STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675044	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor Advanced Rehab & Healthcare	1100 W Minnesota Rd Pharr, TX 78577

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 2 of 4 Residents (Resident #2, Resident #3) reviewed for medical records accuracy, in that: 1.Resident #2's June 2024 Medication Administration Record documentation record was incomplete. Staff did not document or sign off on the administration of physician ordered insulin. 2.Resident #3's June 2024 Medication Administration Record documentation record was incomplete. Staff did not document or sign off on the administration of physician ordered insulin. This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care, and treatment. The findings included: 1. Record review of Resident #2's face sheet, dated 06/10/24, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: COVID-19 (Contagious respiratory disease caused by severe acute respiratory syndrome coronavirus 2), type 2 diabetes mellitus with hyperglycemia (high levels of sugar in blood), enteroinvasive escherichia coli infection (type of pathogenic bacteria that can cause profuse diarrhea and high fever), chronic kidney disease (longstanding disease of the kidneys leading to renal failure). Record review of Resident #2's state optional Minimum Data Set assessment, dated 05/04/24, revealed Resident #2 had a BIMS score of 15, indicating she was cognitively intact. Record review of Resident #2's care plan, retrieved on 06/10/24 revealed Resident #2 had a focus of, Resident #2 had a diagnosis of diabetes and is at risk of unstable blood sugars and abnormal lab results with an initiation date of 08/08/19 and an intervention of Administer sliding scale insulin if ordered. For any blood sugars not within the acceptable parameters as dictated by the physician, document and notify the physician with an initiation date of 08/08/19. Record review of Resident #2's physician's orders, retrieved on 06/10/24, revealed orders for (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. NovoLOG FlexPen Solution Pen-injector 100 UNIT/ML (Insulin Aspart) with directions to Inject as per sliding scale: if 200 - 250 = 2 UNITS; 251 - 300 = 4 UNITS; 301 - 350 = 6 UNITS; 351 - 400 = 8 UNITS >400 ADMINISTER 10 UNITS AND NOTIFY MD, subcutaneously (under the skin) before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA with a start date of 06/27/23, order was active as of 06/10/24. 2. NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) with directions to Inject 8 unit subcutaneously before meals for DM with a start date of 06/23/2023, order was active as of 06/10/24. 3. Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) with directions to Inject 18 unit subcutaneously two times a day related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA with a start date of 05/29/2024, order was active as of 06/10/24. Record review of Resident #2's Medication Administration Record for June 2024 revealed 3 unsigned sections on 06/03/24 at the scheduled time of 4:00pm, for the following physician orders. 1. NovoLOG FlexPen Solution Pen-injector 100 UNIT/ML (Insulin Aspart) with directions to Inject as per sliding scale: if 200 - 250 = 2 UNITS; 251 - 300 = 4 UNITS; 301 - 350 = 6 UNITS; 351 - 400 = 8 UNITS >400 ADMINISTER 10 UNITS AND NOTIFY MD, subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA with a with a start date of 06/27/23, order was active as of 06/10/24. 2. NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) with directions to Inject 8 unit subcutaneously before meals for DM with a start date of 06/23/2023, order was active as of 06/10/24. 3. Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) with directions to Inject 18 unit subcutaneously two times a day related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA with a start date of 05/29/2024, order was active as of 06/10/24. 2. Record review of Resident #3's face sheet, dated 06/10/24, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: COVID-19 (Contagious respiratory disease caused by severe acute respiratory syndrome coronavirus 2), diabetes mellitus due to underlying condition with hyperglycemia (high levels of sugar in blood), hypertension (Blood pressure that is higher than normal), end stage renal disease (kidneys no longer work as they should to meet your body's needs). Record review of Resident #3's state optional Minimum Data Set assessment, dated 05/10/24, revealed Resident #3 had a BIMS score of 13, indicating she was cognitively intact. Record review of Resident #3's care plan, retrieved on 06/10/24 revealed Resident #3 had a focus of, Resident #3 has a diagnosis of diabetes and is at risk of unstable blood sugars and abnormal lab results with an initiation date of 09/17/19 and an intervention of Administer sliding scale insulin if ordered. For any blood sugars not within the acceptable parameters as dictated by the physician, document and notify the physician with an initiation date of 09/17/19. Record review of Resident #3's physician's orders, retrieved on 06/10/24, revealed orders for (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Fiasp FlexTouch Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart (with Niacinamide)) with directions to Inject subcutaneously before meals and at bed time for DM. Record review of Resident #3's Medication Administration Record for June 2024 revealed an unsigned section on 06/03/24 at the scheduled time of 4:00pm, for the following physician orders. 1. Fiasp FlexTouch Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart (with Niacinamide)) with directions to Inject as per sliding scale: if 150 - 199 = 1 unit; 200 - 249 = 2 units; 250 - 299 = 3 units; 300 - 349 = 4 units call md if >350 or <70. Subcutaneously before meals and at bed time for DM. During an interview with LVN A on 06/07/24 at 5:45pm she stated she worked with Resident #2 and #3 on 06/03/24 and stated she took blood sugar readings and provided insulin to both Resident #2 and #3 at their scheduled time of 4:00pm before dinner. LVN A stated she documented blood sugars and insulin administration in her journal on 06/03/24 and had not transferred it into the resident's electronic chart. LVN A provided her journal with documentation and stated she should have transferred her documentation into the resident's electronic charts. LVN A stated medication administration should be documented because it showed proof it was given. LVN A stated she had been trained on documentation of medication administered with the last month. LVN A stated not completing documentation of administered medication could negatively impact residents because someone else may come in and think it had not been given. During an interview with Resident #2 on 06/10/24 at 3:02pm she stated she did not know who LVN A was but stated she had received all her insulin and blood sugar checks in the past week and stated on 06/03/24 she received all her blood sugar checks and all her insulin as ordered. During an interview with Resident #3 on 06/10/24 at 3:07pm she stated she knew who LVN A was and stated on 06/03/24 she checked her blood sugar and provided her with insulin before dinner. Resident #3 stated she had not missed any blood sugar checks or insulin. During a follow up interview and record review with LVN A on 06/10/24 at 5:02pm she stated she was responsible for signing off on the MAR for Resident #2 and #3 on 06/03/24 at their 4:00pm scheduled times. LVN A reviewed Resident #2 and #3's June MAR and confirmed there were 3 blank and unsigned sections for Resident #2's insulin administration and 1 blank and unsigned section for Resident #3's insulin on 06/03/24. LVN A stated a blank on the MAR meant there was not proof it was given. LVN A stated she had not signed it because she had forgotten. LVN A stated her DON and ADON B had provided her with her previous training over documentation. LVN A stated the facility policy for medication administration documentation was to document as you administered. LVN A stated in this situation she had not followed the facility policy. LVN A stated she was not sure how resident charts were monitored to ensure staff was completing accurate documentation and stated she imagined they audited and double checked the documentation, but she was not sure who did. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review with the DON on 06/10/24 at 6:38pm she stated LVN A worked on 06/03/24 with Resident #2 and #3 and was responsible for signing off on the MAR at their 4:00pm scheduled time. The DON reviewed Resident #2 and #3's June MAR and confirmed there were 3 blank and unsigned sections for Resident #2's insulin administration and 1 blank and unsigned section for Resident #3's insulin on 06/03/24. The DON stated a blank on the MAR meant documentation was missed. The DON stated the MAR should have been documented and was not because LVN A was new to working on that station and was previously using a MAR that was all on one sheet and was now having to use an insulin MAR and was not well versed. The DON stated LVN A had taken blood sugar checks and provided insulin and had documented it on her paper but not on the residents' MAR. The DON stated staff should document medication administered for accuracy, compliance, and so other staff members or physicians could refer to it. The DON stated she had provided staff with training over documentation of administered medication within the last 3 months. The DON stated the facility policy for medication administration stated to document after providing medication and stated LVN A did follow the facility's policy because she had documented on paper but stated the MAR and transcription part of it was not followed. The DON stated to ensure accurate documentation was completed she and ADON B would pull a report every morning and would review it during morning meetings to identify if anyone had missed documentation and for what reason. The DON stated negative outcomes on the residents depended on the medication error and what the medication was. Record review of facility Inservice dated 04/30/24 that covered medication/treatment administration and documentation guidelines was presented by the DON to staff, which included LVN A. Record review of facility policy titled, Medication-Treatment Administration and Documentation Guidelines with an implementation date of 02/02/14 and a review date of 02/10/20 included verbiage stating, 5. Document initials and/or signature for medications and treatments administered on the MAR or TAR immediately following administration.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on observation, record review, and interview, the facility failed to establish and maintain an infection prevention and control program, designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for 3 of 6 Residents (Resident #2 and Resident #5 and Resident #6) that were reviewed for infection control and transmission-based precautions policies and practices, in that: 1. CNA C failed to don the appropriate PPE before he entered Resident #2's room. These failures could place residents at risk for infection through cross-contamination of pathogens and infectious diseases. The findings include: 1. Record review of Resident #2's face sheet, dated 06/10/24, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: COVID-19 (Contagious respiratory disease caused by severe acute respiratory syndrome coronavirus 2), type 2 diabetes mellitus with hyperglycemia (high levels of sugar in blood), enteroinvasive escherichia coli infection (type of pathogenic bacteria that can cause profuse diarrhea and high fever), chronic kidney disease (longstanding disease of the kidneys leading to renal failure). Record review of Resident #2's state optional Minimum Data Set assessment, dated 05/04/24, revealed Resident #2 had a BIMS score of 15, indicating she was cognitively intact. Record review of Resident #2's care plan, retrieved on 06/10/24 revealed Resident #2 had a focus of, Resident #2 has a dx of COVID 19 and is a risk for: with an initiation date of 06/09/23 and a revision date on 06/06/24 and an intervention of Isolation: droplet/contact precautions as ordered with an initiation date of 06/06/24. Record review of Resident #2's physician's orders, retrieved on 06/10/24, revealed orders for 1. Resident requires transmission-based precautions of droplet Covid infection. Resident is in private room by herself because of active infection and all meals, activities, rehab and other services being done in room. With a start date of 06/03/24 and was still active on 06/10/24. Record review of Resident #2's SBAR 06/03/24 and completed by LVN A stated, Resident with positive COVID test result. that started on 06/03/24. Observation of Resident #2's signage posted on the outside of her door on 06/06/24 at 5:47pm revealed resident was on droplet precautions. During an interview with Resident #2 on 06/06/24 at 6:13pm CNA C was observed walking into Resident #2's room to deliver a meal tray. CNA C was observed to be wearing an N95 mask, eye protection and a gown but was not wearing gloves. CNA C disposed of PPE, performed hand hygiene, and exited the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA C on 06/06/24 at 6:16pm he stated he had entered Resident #2's room to deliver a meal tray and was not wearing gloves. He stated he did not usually have to wear gloves if he was just dropping of meal trays and then asked if he should be wearing gloves for these types of situations. During a follow up interview with CNA C on 06/10/24 at 5:21pm he stated he worked on 06/06/24 with Resident #2 who was on droplet isolation for COVID at that time. CNA C stated when he entered Resident #2's room on 06/06/24 to deliver a meal tray he was only wearing a gown, N95 and face shield. CNA C stated he was not wearing gloves when he entered Resident #2's room because he had an understanding from other facilities that he did not have to wear gloves if he did not have contact with the resident. CNA C stated he should not have entered Resident #2's room without gloves and stated he should have worn gloves because it was important for him to not get infected or infect someone else. CNA C stated all PPE including gloves were available and stated when entering a COVID positive residents' room who was on droplet isolation the appropriate PPE he needed to wear was a face shield or goggles, N95 mask, a gown, and gloves. CNA C stated the appropriate PPE should be worn when entering a COVID positive residents' room on droplet isolation in order to not infect himself or others. CNA C stated he had been trained on using the appropriate PPE on 06/07/24 by ADON B. CNA C sated nurses and facility leadership staff ensured staff were using the appropriate PPE by checking on staff, and making sure PPE was restocked when needed. CNA C stated he had not reviewed the facility policy regarding what PPE was to be worn when entering a droplet isolation room and stated he had not followed the policy because he followed what he was told at a different facility and stated he had since learned what PPE needed to be worn. CNA C stated not wearing the appropriate PPE in a droplet isolation room with COVID positive residents could negatively impact residents because they were sick and fragile, and they could get worse if staff did not protect themselves or the residents. Record review of staff Inservice dated 06/02/24 that covered COVID-19 infection control, hand washing, donning/doffing PPE and how COVID spreads stated, staff to don/doff PPE on all pts (patients) in quarantine isolation. And included a visual of how to don/doff PPE which included gown, mask or respirator, goggles or face shield and gloves. Inservice was presented by the Administrator to staff which included CNA C. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON who was also the ICP on 06/10/24 at 6:38pm she stated Residents #2 was on droplet isolation on 06/06/24 and stated it was not okay for CNA C to have entered Resident #2's room without gloves. The DON stated managers had trained their staff upon hire and every quarter over PPE, posted signage and what PPE to use when coming into contact with a resident in order to be proactive to prevent any outbreaks or infection to the residents. The DON stated Residents #5 and #6 were on droplet isolation on 06/10/24 and stated the best practice when Housekeeper D was done cleaning a resident's room was to doff her PPE, wash her hands and then go to the cart. The DON stated if Housekeeper D was going to reenter a resident room she should have on her PPE that would include a visor, mask, gown and gloves. The DON stated if Housekeeper D was going to wash her hands she would put on the gloves after she washed her hands. The DON stated they had all PPE available. The DON stated appropriate PPE should be worn in order to protect the residents and prevent further transmission and contain isolation. The DON stated their facility policy stated to wear the same PPE she had mentioned previously such as a visor, masks, gown, and gloves. The DON stated nurses and facility leadership ensure the appropriate PPE is being worn by staff by completing, rounding, spot checks, performing frequent audits to ensure they are tracking and trending infections and providing education. The DON stated the goal was for staff to be compliant and stated they did not want to spread it and wanted to adhere to their policies. The DON stated the stricter and more consistent their infection control measures the more they were collectively working towards ensuring the spread decreased. Record review of facility policy titled, Novel Coronavirus Prevention and Response with a reviewed/revised date of 01/01/24, included a section titled, 8. Procedure when COVID-19 is suspected or confirmed: . Implement standard, contact, and droplet precautions. Wear gloves, gowns, goggles/face shields and a NIOSH - approved N95 or equivalent or higher-level respirator upon entering a room and when caring for the residents.