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	05/29/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews the facility failed to ensure a resident receives treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, and maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or the resident preferences indicate otherwise, for 2 (Resident #1 and Resident #2) of 7 residents, reviewed for nutritional status.The facility failed to ensure Resident #1 and Resident #2 were weighed weekly per physician's orders. This failure could place residents at risk for nutritional deficit, weight loss, skin breakdown, and overall decline in quality of life.Findings included:1. Record review of Resident #1's face sheet, dated 05/28/26, reflected an [AGE] year-old female, admitted on [DATE] diagnoses included: other fracture of left patella (kneecap) encounter for routine healing, muscle wasting and atrophy (reduction in muscle mass and strength), dysphagia (trouble swallowing), cognitive communication deficit (communication is impaired due to underlying cognitive dysfunction rather than a primary language or speech problem), rheumatoid arthritis (chronic autoimmune system that primarily affects the joints, causing pain, swelling, and stiffness), dementia (decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), malignant neoplasm of unspecified site of left breast (breast cancer), and malignant neoplasm of unspecified lung (lung cancer). Resident #1 was discharged on 04/14/26. Record review of Resident #1's MDS assessment, dated 04/13/26, reflected a BIMS was not conducted as Resident #1 was never/rarely understood, indicating severe cognitive impairment. The MDS assessment reflected Resident #1 had a weight of 151 lbs., noted with weight loss and not on a weight-loss regimen. The MDS assessment reflected Resident #1 was dependent (helper does all of the effort) for eating (ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident). Record review of Resident #1's care plan, dated 05/28/26, reflected [Resident #1] was on a mechanical soft diet with thin liquids and at risk for malnutrition. Date initiated: 06/06/25. Interventions included: administer medications as ordered, monitor intake, supplements as ordered, and report signs and symptoms of malnutrition such as emaciation (unusually thin or weak), cachexia (loss of muscle mass), temporal (temple region of the head) wasting or any significant weight loss to the physician as detected. [Resident #1] had unplanned weight loss related to decreased oral intake and cancer. Date initiated: 10/21/25. Interventions included: labs as ordered, monitor and evaluate any weight loss, and offer substitutes. Record review of Resident #1's order summary, dated 05/28/26, reflected the following physician orders: Weekly weights with start date of 02/18/26. Record review of Resident #1's weight summary, dated 05/28/26, reflected weekly weights from 02/18/26 until 03/26/26. The weight summary reflected a weight of 162 lbs. on 03/26/26, and a weight of 151 lbs. on 04/07/26. There was no weight noted for the week of 03/30/26. 2. Record review of Resident #2's face sheet, dated 05/28/26, reflected a [AGE] year-old male, admitted on [DATE], diagnoses included: cerebral palsy (neurological disorders that affect movement, posture, and coordination), unspecified dementia (decline in cognitive function severe enough to interfere with (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily life affecting memory loss, language, problem solving, and other cognitive abilities), cognitive communication deficit (communication is impaired due to underlying cognitive dysfunction rather than a primary language or speech problem), dysphagia (trouble swallowing), and unspecified protein-calorie malnutrition (undernutrition caused by insufficient intake of both protein and calories). Record review of Resident #2's MDS assessment, dated 05/01/26, reflected a BIMS was not conducted as Resident #2 was never/rarely understood, indicating severe cognitive impairment. The MDS assessment reflected Resident #2 had a weight of 105 lbs., noted with weight loss and not on a weight-loss regimen. The MDS assessment reflected Resident #2 required substantial/maximal assistance (helper does more than half the effort) for eating (ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident). Record review of Resident #2's care plan, dated 05/20/26, reflected [Resident #2] was on a mechanical soft diet with thin liquids and at risk for malnutrition. Date initiated: 10/11/23. Interventions included: administer medications as ordered, monitor bowel movements, supplements as ordered, and report signs and symptoms of dysphagia (trouble swallowing) to the physician. [Resident #2] had unplanned weight loss related to poor oral intake. Date initiated: 07/28/25. Interventions included: labs as ordered, monitor and evaluated any weight loss, monitor intake, and offer substitutes. Record review of Resident #2's order summary, dated 05/28/26, reflected the following physician orders: Weekly weights with start date of 04/28/26. Record review of Resident #2's weight summary, dated 05/28/26, reflected a weight of 105 lbs. on 05/01/26, a weight of 105 lbs. on 05/12/26, and a weight of 103 lbs. on 05/27/26. There was no weight noted for the week of 05/04/26 or 05/18/26. During an interview and observation, on 05/28/26 at 3:10 PM, Resident #2 was asked basic questions and he did not respond. Resident #2 was not interviewable. Resident #2 had no visible bruises or skin tears. During an interview, on 05/29/26 at 10:45 AM, ADON A stated RA C weighed the residents and gave the weights to the DON to input in PCC. ADON A stated the residents were weighed either weekly or monthly, depending on the physician's order. ADON A stated residents were weighed weekly if they had weight loss and it was important to follow the order to monitor the weights and see if the interventions worked. ADON A stated Resident #1 had weight loss and weekly weights was ordered as one of the interventions. ADON A stated as far as she knew, Resident #1 was weighed weekly as ordered, but she did not know the weights. During an attempted interview, on 05/29/26 at 12:10 PM, RA C was not working. A phone call was attempted, but RA C did not answer and a voicemail was left requesting a callback. During an interview, on 05/29/26 at 1:15 PM, ADON B stated RA C weighed the residents, weekly or monthly, depending on the physician's order. ADON B stated RA C gave the weights to the DON and the DON input the weights in PCC. ADON B stated she assisted the DON to input the weights, if the DON was unable to. ADON B stated Resident #2 had weight loss and one of the interventions implemented was to do weekly weights. ADON B stated the weights had been taken weekly for Resident #2 and she was unsure if the DON had the weights noted on paper, but the weights should have been documented in PCC. ADON B stated it was important to follow the order for the weekly weights to monitor the weight and to ensure the interventions were effective. During an attempted interview, on 05/29/26 at 1:30 PM, RA C did not answer and a voicemail was left requesting a callback. During an interview, on 05/29/26 at 1:45 PM, the DON stated she made a list of residents and RA C used that list to take the weights that were needed weekly. The DON stated all residents were weighed monthly and certain residents were weighed weekly usually due to weight loss. The DON stated the nursing team ensured the weights were done and then RA C gave her the list of weights which she entered in PCC. The DON stated Resident #1 and Resident #2 were noted with weight loss and one of the interventions implemented was to do weekly weights, which were started on 02/18/26 for Resident #1 and on 04/28/26 for Resident #2. The DON stated she reviewed the records she had in a binder and did not find other weights that were not in PCC for the week of 03/30/26 for Resident #1, and for the week of 05/04/26 or 05/18/26 for Resident #2. The DON stated as far as she knew, the weights for Resident #1 and Resident #2 were done weekly as (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered, but she did not find the weights missing. The DON stated the facility's policy indicated the weights should have been entered in PCC. The DON stated there were no negative outcomes for Resident #1 or Resident #2 as the staff still implemented the interventions for weight loss. The DON stated the purpose of weekly weights was to assess if the interventions were effective. The DON stated Resident #2's weight had been stable and he was doing better with his oral intake. The DON stated Resident #1 was discharged on 04/14/26, but Resident #1 had been terminally ill, on hospice, the family declined a feeding tube, and she continued to refuse to eat. The DON stated the facility was not able to accurately calculate percentages of weight loss without having the weekly weights done or documented appropriately. Record review of the facility's Weight Management policy, dated 10/02/23, reflected - The facility management/clinical team will know the weight status of their residents, including the number of residents who have had a significant and insidious weight loss (gradual, unintended, progressive weight loss over time). Resident weights will be recorded in each resident's medical record monthly, unless specifically ordered otherwise.It is important that weights are accurate for them to be of value as an assessment tool. It is also important that all resident weights are accurately recorded in the individual resident's clinical record in a timely manner.1. All weights (admission, readmission, weekly and monthly) are to be entered into the Point Click Care (PCC) weight system.