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	01/15/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with the comprehensive person-centered care plan and in accordance with professional standards of practice for 1 of 4 residents reviewed for quality of care (Resident #1).The facility failed to respond to Resident #1's call light to provide care for 1 hour and 45 minutes on 12/25/2025.This failure could place residents at risk for a delay in care and services. Findings included:Record review of Resident #1's face sheet dated 1/15/2025 indicated a [AGE] year-old female with an admission date of 7/17/2024. Resident #1's diagnoses included: Hemiplegia and Hemiparesis (paralysis or weakness to one side of the body) affecting left non-dominant side, Contracture of Muscle (muscle in a tight position, making it hard to move) Left Hand, Lack of Coordination, Schizoaffective Disorder (intense mood swings and reality-bending psychotic episodes), Epilepsy (brain disorder causing recurring seizures).Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated a BIMS score of 04 (severe cognitive impairment). Section GG-Functional Abilities GG0130- Self Care indicated she was Dependent on staff for Eating, Oral hygiene, Shower/bathe self, lower body dressing, putting on/taking off footwear, Personal hygiene. She required Substantial/maximal assistance for Toileting hygiene and Upper body dressing. She required substantial/maximal assistance for roll left and rignt, She was dependent sit to lying, lying to sitting on the side of the bed, and chair/bed-to-chair transfer. Toilet transfer, tub/shower transfer, and walk 10 feet were coded as Not Applicable. Record review of Resident #1's care plan with a revision date of 3/19/2025 revealed Resident #1 has an ADL Self Care Performance Deficit and is at risk for not having their needs met in a timely manner. Interventions listed include.Bolsters in bed to aid with positioning, encourage resident to use call light to call for assistance before attempting any activities of daily living that resident cannot do independently, ensure/provide a safe environment: call light in reach, adequate low glare light, bed in lowest position and wheels locked.Record review of Resident #1' care plan with a revision date of 11/19/2025 revealed Resident #1 has the potential for falls related to reduced mobility, hemiplegia-left sided weakness, repeated falls. Had an actual fall. Interventions listed included.floor mat next to bed to aid in fall precaution, Neuro checks, s/p fall, keep bed in the lowest position when not providing care, place the resident's call light is within trach and encourage the resident to use it for CNA assistance.Record review of Resident #1's care plan with a revision date of 1/06/2026 revealed Resident # 1 has a behavior problem as evidenced by.throws herself on the floor, slides down to the mat. Interventions listed include: Monitor behaviors and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Give a clear explanation of daily activities prior to and as they occur during each contact. Encourage as much participation and interaction by the resident as possible,In an observation and interview on 1/14/2026 at 8:53 AM with Resident # 1, she was lying in bed, awake. The resident's bed was at the lowest position, and her call light was in her (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hand. Noted a floor mat at the side of her bed and wedges positioned on both her sides. Resident #1 said, everything is fine. She said the staff take long at times to answer her call light. She said she had fallen a while back because she tried getting up and got dizzy. She said, I slid off my bed and was sitting on the mat they have there. She said it took about one hour for the staff to come into her room and help her back to her bed. She said she had no injuries and was helped back to bed.In an interview on 1/14/2026 at 12:28 PM with a Family member, she said no one came into Resident #1's room to check on her after she pressed the call light. Observed a video shown by Resident #1's family member revealing Resident # 1 slipping to the floor landing on a floor mat on her buttocks and then pressed the call light at 4:43 AM. The next video showed the staff in the room assisting the resident back to bed at 6:36 AM. Resident #1's Family Member said there were no recordings because the camera only records if there was movement. She said she was thankful Resident #1 had no injuries, but no one entered her room until 2 hours later. She said she met with the DON and the social worker and brought forth her concern and showed them the video. During an observation of a surveillance video on 1/14/26 at 12:28 PM from Resident #1's room with a timestamp dated 12/25/25 at 4:37 AM , the resident is observed lying in bed with her feet dangling to the side of the bed. At 4:43 AM, Resident #1 was observed sliding down from the left side of the bed in a sitting position. Resident #1 was observed pressing the call light within eight seconds of her being in a sitting position on the floor mat, against her bed. The call light against the wall was seen turned on and blinking. At 4:44 AM the resident was seen waving the call light up in the air and placing it on top of the bed and at 4:45 AM the resident positioned herself lying on the floor. A second surveillance video from Resident #1's room with a timestamp dated 12/25/2025 at 6:36 AM, revealed CNA A was observed entering the resident room and removing a blanket off Resident #1's legs as Resident #1 was still on the floor, and within 10 seconds, LVN B entered the room and began to check Resident #1. No video footage was provided between 4:45 AM and 6:36 AM.In an interview with LVN B at 11:48 AM on 1/14/2026, LVN B said Resident #1 had a fall during the shift change at 6:30 AM. He said that while he was getting report from the night nurse, the morning CNA reported the resident was on the floor. He said he and the night nurse went into the resident's room to check her and to help her back onto her bed. LVN B said he notified the provider and the RP, and neuro-checks were started and completed according to facility guidelines. He said the resident did not complain of pain and he did not remember if the call light was on upon entering the room.In an interview with CNA C at 12:03 PM on 1/14/2026, CNA C said she received report from the outgoing shift and they had informed her that they were still making rounds, but that Resident #1 was still pending to be seen. She said that while she went for linens, her co-worker, CNA A entered Resident #1's room and quickly notified the nurses that the resident was on the floor. She said she could not remember if the call light was on.In an interview with the ADON at 2:32 PM on 1/14/2026, the ADON said when residents turn on the call lights, the staff is made aware by the light turning on outside of the resident's door and by the monitors located at the nurse's station. She said the monitors indicate the room number and for how long the call light has been on. She said the call light cannot be turned off from the monitors at the nurse's station but instead, the staff would have to physically go into the resident's room to turn it off.In an interview with the Maintenance Director at 8:20 AM on 1/15/2026, the Maintenance Director said that due to the safety of residents, there is no option to turn off the call light from the monitors at the nurse's station. He said that once a resident turns on the call light, it will remain on until the staff physically turn it off from inside the resident's room. He said there used to be a system in place that recorded how long the call lights were on for, but with the new call light system in place, there is no (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recorded log on how long the call lights stay on.In an interview with LVN D at 12:30 PM on 1/15/2026, LVN D said she had peeked her head in to check in on Resident #1 around 4 AM and saw the resident's legs moving and that she was okay. She said that she and another nurse began to make rounds around 5:15 AM until 6:10 AM but did not go into Resident # 1's room. LVN D said did not think the call light was on but she was not sure.In an interview with CNA A at 11:00 AM on 1/15/2026, CNA A said she saw the call light on for Resident # 1 when she came on shift, at 6 AM, and told her co-worker that they were going to begin their round with resident #1 because she was told by the outgoing staff that they had not been able to go into Resident #1's room yet. She said she had opened the door and saw the resident on the floor and immediately notified the nurses. CNA A said the staff immediately went into the room and the nurses checked the resident and assisted Resident #1 back to bed.In an interview with CNA F at 2:19 AM on 1/15/2026, CNA F said that on 12/24/2025 one CNA was scheduled work a double shift (2pm-10pm and 10pm-6am) but called in to work. She said a second CNA was scheduled 10pm-6 am but was a no-call no-show. CNA F said she had informed the night CNAs to assist in Hall 700 due to the shortage. In an interview with CNA E at 3:26 PM on 1/15/2026, CNA E said she worked 12/24/2025 night shift (10pm-6am in Hall 600 (assigned hall) and assisted making rounds in Hall 700. She said she could not remember what time she had done her round in the hall where Resident #1 resided and that around 4:30 AM stood outside Resident #1's door but did not go in. She said that around 6:12 AM, she saw the call light on and figured the other staff were going to go in because they were standing in the area. She said she was in a rush because she had to leave.In an interview with the DON at 3:46 PM on 1/15/2026, the DON said Resident #1's family member showed her a video of Resident #1 scooting herself in bed until she slides off the bed, landing in a sitting position on a floor mat at 4:45 AM and a second video showing the CNA walking into the room at 6:15 AM. The DON said she started the investigative process on 12/25/25 which included skin assessments for all the residents in Station 2 and no negative outcomes, due to the time frame of the call light not answered, were concluded. The DON said she re-instructed the staff on checking in on the residents every 30 minutes. She said Resident #1's family member was upset because of the length of time it took for the staff to respond to the call light. Record review of Staff In-Service on Resident Rights, Abuse/Neglect, and Fall Management indicated a Date Presented 12/25/25for all shiftsRecord review of Staff In-Service on TOPIC: ADON instructed on the importance of maintaining skin integrity, comfort, dignity, and infection prevention by ensuring residents are checked every 2 hours and PRN. Date Presented 12/25/2026 Record review of Staff in-service on Customer Service and Call lights indicated Date presented 12/31/2025 and 1/5/26 for all shifts. Record review of Staff In-Service on Resident Rights, Abuse/Neglect, Fall Management, and Customer Service indicated Date Presented 12/26/25, 12/29/25, and 12/31/2025 for all shifts Record review of Staff In-Service on TOPIC: DON re-educated nursing staff to assure all call lights are being answered on a timely manner- Staff to round every 2 hours and PRN and assure all call lights are within patient reach. Date presented 1/07/26Record review of Staff In-service on Staff in-service TOPIC: Abuse/Neglect- To ensure all staff recognize, report, and prevent abuse and neglect to protect resident safety and dignity. Abuse- Willful infliction of injury, unreasonable confinement, intimidation, or punishment that causes physical harm, pain, or mental anguish. Neglect- failure to provide goods or services necessary to avoid physical harm, pain, mental anguish or emotional stress. Date Presented: 12/31/25 Record review of the facility policy titled Call Light/Bell Response dated 8/11/13 revealed the following: .emphasize that all staff stop and respond to call lights as able. If responding staff is unable to assist the patient, the appropriate licensed nurse or nursing assistant is contacted.