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	07/16/2025

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 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. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 alleged violation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (which included to the State Survey Agency) in accordance with State law through established procedures for 1 of 4 residents (Resident #1) reviewed for reporting injuries of unknown origin. The facility failed to report within 2 hours to Health and Human Services Commission when Resident #1 was found on the floor on [DATE] at 3:30am with a laceration to forehead that the resident was unable to explain and was not witnessed and required her to be sent to the hospital. This failure could place residents at risk for undetected abuse, neglect and/or decline in feelings of safety and well-being. The findings included: Record review of Resident #1's face sheet, dated [DATE], revealed the resident was an [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: cerebral infarction (blocked blood flow to brain causing brain tissues damage), hemiplegia (paralysis or severe weakness to one side of body) and hemiparesis (weakness to one side of body) following unspecified cerebrovascular disease (conditions that affect blood flow to brain) affecting left non-dominant side. Cognitive communication deficit (difficulties in communication could be from cognitive impairment), vascular dementia (decline in thinking skills caused by conditions that block or reduce blood flow to brain), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Record review of Resident #1's quarterly MDS assessment, dated [DATE], revealed Resident #1 was rarely/never understood and indicated a BIMS should not be conducted. Resident #1 was coded as dependent for rolling left and right and toileting/hygiene. Record review of Resident #1's care plan with a closed date of [DATE] reflected Resident #1 was bed bound and required total x2 assist (2-person assistance) for bed mobility and toileting. Record review of Resident #1's task care record reflected CNA A turned and repositioned Resident #1 at 1:13 am on [DATE]. Record review of Resident #1's task care record reflected CNA A checked off that Resident #1 had a small bowel movement at 1:13 am on [DATE]. Observation of facility surveillance footage of Resident #1's hallway on [DATE] revealed CNA A had entered or exited Resident #1's room approximately 4 times between 12:00am and 3:26am for no more than roughly one minute at a time on video footage that was able to be reviewed without any instances of skipped footage. The video surveillance would at times skip forward and miss seconds to a minute of footage, 1 of the 4 times identified did not show CNA A entering Resident #1's room when the footage skipped roughly 45 seconds from 3:23am to 3:24am where CNA A was then seen exiting Resident #1's room. LVN B was noted to have entered Resident #1's room at 1:19am and exited by 1:20am. At 3:27am CNA A was seen on video footage taking an item from a linen cart into Resident #1's room, CNA A remained in Resident #1's room until approximately 3:39am a total of about 12 minutes when he then exited the room and proceed down the hall to the nurse's station and briefly spoke with LVN B and C before he was noted returning down Resident #1's hall. At time of CNA A seen walking back down the hall video surveillance then skipped forward about a minute to 3:41am where CNA A was seen entering Resident #1's room for about 10 seconds and then exited and proceeded down hall way to nurses station to call LVN B and C when all 3 staff members went to Resident #1's room, prior to this time, CNA A was not seen entering Resident #1's room with any other staff member. During an interview with Administrator on [DATE] at around 6:00pm stated the time stamp on the video surveillance footage was 10 minutes ahead or 10 minutes behind. During an interview on [DATE] at 6:18pm with LVN B who stated she called EMS at 3:32am as per the time stamp of the call on her phone, when compared to the video footage time stamp LVN B is seen running back to the nurse's station to make call at 3:42am indicating the time stamp on the video surveillance was 10 minutes ahead. Record review of Resident #1's nursing notes dated [DATE] at 3:45am written by LVN B stated an aide had reported they found Resident #1 on the floor and saw blood, LVN B and other charge nurse (LVN C) went to assess and identified a laceration to scalp and active bleeding, pressure was applied to stop bleeding until the paramedics arrived, vitals were taken, 3rd party on call service was called, hospice and responsible party for Resident #1 were made aware. Resident #1 received order to be sent out to emergency room. Record review of Resident #1's physician orders reflected an order dated [DATE] at 3:45AM for her to be transferred to the emergency department. Record review of Resident #1 hospital

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure adequate supervision was provided to prevent accidents for 1 of 4 residents (Resident #1) reviewed for supervision.CNA A did not follow 2-person assist as stated on Resident #1's care plan when providing incontinent care and repositioning on two separate occasions on [DATE] at around 12:00am and 1:00am. On [DATE] at 3:30am CNA A found Resident #1 on the floor. Resident #1 was sent to the hospital and later expired on [DATE].An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 3:51pm. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These deficient practices could affect residents who require 2-person assist by placing them at risk of injuries and not receiving the appropriate level of assistance and care. The findings included: Record review of Resident #1's face sheet, dated [DATE], revealed the resident was an [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses that included: cerebral infarction (blocked blood flow to brain causing brain tissues damage), hemiplegia (paralysis or severe weakness to one side of body) and hemiparesis (weakness to one side of body) following unspecified cerebrovascular disease (conditions that affect blood flow to brain) affecting left non-dominant side. Cognitive communication deficit (difficulties in communication could be from cognitive impairment), vascular dementia (decline in thinking skills caused by conditions that block or reduce blood flow to brain), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Record review of Resident #1's quarterly MDS assessment, dated [DATE], revealed Resident #1 was rarely/never understood and indicated a BIMS should not be conducted. Resident #1 was coded as dependent for rolling left and right and toileting/hygiene. Record review of Resident #1's care plan with a closed date of [DATE] reflected Resident #1 was bed bound and required total x2 assist (2-person assistance) for bed mobility and toileting. Record review of Resident #1's task care record reflected CNA A turned and repositioned Resident #1 at 1:13 am on [DATE]. Record review of Resident #1's task care record reflected CNA A checked off that Resident #1 had a small bowel movement at 1:13 am on [DATE]. Observation of facility surveillance footage of Resident #1's hallway on [DATE] revealed CNA A had entered or exited Resident #1's room approximately 4 times between 12:00am and 3:26am for no more than roughly one minute at a time on video footage that was able to be reviewed without any instances of skipped footage. The video surveillance would at times skip forward and miss seconds to a minute of footage, 1 of the 4 times identified did not show CNA A entering Resident #1's room when the footage skipped roughly 45 seconds from 3:23am to 3:24am where CNA A was then seen exiting Resident #1's room. LVN B was noted to have entered Resident #1's room at 1:19am and exited by 1:20am. At 3:27am CNA A was seen on video footage taking an item from a linen cart into Resident #1's room, CNA A remained in Resident #1's room until approximately 3:39am a total of about 12 minutes when he then exited the room and proceed down the hall to the nurse's station and briefly spoke with LVN B and C before he was noted returning down Resident #1's hall. At time of CNA A seen walking back down the hall video surveillance then skipped forward about a minute to 3:41am where CNA A was seen entering Resident #1's room for about 10 seconds and then exited and proceeded down hall way to nurses station to call LVN B and C when all 3 staff members went to Resident #1's room, prior to this time, CNA A was not seen entering Resident #1's room with any other staff member.During an interview with Administrator on [DATE] at around 6:00pm stated the time stamp on the video surveillance footage was 10 minutes ahead or 10 minutes behind. During an interview on [DATE] at 6:18pm with LVN B who stated she called EMS at 3:32am as per the time stamp of the call on her phone, when compared to the video footage time stamp LVN B is seen running back to the nurse's station to make call at 3:42am indicating the time stamp on the video surveillance was 10 minutes ahead. Record review of Resident #1's nursing notes dated [DATE] at 3:45am written by LVN B stated an aide had reported they found Resident #1 on the floor and saw blood, LVN B and other charge nurse (LVN C) went to assess and identified a laceration to scalp and active bleeding, pressure was applied to stop bleeding until the paramedics arrived, vitals were taken, 3rd party on call service was called, hospice and responsible party for Resident #1 were made aware. Resident #1 received order to be sent out to emergency room. Record review of Resident #1's physician orders reflected an order dated [DATE] at 3:45am for her to be transferred to the emergency department. Record review of