room and was asked to leave. This agitated Resident #1, and he followed Resident #3 down the hall to initiate a fist fight. Resident #1 punched Resident #3 from his wheelchair and a brief fight began until they were told to stop. Stopped on command and no signs or symptoms of injury were found. Arms made contact but no contact with face or body. No complaints of pain. Review of Resident #1's progress note dated 01/31/2026 by LVN A reflected Resident #3 wandered into Resident #1's room and was asked to leave. Resident #1 followed Resident #3 down the hall and initiated fight. The residents were redirected away from each other with no resistance. Residents were stopped on command and only arms made contact. Residents were assessed for injury with no signs or symptoms of injury. The administrator, DON, and ADONs notified. During an interview on 02/12/2026 at 12:28 PM, LVN C stated he worked with Resident #1 who was a private guy and was no longer in the secured unit. Resident #1 was moved to the general area. LVN C said he was aware that Resident #1 was involved in two resident-to-resident altercations with physical contact. LVN C said he worked on 01/05/2026 and a nurse was called by CNA A to Resident #1's room. When the staff arrived at Resident #1's room Resident #2 was covering up his face and Resident #1 had red marks on his knuckles. Resident #2 had redness under his eyes and a bruise beginning under one eye. Resident #2 was in a fetal position with his hands over his face. Resident #1 was sitting on his bed. Resident #1 said he did not hit Resident #2 and said Resident #2 would not shut up. LVN C said there had been times when Resident #1 would yell at Resident #2, but LVN C did not think Resident #1 would get physical. After they moved Resident #1 to his own room he did not think there would be (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	additional physical altercations. LVN C said Resident #1 would yell at residents if they went into his room. LVN C said he was not surprised when Resident #1 had an incident with Resident #3 because Resident #3 had wandered in Resident #1's room a few times. When Resident #3 wandered into Resident #1's room, Resident #1 would yell at Resident #3. Resident #1 was not an elopement risk, and he was moved to the general resident area. Resident #1 was moved because he would have more privacy. LVN C said Resident #1 was not placed on 1:1 (continuous and direct supervision strategy where a dedicated staff member is assigned to observe only one patient at all times) but they added an additional CNA on the hallway. LVN C was aware that there had been other incidents where Resident #1 would yell at residents for wandering into his room, but staff intervened and de-escalated the situation before there was any physical altercation. During an interview by phone on 02/12/2026 at 12:20 PM, CNA A stated she was present the evening of the altercation on 01/05/2026 between Resident #1 and Resident #2. CNA A said she did not see Resident #1 hit Resident #2 but when she pulled back the curtain in the room Resident #1 and Resident #2 used to share, she saw Resident #1's hand was drawn back to hit Resident #2. CNA A said she heard Resident #2 crying and that was why she walked into the room. CNA A said Resident #2 had a visible injury on his eye and across the bridge of his nose. She said LVN C instructed Resident #1 to be moved to another room without a roommate. She said she was not concerned that Resident #1 would engage in another resident-to-resident altercation. She said the facility added another staff member to the unit for an additional safety precaution. She said there was not an in-service that said that staff need to make sure that Resident #1 did not have other residents go into his room but this was discussed during shift report. During an interview on 02/12/2026 at 12:56 PM, LVN A stated on 01/31/2026 Resident #3 poked his head into Resident #1's room and Resident #1 began swinging his fists at Resident #3's head. LVN A said Resident #1 and Resident #3 started to hit each other but they did not make contact. LVN A said there were no injuries and he reported the incident to the Administrator, the DON, and the ADON. During an interview by phone on 02/12/2026 at 1:51 PM, the psychiatric NP stated that Resident #1 had a history of alcoholism with vascular dementia, and he got agitated if someone came into his room. She said Resident #1 slept a lot and stayed in his room. The Psychiatric NP said the facility called her and told her about the altercations he had on 01/05/2026 and 01/31/2026. She said he was on the secured unit and after the incident on 01/05/2026 Resident #1 was moved to his own room on the secured unit. She said she did not know if it was possible to keep people away from Resident #1 on the secured unit because residents in the secured unit sometimes wandered into other residents' rooms. She said Resident #1 was not exit seeking and after the incident on 01/31/2026 he was moved to his own room on the non-secured unit. The psychiatric NP said she was not concerned about Resident #1 hurting anyone now that he was no longer in the secured unit because residents in the non-secured unit do not wander and Resident #1 stays in his room. During an interview on 02/12/2026 at 3:49 PM, Resident #1 did not respond when asked about any difficulties with other residents at the facility. When asked if he was okay, he said he was okay. During an interview on 02/12/2026 at 3:56 PM, Resident #2 did not respond when asked if he had any difficulties with other residents. Attempted an interview on 02/12/2026 at 3:59 PM, with Resident #3 but he was not interviewable. During an interview on 02/12/2026 at 4:48 PM, CNA B stated that she and CNA A heard a noise like someone was calling for help and they pulled away the privacy curtain around Resident #2's bed and Resident #1 was trying to punch Resident #2 in the face. Resident #2 had redness on his face, and a little bit of bleeding and Resident #1 was standing over Resident #2 with his fist up. She said Resident #1 did not like to be bothered. Resident #1 just wanted to stay in his room and for staff to bring him coffee. She said if a resident hits another resident, it was abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	She said she was trained to tell the Administrator, who was the abuse and neglect coordinator, about any abuse immediately. Resident #4 Record review of Resident #4's face sheet, dated 02/13/2026, revealed a seventy-nine-year-old female who was admitted to the facility on [DATE]. Her admitting diagnoses included Alzheimer's disease, dementia, and depression (a common, serious mood disorder characterized by persistent sadness, loss of interest in activities, and, in severe cases, thoughts of suicide). Review of Resident #4's care plan revealed a focus dated 01/05/2026 of wandering/exit seeking, Resident #4 wanders related to cognitive impairment and is at risk for injury with intervention dated 01/05/2026 attempt to determine any pattern or cause of wandering. Record review of Resident #4's MDS (clinical assessment to determine resident's strength and needs) dated 01/28/2026 Resident Comprehensive and Care Screening Section C - Cognitive Patterns revealed a score of 10 indicating moderate cognitive issues. Record review of statement, undated, from CNA D reflected LVN B was yelling at Resident #4 and told Resident #4 to sit down in her chair, not move and Resident #4 was going to staying down there with her. Resident #4 kept telling LVN B that she wanted to go the restroom and had to pee real bad. LVN B told Resident #4 that she had just put her in her bed and that Resident #4 kept getting up and that LVN B was not going to keep putting her in her bed all night. Resident #4 kept repeating, I have to pee, I have to pee, I'm going to pee on myself. If you let me go to the bathroom then I'll go to bed. LVN B told Resident #4 that she was lying again. CNA D said she told LVN B that she was going to take Resident #4 to the restroom and LVN B told her no, leave her there. CNA D said that Resident #4 tried to stand up at least twice and LVN B made Resident #4 sit down. CNA D said Resident #4 stood up facing her chair and began to pull her dress up saying that she had to pee. Resident #4 threaten to pee on the floor because she could not hold it. CNA D came down to get Resident #4 again. When LVN B told CNA D to again leave Resident #4 where she was CNA D told LVN B that the girls on the other end were to be watching Resident #4 because she was a fall risk. CNA D said she took Resident #4 to the other end of the hall with the aides to remove her from the verbal abuse and neglect. Record review of statement dated 01/09/2026, written by LVN B reflected the Administrator asked LVN B what happened on 01/08/2026 and LVN B said Resident #4 was up all night and Resident #4 did not feel tired and was not staying in bed. LVN B denied she yelled at Resident #4. LVN B said she did tell Resident #4 she had just taken Resident #4 to the bathroom and would have to wait a minute before she took her again since she had just taken her out of the bathroom. LVN B stated she had taken Resident #4 to the bathroom four times. Record review of statement dated 01/09/2026, written by ADON A reflected Resident #4 was asked by ADON A if any staff was yelling at her. Resident #4 stated in one (pointed to her ear) out the other (pointed to her other ear). ADON A said she asked Resident #4 if she had any problems through the night. Resident #4 stated I don't want any trouble. ADON A assured Resident #4 she would not be in trouble, but ADON A needed to make sure she was safe. Resident #4 began joking about various topics. Review of Facility Termination Form dated 01/12/2026 revealed LVN B's employment with the facility was terminated by phone on 01/12/2026 by the DON for resident abuse. During an interview on 02/12/2026 at 5:02 PM, CNA D stated she was working with LVN B and Resident #4 came out of her room. CNA D said Resident #4 had gone back and forth from her room to the dining room several times. CNA D said LVN B yelled at Resident #4 telling her she was a fall risk and to sit down in her wheelchair and not move. CNA D said Resident #4 told LVN B that she needed to go to the bathroom. CNA D said that LVN B told Resident #4 that she was lying and if LVN B took Resident #4 back to her room, Resident #4 would just get in her bed then get up again and end up falling. CNA D said Resident #4 kept telling LVN B that she had to go to the bathroom and LVN B told Resident #4 she was nothing but a liar. CNA D said Resident #4 told LVN B that she was going to (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	pee on herself if LVN B, who was standing in front of Resident #4's wheelchair blocking here from getting up did not let her go to the bathroom. CNA D said Resident #4 was upset, crying and begged to go to the bathroom. CNA D said she intervened and took Resident #4 to the bathroom and reported the incident to the Administrator. CNA D said that CNA E and CNA F witnessed the incident. During an interview on 02/13/2026 at 8:56 AM, LVN E said she worked with LVN B and LVN B could be hostile to residents, but she did not see LVN B deny residents' care. LVN E said she heard LVN B tell a resident (she did not recall resident's name) you need to go to your room, lay down, and stay down. LVN E said this was against residents' rights because a resident had the right to stay up as long as they wanted. She said this was about two years ago and she reported it to the former Administrator who said he would address it. During an interview on 02/13/2026 at 9:11 AM, Resident #4 said everybody was nice to her and she did not have a problem with any of the nurses telling her she had to go to bed or not letting her go to the bathroom. Attempted an interview via phone with CNA F on 02/13/2026 at 9:41 AM. Surveyor left a voice mail and sent a text message. During an interview on 02/13/2026 at 9:55 AM, the SW said she spoke with Resident #4 after the incident that involved Resident #4 and LVN B. The SW said Resident #4 said she did not remember anything that happened with LVN B and Resident #4 did not exhibit any emotional distress when the incident was discussed. During an interview on 02/13/2026 at 10:35 AM, LVN B stated on 01/08/2026, Resident #4 was restless and kept going back and forth from her room to the nurse's station and kept saying she needed to go to the bathroom. LVN B said she did tell Resident #4 she was lying when Resident #4 said she needed to go to the bathroom. LVN B said she should not have told the resident she was lying. LVN B said she did not prevent Resident #4 from leaving her wheelchair and did not yell at Resident #4. During an interview on 02/13/2026 at 10:36 AM, CNA E stated she had worked with LVN B and said that LVN B could be rude and ugly when speaking to residents, but she did not hear LVN B be verbally abusive to residents. During an interview on 02/13/2026 at 1:07 PM, the Administrator said if a nurse told a resident they were a liar that was inappropriate and a form of abuse and neglect. He said he could not imagine why someone would tell a resident they were a liar because that was a derogatory term. During an interview on 02/13/2026 at 2:03 PM, ADON B said it was not okay to tell a resident that they were a liar. She said it was abuse to tell a resident they were lying, and it might make the resident feel offended and the resident might be defensive. She said it could be considered emotional abuse to tell a resident they were a liar. During an interview on 02/13/2026 at 3:08 PM, the DON said to call a resident a liar was verbal abuse and it could possibly hurt a resident's feelings. Review of Policy and Procedures dated 09/06/2024 titled Abuse, Neglect and Exploitation revealed it is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. Mental Abuse'' includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the State Survey Agency in accordance with State law through established procedures for 1 of 4 residents (Resident #3) reviewed for reporting allegations of abuse. The facility failed to report a resident-to-resident altercation on 01/31/2026, when Resident #1 followed Resident #3 down the hall to initiate a fist fight, residents' arms made contact with no injuries. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings include: Record review of Resident #1's face sheet, dated 02/12/2026, revealed a sixty-one-year-old male who was admitted to the facility on [DATE]. His admitting diagnoses included alcoholic polyneuropathy (nerve damage caused by chronic, heavy alcohol consumption and associated nutritional deficiencies), vascular dementia (a cognitive decline caused by reduced blood flow to the brain, damaging brain tissue and causing symptoms like memory loss, confusion, and impaired planning) and aphasia (a language disorder that impairs the ability to speak, understand, read, and write, with symptoms ranging from mild word-finding difficulties to total communication loss). Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) dated 01/28/2026 Quarterly Assessment Section C - Cognitive Patterns revealed a score of 0 indicating severe cognitive issues, E0200 - Behavioral Symptom - Presence and Frequency - Physical behavioral symptoms directed toward others Behavior of this type occurred 1 to 3 days. Record review of a care plan revealed dated 12/30/2025, revealed a focus of Resident #1 had a behavioral problem as evidenced by Resident #1 hit another resident with intervention dated 02/03/2026 Resident #1 moved to a private room with a private bathroom and intervention dated 01/06/2026 staff will check on Resident #1 frequently to ensure needs are met. Record review of Resident #3's face sheet, dated 02/12/2026, revealed a seventy-five-year-old male who was admitted to the facility on [DATE]. His admitting diagnoses included dementia (a progressive, non-normal aging condition involving a decline in mental abilities severe enough to disrupt daily life), bipolar disorder (chronic mental health condition characterized by extreme shifts between high-energy mania and low-energy depression), and anxiety disorder. Review of Resident #3's care plan revealed a focus dated 12/12/2026 Resident #3 had a behavior problem as evidenced by become agitated when staff attempted to redirect causing aggression toward staff attempted to hit resident punches at the air at times when frustrated with intervention dated 12/17/2025 monitor behavior episodes and attempt to determine underlying cause, assess and anticipate Resident #3's needs, intervention dated 11/17/2025 approach Resident #3 in a calm manner, intervention dated 11/17/2025 when Resident #3 becomes agitated intervene before the agitation escalates by guiding away from source of distress engaging calmly in conversation or attempting to [other] interventions. If response is aggressive then approach at a later time after ensuring the safety of Resident #3 and nearby residents. Record review of Resident #3's MDS (clinical assessment to determine resident's strength and needs) dated 11/16/2025 Resident Comprehensive and Care Screening Section C - Cognitive Patterns revealed a score of 0 indicating severe cognitive issues, Section C - Cognitive Patterns - Delerium C1310 - signs and symptoms of delirium inattention - did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was (continued on next page)

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 02/13/2026
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.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being said and disorganized Thinking - was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject) - behavior continuously present, did not fluctuate. Review of Resident #1's progress note dated 01/31/2026 by LVN A reflected Resident #3 entered Resident #1's room and was asked to leave. This agitated Resident #1, and he followed Resident #3 down the hall to initiate a fist fight. Resident #1 punched Resident #3 from his wheelchair and a brief fight began until they were told to stop. Stopped on command and no signs or symptoms of injury were found. Arms made contact but no contact with face or body. No complaints of pain. Review of Resident #1's progress note dated 01/31/2026 by LVN A reflected Resident #3 wandered into Resident #1's room and was asked to leave. Resident #1 followed Resident #3 down the hall and initiated fight. The residents were redirected away from each other with no resistance. Residents were stopped on command and only arms made contact. Residents were assessed for injury with no signs or symptoms of injury. The administrator, DON, and ADONs notified.Record review of TULIP (state online abuse reporting portal) did not indicate any reports from facility regarding the incident dated 01/31/2026. Resident #1 followed Resident #3 down the hall to initiate a fist fight until 02/13/2026. Record review of TULIP provider investigation report dated 02/13/2026 reflected incident dated 01/31/2026 Resident #1 history of physical aggression and Resident #3 history of wandering description of the allegation reflected there was an altercation between two male residents. Resident #3 went into Resident #1's room. Resident #1 followed Resident #3 into the hallway, and a verbal altercation took place. Resident #1 struck Resident #3 when he was seated. Staff intervened and there were no injuries. During an interview on 02/12/2025 at 12:56 PM, LVN A stated on 01/31/2026 Resident #3 poked his head into Resident #1's room and Resident #1 began swinging his fists at Resident #3's head. LVN A said Resident #1 and Resident #3 started to hit each other but they did not make contact. LVN A said there were no injuries and he reported the incident to the Administrator, the DON, and the ADON.During an interview on 02/12/26 at 2:12 PM, the Administrator said he did not self-report the incident on 01/31/2026 between Resident #1 and Resident #3 because there was no physical contact. The Administrator said it was his understanding that staff saw Resident #1 come after Resident #3, but staff intervened before there was any abuse. He said the way it was explained to him he did not think he needed to report it but if he read Resident #1's progress note dated 01/31/2026 by LVN A he probably would have reported the incident. The progress note indicated Resident #1's intent to hurt Resident #3 and Resident #1 might have frightened Resident #3 when he followed him down the hallway with intent of a fist fight. During an interview on 02/13/2026 at 3:08 PM, the DON said the incident on 01/31/2026 with Resident #1 and Resident #3 was a resident-to-resident physical altercation and it was not investigated or reported to HHS. The DON said it was the facility policy to both investigate and report all resident-to-resident abuse allegations and it should have been reported as soon as the Administrator learned about the incident. Review of the facility Policy and Procedures dated 09/06/2024 titled Abuse, Neglect and Exploitation revealed the facility reports abuse and abuse allegations that include: 1. Reporting allegations involving staff to-resident abuse, resident-to resident altercations involving allegations of abuse, injuries of unknown source, misappropriation of resident property exploitation, and mistreatment.2. It is the responsibility of the staff to immediately protect the residents by removing them from the situation providing them safety and then immediately reporting to the Abuse Coordinator (The Administrator or Designee) if they become aware of an incident of resident or patient abuse or neglect, whether alleged, suspected or observed. It is a criminal offense to be aware of suspected or observed resident or patient abuse and not rcpo1t it. Staff failure to report suspected or observed Abuse or Neglect will (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor Nursing Center	2035 N Granbury St Cleburne, TX 76031

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	result in disciplinary action up to and including termination of employment3. Reporting of all alleged violations to the Adn1inistrator is in11nediate without any delay, the Administrator will then report to state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified time frame:a. Immediately, but not later than2 hours after the allegation is made, if the events that cause the allegation involves Abuse (with or without bodily injury)b. An Incident that results in serious bodily injury and that involves any of the following: Neglect Exploitation Mistreatment injuries of unknown source Misappropriation of resident propertyc. Not later than 24 hours after the incident occurs or is suspected. An incident that doesnot result in serious bodily injury but that involves any of the following: Neglect Exploitation A missing resident Misappropriation of resident property Drug thief