

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2026
NAME OF PROVIDER OR SUPPLIER Colonial Pines Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete and accurately documented for 4 of 4 residents (Residents #5, #6, #17, and #35) reviewed for medical records. The facility failed to ensure Resident #5, Resident #6, Resident #17 and Resident #35's medical records were accurate when staff did not document meal intake for evening meal for dates of January 1, 2026 thru January 20, 2026. This deficient practice could place residents at risk of improper care and monitoring due to inaccurate medical records. Findings included: 1. Record review of Resident #5's admission record, dated 1/21/2026, indicated an [AGE] year old female admitted on [DATE] with diagnoses that included hypertension (high blood pressure), anxiety (fear characterized by behavioral disturbances), and schizophrenia (a severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking). Record review of Resident #5's annual MDS, dated [DATE], indicated severe impairment with thinking with a BIMS score of 04. She required supervision with meals. Record review of Resident #5's care plan, dated 12/04/2025, indicated cognitive loss and risk for dehydration and malnutrition. Interventions included to monitor oral intake of food and fluids. Record review of Resident #5 weekly weight record, dated 01/21/26, indicated a stable weight of 112.4 pounds for six weeks. During observations on 01/19/26 Resident # 5 was observed eating lunch consuming greater than 75% of meal. Observation on 01/20/26 Resident #5 was observed eating breakfast and consuming greater than 75% of meal. Unable to interview Resident #5 due to cognitive impairment, Resident #5 oriented to person only. Record review of Resident #5's nurse aide flow sheet, dated January 2026, indicated evening meal intake percentages were not documented for 01/01/2026 through 01/20/2026. 2. Record review of Resident #6's admission record, dated 1/21/2026, indicated an [AGE] year old female, admitted [DATE], with diagnosis that included: Alzheimer's Disease (a neurodegenerative disease that usually starts slowly and progressively worsens), hypertension (high blood pressure), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #6's annual MDS, dated [DATE], indicated severe impairment with thinking with a BIMS score of 03. She was independent with meals. Record review of Resident #6's care plan, dated 12/26/2025, indicated she had Alzheimer's Disease and required assistance with ADLs. Record review of Resident #6 weight record, dated 01/21/26, indicated stable weight with no weight loss for one month. Weight was 145 pounds. During observations on 01/19/26 Resident # 6 was observed eating lunch consuming greater than 75% of meal. Observation on 01/20/26 Resident #6 was observed eating breakfast and consuming greater than 75% of meal. Unable to interview Resident #6 due to cognitive impairment, Resident #6 oriented to person only. Record review of Resident #6's nurse aide flow sheet, dated January 2026, indicated evening meal intake percentages were not documented for 01/01/2026[KA20] through 01/20/2026[KA21] [KA22] . 3. Record review of Resident #17's admission record, dated 1/21/2026, indicated a [AGE] year old female, admitted [DATE], with diagnosis that included Alzheimer's Disease (a neurodegenerative disease that usually starts slowly (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and progressively worsens), and hypertension (high blood pressure). Record review of Resident #17's annual MDS, dated [DATE], indicated severe impairment with thinking with a BIMS score of 01. She required moderate assistance with meals. Record review of Resident #17's care plan, dated 1/09/2026, indicated she had Alzheimer's Disease and required assistance with ADLs. Record review of resident #17 weight record, dated 01/21/26, indicated stable weight of 87 pounds with no weight loss for one month. During observations on 01/19/26 Resident # 17 was observed eating lunch with assistance of staff consuming greater than 75% of meal. Observation on 01/20/26 Resident #6 was observed eating breakfast with assistance of staff and consuming greater than 75% of meal. Unable to interview Resident #17 due to cognitive impairment, Record review of Resident #17's nurse aide flow sheet, dated January 2026, indicated evening meal intake percentages were not documented for 01/01/2026 through 01/20/2026. 4. Record review of Resident #35's admission record, dated 1/21/2026, indicated an [AGE] year old female, admitted [DATE], with diagnosis that included dementia (a group of symptoms that affects memory, thinking and interferes with daily life), chronic obstructive pulmonary disease (a condition that limits airflow into and out of the lungs) and history of cerebrovascular accident (the pathologic process that results in an area of necrotic tissue in the brain). Record review of Resident #35's annual MDS, dated [DATE], indicated moderate impairment with thinking with a BIMS score of 05. She was independent with meals. Record review of Resident #35's care plan, dated 1/14/2026, indicated she had cognitive loss and required assistance with ADLs. Record review of resident # 35 weight record, dated 01/21/26, indicated stable weight of 118 pounds with no weight loss for one month. During observations on 01/19/26 Resident # 35 was observed eating lunch consuming greater than 75% of meal. Observation on 01/20/26 Resident #35 was observed eating breakfast and consuming greater than 75% of meal. Unable to interview Resident #35 due to cognitive impairment, Resident #5 oriented to person only. Record review of Resident #35's nurse aide flow sheet, dated January 2026, indicated evening meal intake percentages were not documented for 01/01/2026 through 01/20/2026. During an interview on 01/21/2026 at 11:00 a.m., CNA C stated she worked the day shift on the secured unit. She stated the CNA's were responsible for documenting meal intakes after each meal. She stated day shift CNAs documented all three meals because all meal services occurred during the day shift. She stated she documented all meals each shift she worked, including the evening meal. She said she documented the percentage of meals eaten by each resident on the CNA flow sheet using the computer on the secured unit. She stated she did not understand why resident evening meal intakes were not available to view on the monthly report. She stated she documented meal percentages for the evening meals for all residents on the secured unit when she worked. She stated meal intake monitoring was important for monitoring residents' nutritional intake and possibly any changes in the residents' condition. During an interview on 01/21/2026 at 11:20 am LVN D stated she worked the day shift. She stated the CNA's were responsible for recording residents' meal intakes after meals. She stated the resident's electronic medical record did not alert for meal intake percentages not recorded. She stated the nurse would have to check every residents' flow sheet to ensure that meal intake percentages were documented. She stated she did not check resident flow sheets, but the CNAs reported if a resident had poor intake to the charge nurse. She stated the risk of not tracking resident meal intakes was malnutrition, weight changes and change in condition. During an interview on 01/21/2026 at 11:30 a.m., the DON stated the CNAs were responsible for charting resident meal intake percentages in the computer system. She stated the day shift CNAs charted intakes for all three meals throughout the facility. She said the current charting system did not alert if meal intakes were not entered. She stated the charge nurses were responsible for monitoring that CNA flow sheets were completed at the end of each shift. She said she was currently working with her corporate information technology department on a solution to the evening meal intakes not available to view. She stated there was possibly an error in the system and the information was not being displayed. She said the risk of not monitoring resident intakes could include not recognizing changes in resident conditions and nutritional concerns. She (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated her expectations, moving forward, were CNAs accurately record all residents' meal intake percentages after each meal and the charge nurses monitored CNA flow sheets were completed daily at the end of the shift. During an interview on 01/21/2026 at 11:50 a.m., the administrator stated the CNAs and nurses were responsible for ensuring resident meal intakes were charted. He stated the risk of not monitoring resident meal intakes could include weight loss and weight gains as well as impact on overall nutrition. He stated he expected meal intakes were recorded in the medical record and that providers have access to the information when needed. Record review of a facility policy titled Meal Intake Documentation, dated revised 01/12/2020, . 7. The nursing assistant may use the tray ticket as a worksheet to document intake at the end of the meal and then from this, documents on the Meal Intake Record either in percents or points.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents for 1 of 1 dining room reviewed for pest control. The facility failed to ensure the dining room remained free from roaches on 01/19/2026, during the lunch meal, when observed crawling on the floor. This failure could place residents at risk for reduced quality of life and poor sanitary environment. Findings included: During an observation and interview on 01/19/2026 at 11:45 a.m., a live roach was seen crawling on the floor underneath a dining table while residents were eating the lunch meal. The Medical Records Director walked over and stepped on the roach and killed it. The Medical Records Director said that roaches were a problem in the dining area and on hallway A. During an interview on 01/21/2026 at 8:45 a.m., the Floor Tech said they had a problem with a resident hoarding food in their room on the A hallway, but the facility cleaned everything out of the room and treated the area. The Floor Tech said that the contracted pest service treated the facility about every two weeks. He said roaches were unsanitary and needed to be eliminated. During an interview on 01/21/2026 at 8:55 a.m., the Maintenance Director- Housekeeping Supervisor said the roaches were an ongoing problem in the facility. He said the contracted pest control services treated the facility last Saturday (1/17/2026) . He said roaches were unsanitary. During an interview on 01/21/2026 at 11:45 a.m., the Administrator said he knew about the roach problem in the dining area. He said the contracted pest control company treated the area every two weeks to address the roach problem. He said he was aware there were still roaches in the dining area and he contacted the contract service on 01/20/2026 to return , after he was made aware of the roaches in the dining room on 1/19/2026. The Administrator said the pest control service would provide a new chemical product to exterminate the roaches. He said the roaches were an infection control issue. Record review of contracted pest control company invoice, dated 11/15/2025, indicated treated all hallways, treated kitchen area, nurse's stations, dining room, lobby, treated exterior building, and put granules out for ants and other crawling insects. Record review of contracted pest control company invoice, dated 11/26/2025, indicated treated interior building, kitchen area, washroom area, preparation area. dining room, nurses station, all hallways, treated exterior building, and put granules out for ants and other crawling insects. Record review of contracted pest control company invoice, dated 12/10/2025, indicated treated interior, treated all hallways, nurses station, activity rooms, dining room, kitchen, treated exterior building, and put granules out for ants and other crawling insects. Record review of contracted pest control company invoice, dated 12/22/2025, indicated Treated interior. All hallways. Cafeteria. Dining room. Nurse station. Treated exterior building. Put granules out for ants and other crawling insects. Record review of contracted pest control company invoice dated 01/17/2026 indicated Treated interior. All hallways. Nurses station. Kitchen. Dining room. Lobby. Treated exterior building. Put granules out for ants and other crawling insects. Record review of an undated facility policy for Pest Control indicated: Policy: Our facility shall maintain an effective pest control program. Policy Interpretation and Implementation 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. 2. Pest control services are provided by Contracted Pest Control 3. Windows are screened at all times. 4. Only approved Federal Drug Administration and Environmental Protection Agency insecticides and rodenticides are permitted in the facility and all such supplies are stored in areas away from food storage areas. 5. Garbage and trash are not permitted to accumulate and are removed from the facility daily. 6. Maintenance services assist, when appropriate and necessary, in providing pest control services.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean and homelike environment for 1 of 8 (Resident #41 residents reviewed for resident rights. The facility failed to ensure Resident #41 had a wheelchair that was not soiled with old food particles on 01/19/2026 and 01/20/2026. This failure could place residents at risk infections and dignity issues. Findings included: Record review of Resident #41's facility face sheet, dated 1/20/2026, indicated Resident #41 was an [AGE] year-old female, admitted [DATE], with diagnoses of cerebral infarction (stroke) and dysphagia (difficulty swallowing). Record review of Resident #41's quarterly MDS assessment, dated 12/18/2025, indicated Resident #41 had a BIMS of 00 indicating severely impaired cognition, was dependent on staff for assistance with all ADLs, required a mechanically altered diet, received hospice care, used a wheelchair, and had functional limitation of range of motion to both upper and lower extremities. Record review of Resident #41's comprehensive care plan, dated 12/19/2025, indicated Resident #41 had CVA late effects with potential for further decline related to late effects of CVA as evidenced by decreased mobility and required adaptive equipment wheelchair. During an observation and interview on 01/19/2026 at 9:24 a.m., Resident #41 was in a wheelchair at the nurses' station that was soiled with old food particles and residue that was thick and white. She was nonverbal and unable to answer any questions. During an observation on 01/19/2026 at 11:43 a.m., Resident #41 was in her wheelchair near the dining room and the wheelchair was soiled with old food particles and residue that was white and thick. During an observation on 01/20/2026 at 9:01 a.m., Resident #41 was up in the activity room. Her wheelchair continued to be soiled with food particles and residue that was thick and white. During an interview 01/20/2026 11:21 a.m., LVN E said the night CNAs had a schedule for cleaning resident wheelchairs and the night nurse should make sure they were cleaned. He said if he noticed a dirty wheelchair he would see that it was cleaned but had not noticed Resident #41's wheelchair being dirty. He said having a dirty wheelchair could make the residents feel bad. During an interview on 01/20/2026 at 6:09 p.m., CNA F said she was assigned to Resident #41's hall, and she was not sure about the cleaning schedule for resident equipment, such as wheelchairs. She said this was her first night back from leave. She said the night aides were responsible for cleaning the resident's wheelchairs at least weekly and as needed. She said residents that were in soiled wheelchairs could be embarrassed or get sick. During an interview on 01/20/2026 at 6:22 p.m., CNA G said she worked the night shift and each resident's equipment was to be cleaned no less than weekly. She said there was a schedule for cleaning posted at one time but was not sure where that schedule was now. She said there was nowhere she knew to document that the equipment was cleaned. She said that dirty resident equipment could be embarrassing and cause infections. During an interview on 01/21/2026 at 10:40 a.m., the DON said all resident equipment should be cleaned weekly by the night CNAs and there was a cleaning schedule located at the nurses' station. She said the charge nurse on night shift should be overseeing that the CNAs were cleaning the equipment. She said there was not a place to document that the equipment was cleaned. She said that resident's using dirty equipment could cause them to be upset or get sick. During an interview on 01/21/2026 at 11:35 a.m., the Administrator said all resident equipment was to be cleaned by the night nurse aides. He said there was a cleaning schedule posted on each hall by the shower rooms. He said the administration staff should be monitoring the residents' equipment, like wheelchairs, to ensure the schedule was being followed. He said using soiled equipment could affect the residents' dignity and expected the staff to keep every resident's care equipment clean and sanitary. Record review of an undated document titled Wheelchair Cleaning Schedule revealed Resident #41's wheelchair was to be cleaned on Wednesday night. Record review of a facility policy titled Resident General Equipment Cleaning, dated 2/20/2023, indicated, .Resident's general equipment will be (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleaned on a routine basis in accordance with manufacturer's specifications and guidelines. Guidelines: Facility will check equipment weekly or as needed General equipment may include, but it not limited to: Enteral Feeding Equipment, Respiratory Equipment, Oxygen Equipment, Wheelchairs, Beds, Scaled, Miscellaneous .		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess each resident quarterly, once every three months, using the quarterly review instrument specified by the state and approved by CMS for 1 of 12 residents (Resident # 41) reviewed for quarterly assessments. The facility failed to ensure Residents # 41 had a quarterly MDS assessment completed within three months from the previous assessment. This failure could place residents at risk of not receiving necessary care or receiving inappropriate care for their conditions. Findings included: Record review of Resident #41's facility face sheet, dated 1/20/2026, indicated Resident #41 was an [AGE] year-old female, admitted [DATE], with diagnoses of cerebral infarction (stroke) and dysphagia (difficulty swallowing). Record review on (date record review conducted) of Resident #41's medical record revealed a quarterly MDS was completed on 09/19/2025 and subsequent quarterly MDS dated [DATE] was not completed until 01/06/2026, 17 days overdue. During an attempted interview on 01/20/2026 at 5:50 p.m., a voicemail message was left for the MDS nurse at the contact number provided by the facility with no return call received. During an interview on 01/21/2026 at 8:23 a.m., the Corporate Reimbursement Nurse said she was responsible for oversight of the MDS assessments at the facility. She said a quarterly review assessment should be completed at least every 92 days. She said with Resident #41 the facility was having internet issues, and she was unable to sign her 12/18/2025 Quarterly MDS assessment until 1/06/2026. She said there was a report she could run to ensure all assessments were completed and transmitted but she only reviewed that report monthly. She said resident assessments that were not completed by the guidelines could cause an inaccurate depiction of the resident and delay generation of the resident's care plan. During an interview on 01/21/2026 at 10:40 a.m., the DON said the MDS nurse was responsible for the timely completion of each MDS assessment. She said she did not provide oversight of the MDS assessments and that was done at the corporate level. She said that completing MDS assessments late could result in care plan inaccuracy and negative outcomes to the residents. During an interview on 01/21/2026 at 11:35 a.m., the Administrator said the MDS nurse was trained on MDS assessments, and the Corporate Reimbursement Nurse assisted her with the completion of assessments per the guidelines. He said he expected all MDS assessments to be completed by the regulations to prevent reimbursement and care plan issues. Record review of facility policy titled, Resident Assessment, dated 1/12/2020, indicated, . It is the Standard of Care at this facility to conduct, initially and periodically, a comprehensive, accurate assessment of each resident's functional capacity utilizing the Minimum Data Set (MDS) according to the guidelines set forth in the Resident Assessment Instrument (RAI) manual. Review of the RAI manual, dated October 2019, indicated, quarterly assessments are completed by calculating from the ARD (assessment reference date) of the previous assessment plus 92 calendar days.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review , the facility failed to develop a person-centered comprehensive care plan to address medical needs for 1 of 12 residents (Resident #41) reviewed for comprehensive care plans. The facility failed to ensure Resident #41's comprehensive care plan was revised to reflect current transfer status of requiring a mechanical lift, hospice services, swallowing difficulties that required an altered diet and a contracture with mobility limitations. This failure could place residents at increased risk of falls, injuries, and a decreased quality of life. Findings included: Record review of Resident #41's facility face sheet, dated 1/20/2026, indicated Resident #41 was an [AGE] year-old female, admitted [DATE], with diagnoses of cerebral infarction (stroke) and dysphagia (difficulty swallowing). Record review of Resident #41's quarterly MDS assessment, dated 12/18/2025, indicated Resident #41 had a BIMS of 00 indicating severely impaired cognition, was dependent on staff for assistance with all ADLs, required a mechanically altered diet, received hospice care, used a wheelchair, and had functional limitation of range of motion to both upper and lower extremities. Record review of Resident #41's comprehensive care plan, dated 12/19/2025, indicated Resident #41's care plan did not reflect the current transfer status of requiring a mechanical lift, hospice services, swallowing difficulties that required an altered diet, and a contracture with mobility limitations. Record review on (date record review conducted) of Resident #41's order summary report revealed Resident #41 had an order on 6/18/2025 for hospice services and a pureed diet. There was no order related to Resident #41's contractures or use of mechanical lift. During an attempted interview on 01/20/2026 at 5:50 p.m., a voicemail message was left for the MDS nurse at the contact number provided by the facility with no return call received. During an interview on 1/21/2026 at 8:23 a.m., the Corporate Reimbursement Nurse said the MDS assessment generated the care plan and the MDS nurse should be ensuring each care area the resident required was on the comprehensive care plan. She said with each assessment the care plan should be reviewed and revised as needed to ensure accuracy. She said she was responsible for oversight of the care plans at the facility. She said not having an accurate comprehensive care plan could potentially cause the staff to be unaware of resident needs. During an interview on 1/21/2026 at 10:40 a.m., the DON said that each resident should have a thorough and accurate care plan that covered the care areas the residents needed. She said the Corporate Reimbursement Nurse provided the oversight of the comprehensive care plans, but they were reviewed by the IDT during their standards of care meetings. She said somehow Resident #41 's care plan was not accurate after changing to their new charting system. She said if the comprehensive care was not reviewed and revised to depict the full picture of the resident, residents could affect receiving services. During an interview on 1/21/2026 at 11:35 a.m., the Administrator said the MDS nurse was responsible for completing the comprehensive care plan thoroughly and accurately. He said he expected each residents' care plan should be reviewed and revised per the regulations to prevent any possible care issues. Record review of a facility policy titled Care Plan - Process dated 3/27/2023 indicated, .4. Interdisciplinary Team meets & reviews the care plan as follows: Seven (7) days after the closure on the date of the admission MDS Quarterly and annually Within fourteen (14) days after a significant change MDS With any change of condition .		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility was demonstrably unavoidable for 1 of 4 (Resident #41) residents reviewed for mobility services. The facility failed to implement interventions to prevent further decline of Resident #41's contracture to her left hand and lower extremities on 01/19/2026 and 01/20/2026. This could affect residents with contractures and mobility limitations and could result in a decrease in mobility. Findings included: Record review of Resident #41's facility face sheet, dated 1/20/2026, indicated Resident #41 was an [AGE] year-old female, admitted [DATE], with diagnoses of cerebral infarction (stroke) and dysphagia (difficulty swallowing). Record review of Resident #41's quarterly MDS assessment, dated 12/18/2025, indicated Resident #41 had a BIMS of 00 indicating severely impaired cognition, was dependent on staff for assistance with all ADLs, required a mechanically altered diet, received hospice care, used a wheelchair, and had functional limitation of range of motion to both upper and lower extremities. Record review of Resident #41's comprehensive care plan, dated 12/19/2025, indicated Resident #41's care plan did not reflect the resident had a contracture with mobility limitations. Record review of Resident #41's physician order summary report dated 1/20/2026 revealed Resident #41 did not have an order related to contractures or use of any device. During an observation on 1/19/2026 at 9:27 a.m., Resident #41 was in a wheelchair at the nurse's station and both feet and legs were dangling. There was no footrest on her wheelchair. She had a contracture to her left hand, and no contracture device was present. She was unable to answer questions. During an observation on 1/19/2026 at 11:34 a.m., Resident #41 was in a wheelchair in the dining room and both feet and legs were dangling, and no footrest was on her wheelchair. Resident #41 did not have any contracture device present in her left hand. During an observation on 1/20/2026 at 9:01 a.m., Resident #41 was up in a wheelchair in the activity room with legs and feet dangling and no footrest. She had a hand device in her left hand that looked like a carrot. During an interview on 1/20/2026 at 11:54 a.m., CNA B said she was assigned to Resident #41 and was not sure why Resident #41 did not have footrest on her wheelchair. She said she had them in the past. She said Resident #41's legs should be supported to prevent discomfort. She said Resident #41 required the carrot device in her hand during the day but could not recall if she placed the device in the resident's hand yesterday or not. She said the device helped prevent further worsening of her contracture. During an interview on 1/20/2026 at 11:58 a.m., LVN E said the nurse should monitor each resident's position and ensure each resident had the devices they needed for proper positioning. He said not properly supporting a resident's feet and legs could cause circulation changes and pain. He said residents with hand contractures were to have a hand device to prevent the worsening of the contracture and the nurse should monitor that they were in place. He said he could not recall if Resident #41 had hers yesterday or not. During an interview on 1/21/2026 at 10:40 a.m., the DON said dependent residents should have their body supported and positioned and should not have their legs and feet dangling from their wheelchair. She said that non-positioned and supported legs could cause circulation changes and increase in contractures of the feet. She said she was not sure why Resident #41 did not have leg supports on her wheelchair and all staff should monitor residents for proper support. She said that Resident #41 had hand contractures and should have a device in place to prevent the worsening of the contracture. She said the nurses and aides should be ensuring those services were in place. She said the facility did not have a policy for contracture management or position management. During an interview on 1/21/2026 at 11:35 a.m., the Administrator said dependent residents should have proper support of their lower body when up in a wheelchair and some kind of device to prevent worsening of (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Colonial Pines Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contractures. He said if a resident's legs were dangling without support it could affect circulation, the skin and muscles. He said contractures could worsen without the use of devices to help prevent them and expected all staff to monitor every resident for the care they needed and provide it to prevent further decline.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' environment remains as free of accident hazards as possible for 1 of 4 residents reviewed for quality of care. (Resident #41)The facility failed to remove worn and damaged mechanical lift slings from service for Resident's #41.This failure could result in a loss of quality of life due to injuries.Findings included:Record review of Resident #41's facility face sheet, dated 1/20/2026, indicated Resident #41 was an [AGE] year-old female, admitted [DATE], with diagnoses of cerebral infarction (stroke) and dysphagia (difficulty swallowing).Record review of Resident #41's quarterly MDS assessment, dated 12/18/2025, indicated Resident #41 had a BIMS of 00 indicating severely impaired cognition, was dependent on staff for assistance with all ADLs, required a mechanically altered diet, received hospice care, used a wheelchair, and had functional limitation of range of motion to both upper and lower extremities.Record review of Resident #41's comprehensive care plan, dated 12/19/2025, indicated Resident #41's care plan did not reflect current transfer status of requiring a mechanical lift.Record review of resident #41's physicians order summary report dated 1/20/2026 revealed Resident #41 did not have an order related to use of a mechanical lift.During an observation on 1/19/2026 at 9:47 a.m., Resident #41 was up in the common area in her wheelchair with a lift sling pad under her. The lift sling's loops were faded in color. She was unable to answer questions. During an observation on 1/20/2026 at 9:01 a.m., Resident #41 was up in her wheelchair in the activity room and the lift sling's loops were faded in color. During an interview on 1/20.2026 at 12:00 p.m., CNA B said that before a resident was transferred by a lift the sling should be inspected for fading and breakdown of the materials. She said she had gotten Resident #41 up yesterday and today and her sling looked good to her, and the faded loops were just from every day washing. She said the laundry only washed them and hung them to dry. She said she could see how the fading could be from use of bleach but was not sure. She said using slings that were faded could break and cause resident injuries. During an interview on 1/20/2026 at 12:10 p.m., the Laundry Aide said she was new at her position, and she washed all lift slings on the same setting as the towels and bleach was automatically distributed in the wash per the settings. She said she was not aware bleach was not allowed but she was told not to dry the lift slings by the housekeeping supervisor, and they had to be hung to dry. She said lift slings that were damaged could cause a resident to get hurt. During an interview on 1/21/2026 at 10:40 a.m., the DON said before a CNA used a lift sling, they should inspect the sling for fraying, fading, and/or wear. She said the slings were sent to the laundry but should not be bleached or dried. She said the housekeeping supervisor assisted with monitoring the slings and removing them from service. She said lift slings that were not in good order could cause resident injuries during transfers. During an interview on 1/21/2026 at 11:35 a.m., the Administrator said all lift slings were to be washed without bleach and hung to dry. He said all slings should be inspected by the housekeeping director before placing them on the floor and again by the CNAs before using them. He said if a sling was frayed, faded, or worn it should not be used to prevent resident injury. He said he expected the staff responsible to properly wash, dry, inspect and use all lift slings per the manufacturer's guidelines. During an interview on 1/21/2026 at 1:07 p.m., the Housekeeping Director said he was now assigned to monitor the lift slings for wear and fading. He said he had a book he kept track of them by and as he removed them from service he replaced them with new ones. He said he was not aware that the new laundry aide was using bleach on the slings until today and would reeducate his staff on proper care of the slings. He said slings that were damaged could result in resident injuries. Record review of a facility policy titled Mechanical Lifts, dated 5/12/2023, indicated, .1. Mechanical Lift Pre-Operations Check e. Check to ensure the sling is in good working condition with no torn or ripped areas, etc .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #26) and 2 of 5 staff (CNA A and CNA B) reviewed for infection control. The facility failed to ensure CNA A and CNA B followed EBP for Resident #26 when providing care on 1/19/2026. This failure could place residents at risk of exposure to infectious diseases. Findings included: Record review of Resident #26's admission Record, dated 1/20/2026, indicated a [AGE] year-old male, admitted [DATE], with diagnoses of type 2 diabetes, morbid obesity (extremely overweight), and dementia. Record review of Resident #26's active physician orders, dated 1/20/2026, indicated he had an order for EBP every shift that started on 12/23/2025. Record review of Resident #26's care plan, dated 11/12/25, indicated he had a diabetic wound on his left fifth toe. Interventions included EBP that were effective 1/19/2026. Record review of Resident #26's Quarterly MDS Assessment, dated 10/14/2025, indicated moderate impairment in thinking with a BIMS score of 7. He was totally dependent on all ADLs and always incontinent of urine/bowel. During an observation on 1/19/2026 at 3:01 p.m., CNA A and CNA B were in the room to provide incontinent care to Resident #26. Both staff washed their hands. There was PPE hanging on the bathroom door that included gowns and gloves. CNA B placed water in a basin with soap and placed it on Resident #26's over bed table with washcloths. Both CNAs applied gloves to their hands but did not don (put on) a gown. Resident #26's brief was opened and pulled down between his thighs. CNA B took a washcloth, dipped it in the water, wiped his inner thighs, and placed the washcloth in a plastic bag. CNA B took another washcloth, dipped it in the water, and wiped his penis in a circular motion and pushed his foreskin back and cleaned and then she placed the foreskin back and cleaned the shaft of his penis. CNA A rolled Resident #26 onto his right side. CNA B took a washcloth, placed it in the water, and handed it to CNA A. CNA A wiped Resident #26's rectal area and removed the brief and placed it in the trash. CNA B removed her gloves and placed them in the trash and washed her hands and applied clean gloves. CNA A removed her gloves and placed them in the trash, washed her hands, and put on clean gloves. CNA A placed a clean brief underneath his buttocks, and he was rolled onto his back and then to his left side and the brief was secured. Resident #26 was repositioned in bed. Both CNA A and CNA B removed their gloves and placed them in the trash and washed their hands. During an interview on 1/19/2026 at 3:14 p.m., CNA B said she was employed at the facility for 37 years. She said residents on EBP had blue signs on the door in the hallway by their names to indicate they were on EBP. She said PPE would be hanging on the bathroom doors in those rooms. She said Resident #26 did not require EBP. She said the charge nurses in the facility notified the staff of a resident that required more PPE than just gloves. She said if the appropriate PPE was not worn during care, then the staff could transfer things to different residents in the facility. She said there were not any residents on Resident #26's hall on EBP. During an interview on 1/19/2026 at 3:28 p.m., CNA A said she was employed at the facility for four years. She said residents who were on EBP required a gown and gloves when care was provided and EBP was for residents with open wounds. She said she thought there were two residents on A hall that required EBP. CNA A said she was not sure if Resident #26 required EBP. She said if the appropriate PPE were not worn, residents could be at risk for infections. She said the residents would have a blue tag by their name plates outside their doors if they required EBP. During a follow up interview on 1/19/2026 at 3:45 p.m., CNA A said during the care provided to Resident #26, they should have worn a gown and gloves because he had a blue tag by his name. During an interview on 1/21/2026 at 10:26 a.m., the ADON said she was the IP for the facility and she along with the DON were both responsible for training staff on infection control and the staff had training monthly. She said Resident #26 was on EBP for a wound to his toe. She said EBP required (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff to wear a gown and gloves when direct patient care was provided and that included any resident with an indwelling device or wounds. She said staff were made aware of residents who required EBP by her and the residents would have a blue tag with their name plate along with PPE hanging on their bathroom doors. She said both staff CNA A and CNA B both had training on EBP in October 2025 during a skills checkoff. She said residents were at risk for infections if staff did not follow EBP. During an interview on 1/21/2026 at 11:00 a.m., the DON said the ADON was over infection control but they both trained staff on infection control. She said staff were trained all the time and as needed and EBP was required for anyone with a wound, g-tube, catheter, or PICC lines. She said Resident #26 was on EBP because he had a diabetic wound to his fifth left toe. She said staff should wear gowns and gloves when care was provided. She said on the door were blue tags by their name plates and the Kardex (electronic medical record) for the nurse aides indicated if a resident required EBP. She said if EBP were followed, it would help to prevent organisms from transferring from the staff to residents and if it were not followed it could cause infections. During an interview on 1/21/2026 at 11:32 a.m., the Administrator said the administrative nursing staff that included the DON and ADON were responsible for training staff on infection control on hire and as needed. He said EBP was for any resident with open wounds or indwelling devices. He said the residents had a blue name tag on the door for staff to recognize who required EBP and PPE was on the bathroom doors. He said staff should wear gowns and gloves for residents on EBP and if they did not follow infection control then residents could be at risk for infections. Record review of a facility policy titled Enhanced Barrier Precautions, dated revised March 2025, indicated, .Many residents in nursing homes are at increased risk of becoming colonized and developing infections with multi-drug resistance organisms. Enhanced barrier precautions: EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact care activities that provide opportunities for transfer of MDROs to staff hands and clothing. 3. High contact resident care activities: f. Changing briefs .		