STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675358	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Pines Healthcare Center	1203 Fm 1277 San Augustine, TX 75972

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observation, interview, and record review the facility failed to ensure each resident was treated with respect, dignity, and care for 1 of 2 Residents (Resident # 3) observed for care in that: The facility failed to ensure Resident #3's urinary drainage bag had a privacy cover on 10/22/2024. This failure could affect residents in the facility who received care and could result in residents not being treated with dignity and respect. Findings included: Record review of a Face Sheet for Resident #3 dated 10/22/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of intellectual disabilities (a condition that limits intelligence and disrupts the ability to live independently), anemia (low red blood cells that affect oxygen delivery to the body), and retention of urine (bladder not able to empty urine). Record review of a care plan for Resident #3 dated 9/18/2024 indicated he was at risk for problems with elimination related to retention of urine. He had a urinary catheter with interventions for care/changing of urinary catheter as ordered. Record review of an Annual MDS assessment for Resident #3 dated 9/3/2024 indicated his speech was unclear and he was usually able to understand others. He required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene. He had an indwelling catheter. Record review of active physician orders for Resident #3 indicated an order dated 6/28/2024 for foley catheter 16 Fr to continuous gravity drainage and catheter care, privacy bag checked, and placement of leg strap verified q shift. During an observation on 10/22/2024 at 9:36 AM, Resident #3 was in his room in bed, snoring, with a sheet pulled over his head. His bed was in a low position. His urinary catheter drainage bag was noted in the bed with a small amount of pink, tinged urine, resting by his feet without a privacy cover. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/22/2024 at 10:50 AM, Resident #3 was propelling himself in a wheelchair using his feet down the hallway toward the nurse station. Foley catheter drainage bag noted hanging underneath his wheelchair without a privacy cover. During an observation on 10/22/2024 at 11:47 AM, Resident #3 was propelling himself in a wheelchair by the nurse station with his Best Friend walking behind him headed to the activity room. The urine drainage bag was noted hanging underneath his wheelchair without a privacy cover. The ADON was standing up by the nurse station and instructed staff to take Resident #3 to his room so they could put a leg bag on him. During an interview on 10/22/2024 at 2:31 PM, LVN A said she had been employed at the facility since April 2024 and was assigned to the hall where Resident #3 resided. She said he was nonverbal and had a foley catheter. She said the nurses were responsible for ensuring the foley catheters were positioned properly. She said she was not aware the drainage bag was on the bed earlier that morning. She said he had gone to the ER that morning because he had ripped out his catheter and had to get it replaced. She said when he arrived back to the facility, she assisted EMS put him back to bed and did not see where they had positioned the drainage bag. She said she did not notice the drainage bag did not have a privacy cover until after he had been out and about in the facility. She said when the residents leave out of their rooms, they should have a cover on the bag. She said not having a cover over the drainage bag, could make them feel bad and be a dignity issue. During a joint interview on 10/22/2024 at 3:25 PM, the ADON said she had been employed at the facility for 2 years. The DON said she had been employed at the facility for [AGE] years but in her current position since 7/25/2024. Both said nursing staff were responsible for the privacy covers on the foley drainage bags when the residents were out of their rooms and the bags should be positioned below the bladder. Both said staff noticed Resident #3 did not have a privacy cover when he was out and about in the facility but did place a leg bag on him. Both said residents could be at risk for UTI's and it could be a dignity issue. During an interview on 10/23/2024 at 9:24 AM, the Administrator said foley catheters were the responsibility of the charge nurses. He said the facility had drainage bags with covers built in but when he came back from the ER that morning with a new foley catheter from the ER, the charge nurse did not ensure the bag had a cover. He said the drainage bags should not be placed in the bed; they should be positioned below the bladder. He said they started an in-service with staff to make sure they positioned the drainage bags properly. He said there could be a risk for urine to back into the bladder, infections, and urinary retention. Record review of a urinary catheter infection prevention policy revised August 2018 indicated, .Indwelling or intermitted urinary catheterization will be used for those residents whose medical condition requires intervention for urinary elimination. III. Catheter Maintenance and Care: K. Gravity Drainage Bag: 8. Gravity drainage bags are positioned below the level of the patient's bladder .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 2 Resident's (Resident #3) reviewed for catheter and incontinence care. 1. The facility failed to ensure LVN A maintained the urine catheter drainage bag below Resident #3's bladder on 10/22/2024. These failures could place residents at risk for not receiving care appropriate to address their incontinence and could increase the risk of urinary tract infections. Findings included: Record review of a Face Sheet for Resident #3 dated 10/22/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of intellectual disabilities (a condition that limits intelligence and disrupts the ability to live independently), anemia (low red blood cells that affect oxygen delivery to the body), and retention of urine (bladder not able to empty urine). Record review of a care plan for Resident #3 dated 9/18/2024 indicated he was at risk for problems with elimination related to retention of urine. He had a urinary catheter with interventions for care/changing of urinary catheter as ordered. Record review of an Annual MDS assessment for Resident #3 dated 9/3/2024 indicated his speech was unclear and he was usually able to understand others. He required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene. He had an indwelling catheter. Record review of active physician orders for Resident #3 indicated an order dated 6/28/2024 for foley catheter 16 Fr to continuous gravity drainage and catheter care, privacy bag checked, and placement of leg strap verified q shift. During an observation on 10/22/2024 at 9:36 AM, Resident #3 was in his room in bed, snoring, with a sheet pulled over his head. His bed was in a low position. His urinary catheter drainage bag was noted in the bed with a small amount of pink, tinged urine, resting by his feet without a privacy cover. During an observation on 10/22/2024 at 10:50 AM, Resident #3 was propelling himself in a wheelchair using his feet down the hallway toward the nurse station. Foley catheter drainage bag noted hanging underneath his wheelchair without a privacy cover. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/22/2024 at 11:47 AM, Resident #3 was propelling himself in a wheelchair by the nurse station with his Best Friend walking behind him headed to the activity room. The urine drainage bag was noted hanging underneath his wheelchair without a privacy cover. The ADON was standing up by the nurse station and instructed staff to take Resident #3 to his room so they could put a leg bag on him. During an interview on 10/22/2024 at 2:31 PM, LVN A said she had been employed at the facility since April 2024 and was assigned to the hall where Resident #3 resided. She said he was nonverbal and had a foley catheter. She said the nurses were responsible for ensuring the foley catheters were positioned properly. She said she was not aware the drainage bag was on the bed earlier that morning. She said he had gone to the ER that morning because he had ripped out his catheter and had to get it replaced. She said when he arrived back to the facility, she assisted EMS put him back to bed and did not see where they had positioned the drainage bag. She said she did not notice the drainage bag did not have a privacy cover until after he had been out and about in the facility. She said when the residents leave out of their rooms, they should have a cover on the bag. She said not having a cover over the drainage bag, could make them feel bad and be a dignity issue. During a joint interview on 10/22/2024 at 3:25 PM, the ADON said she had been employed at the facility for 2 years. The DON said she had been employed at the facility for [AGE] years but in her current position since 7/25/2024. Both said nursing staff were responsible for the privacy covers on the foley drainage bags when the residents were out of their rooms and the bags should be positioned below the bladder. Both said staff noticed Resident #3 did not have a privacy cover when he was out and about in the facility but did place a leg bag on him. Both said residents could be at risk for UTI's and it could be a dignity issue. During an interview on 10/23/2024 at 9:24 AM, the Administrator said foley catheters were the responsibility of the charge nurses. He said the facility had drainage bags with covers built in but when he came back from the ER that morning with a new foley catheter from the ER, the charge nurse did not ensure the bag had a cover. He said the drainage bags should not be placed in the bed; they should be positioned below the bladder. He said they started an in-service with staff to make sure they positioned the drainage bags properly. He said there could be a risk for urine to back into the bladder, infections, and urinary retention. Record review of a urinary catheter infection prevention policy revised August 2018 indicated, .Indwelling or intermitted urinary catheterization will be used for those residents whose medical condition requires intervention for urinary elimination. III. Catheter Maintenance and Care: K. Gravity Drainage Bag: 8. Gravity drainage bags are positioned below the level of the patient's bladder .