

|  |  |   |  |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>675044 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>03/20/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Colonial Manor Advanced Rehab & Healthcare |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1100 W Minnesota Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761</b></p> <p>Based on observation, interview, and record review 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 one resident (Resident #1) of 1 observed for incontinent care, in that:</p> <p>CNA A did not use one wipe per swipe on the buttock area during incontinent care on Resident #1.</p> <p>This failure could place residents at risk for infections and cross contamination.</p> <p>The findings included:</p> <p>Record review of Resident #1's Face Sheet dated 03/18/25, reflected a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included nontraumatic intracerebral hemorrhage (bleeding into the substance of the brain in the absence of trauma or surgery), anoxic brain damage (damage or death of brain cells due to lack of oxygen), spastic quadriplegic cerebral palsy (a movement disorder where the muscles of all four limbs are stiff).</p> <p>Record review of Resident #1's Quarterly MDS dated [DATE], revealed Resident #1's cognitive status was severely impaired, she was totally dependent with two-person assistance for bed mobility, dressing, toilet use, and personal hygiene.</p> <p>Record review of Resident #1's Care Plan dated 01/30/25, revealed,</p> <p>FOCUS: o Incontinence: I Resident #1 is incontinent of bowel/bladder related to Activity Intolerance Date Initiated: 09/03/2019 Revision on: 09/03/2019</p> <p>GOAL: o I Resident #1 will remain free from skin breakdown due to incontinence and brief use through next review date. Date Initiated: 09/03/2019 Revision on: 06/13/2022 Target Date: 01/28/2025 o I Resident #1 will be clean and odor free through next review date. Date Initiated: 09/03/2019 Revision on: 06/13/2022 Target Date: 01/28/2025</p> <p>INTERVENTIONS/TASKS: o INCONTINENT: Check frequently for wetness and soiling, and change as needed. Date Initiated: 09/03/2019 Revision on: 06/04/2021 C.N.A. CN o Briefs or incontinence products as needed for protection.</p> <p>(continued on next page)</p> |

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:<br><br>675044   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>03/20/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Colonial Manor Advanced Rehab & Healthcare   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1100 W Minnesota Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Observation on 03/20/25 at 02:10 pm, CNA A and CNA B performed incontinent care on Resident #1. During incontinent care, CNA A wiped buttock area with one wipe per swipe four times. With fifth wipe, CNA A used wipe to wipe buttock five times with same wipe front to back. With wipes six and seven, CNA A used one wipe per swipe. CNA A removed gloves, used hand sanitizer, and put on new gloves.</p> <p>In an interview on 03/20/25 at 02:31 pm, CNA A stated when wiping during incontinent care, she was not sure how many times she could wipe with one wipe. CNA A stated cross-contamination could happen when she used a wipe more than once during incontinent care. CNA A stated they were in-serviced all the time on incontinent care. She said the last time they were in-serviced had been 4 or 5 days ago.</p> <p>In an interview on 03/20/25 02:35 pm, CNA B stated they were to use one wipe per swipe otherwise they could cause cross contamination. CNA B stated when they were in-serviced, they were also checked off on incontinent care. CNA B stated they were checked off on incontinent care either 4 or 5 days ago and they were checked off annually.</p> <p>In an interview on 03/20/25 at 03:45 pm, ADON D stated she would sometimes complete the in-service with CNAs. ADON D stated in-services for incontinent care were PRN, if there were incidents or allegations. ADON D stated check offs on incontinent care were done on hire, quarterly, and PRN. ADON D stated during incontinent care, one wipe was used once and thrown away. ADON D stated if a wipe were used more than once that would be cross contaminating.</p> <p>In an interview on 03/20/25 at 04:35 pm, the DON stated she and the ADONs held the in-services for the CNAs. The DON stated CNAs had check offs every quarter and as needed for incontinent care. DON stated either she or her ADONs complete the check offs for CNAs. The DON stated during incontinent care a wipe was used once (per swipe). The DON stated cross contamination can happen if a wipe was used more than once.</p> <p>Review of the facility's Infection Prevention and Control policy dated 10/24/22 with last revision 11/06/24 revealed:</p> <p>Policy:</p> <p>This facility has established and maintains 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 as per accepted national standards and guidelines.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>2. All staff are responsible for following all policies and procedures related to the program.</p> |   |  |