

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Colonial Manor Advanced Rehab & Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for 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. (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 0600</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 observation, interview, and record review the facility failed to ensure each resident the right to be free from abuse for two residents (Resident #2 and Resident #3) of 6 residents reviewed for abuse. The facility failed to protect R #2 and R #3 from being hitting each other on 10/15/25 as they passed each other in the hallway. These failures have the potential to place residents at risk of serious injury and continued abuse. The Findings Include: Resident #2 Record review of R #2 face sheet revealed an [AGE] year-old male initially admitted on [DATE] and then readmitted on [DATE] with diagnosis of physiological condition(the internal physical and chemical states of a living organism that affect its bodily functions, ranging from maintaining homeostasis to experiencing illness or stress, Dementia (A group of thinking an social symptoms that interferes with daily functioning), and Insomnia (a common sleep disorder characterized by difficulty falling asleep, staying asleep, or both, leading to insufficient or poor-quality sleep) Non-Alzheimer's Dementia(Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-[NAME] disease), and Psychotic Disorder (other than schizophrenia a serious mental illness characterized by a loss of contact with reality, known as psychosis). Record review of R #2's Care Plan date 08/22/25 revealed R#2 has an activity of daily life self-care performance deficit and is at risk for not having their needs met in a timely manner. Performance deficit is related to dementia, debility, history of falls, right knee effusion surgery, muscle weakness, lack of coordination, abnormalities of gait and mobility, a need for assistance with personal care, is independent for meeting emotional, intellectual, and social needs. R#2 has a behavior problem as evidenced by pulling IV out, aggression with staff. R#2 is resistant to care and is at risk for injury, a decline in functional abilities, and not having their needs met in a timely manner. R#2 requires cueing for activity attendance and social interaction related to cognitive impairment and is at risk for isolation. Record review of R #2' s progress notes dated to 10/15/2025 revealed R #2 social worker was informed resident was involved in a physical altercation with a female resident. R #2 explained when he was wheeling himself towards the nurse's station from the dining room the fR#3 grabbed him by the shirt on his left side and would not let him go. When R#2 verbalized to R#3 to release him R#3 refused. R #2 explained how he attempted to remove R#3's hand and that was when R#3 struck his left shoulder. R#2 voiced how he attempted to stop R#3 from hitting him but was unsuccessful. Upon reviewing video surveillance, it was shown that R#3 was the aggressor and struck at R#2 several times on the left shoulder. R#2 was assessed by charge nurse and did not see any signs of discoloration or redness. R#2 did not voice having any pain. R#2 voiced that he felt fine. The local police department came into the facility to take report resident voiced would not like to press any charges R#2's family member however voiced she would like to press charges against R#3. The family was to follow up with local police department with the case number given from the report taken by officer. R#2 would continue to be monitored for any pain or change in condition. Staff would continue to monitor and meet residents' needs. Record review of R #2's MDS Quarterly dated 10/29/25 revealed R#2 had a BIMS Score of 06 which indicated that a resident's cognition was severely impaired dad significant difficulty with cognitive tasks and may require increased staff support for daily living activities. The MDS revealed no change in cognitive, or behaviors. R#2's Mood indicated to rarely feel isolated. not indicated to be present at time of assessment. The MDS indicated Resident #2 used a wheelchair and is dependent on staff to help in some daily activities. Resident #3 Record review of R #3 face sheet revealed a [AGE] year-old female initially admitted on [DATE], with diagnosis of Cerebral Infarction due to Embolism of Right Middle Cerebral Artery(a condition were a blood clot travels through the blood to the brain and blocks oxygen and blood flow to blood vessels in the brain, causing tissue damage.), Dementia (a group of thinking an social symptoms that interferes with daily functioning), Unspecified Psychosis (a diagnostic category for a patient experiencing psychotic symptoms like delusions or hallucinations, but where there is not enough information to make a specific diagnosis, or the symptoms don't meet the criteria for another disorder), Delusional disorders (a serious mental illness characterized by one or more non-bizarre, false beliefs that persist for at least one month, despite evidence to the contrary) and Alzheimer's Disease with late on set (a progressive disease that destroys memory and other important mental functions). Record review of Resident #3's MDS Quarterly dated 09/23/25 revealed Resident #3 had a BIMS Score of 09-moderate cognitive impairment a notable change for normal cognitive abilities and could signal a need for further assessment as it suggests problems with thinking and memory</p>		