STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675453	A. Building B. Wing	12/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Collinwood Nursing and Rehabilitation	3100 S Rigsbee Rd Plano, TX 75074

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444 Based on observations, interviews, and record review, the facility failed to implement written policies and procedures that prohibit and prevent neglect for 1 (Resident #12) of 1 resident reviewed for reporting. 1. The facility failed to follow their policy to report to the State Agency when Resident #12 told staff she had pulled the call light cord around her neck to kill herself on 12/10/24. 2. The facility failed to ensure the Administrator or person(s) delegated followed their policy to report to the State Agency and initiate an investigation after Resident #12 told staff she pulled the call light around her neck to kill herself on 12/10/24. This failure could place residents at the facility at risk of continued abuse and neglect. Findings included: Review of Resident #12's Face Sheet, dated 12/14/2024, reflected that the resident was a [AGE] year-old female admitted on [DATE]. Resident #12 was diagnosed with chronic respiratory failure (airway to lungs because narrow and damaged), anxiety disorder (intense feelings of fear or worry that recur for 6 months or longer), post-traumatic stress disorder (mental health condition caused by an extremely stressful or terrifying event), major depressive disorder (persistent feeling of sadness and loss of interest), and Asperger syndrome (disorder that impacts how a person perceives and socializes with others). Review of Resident #12's Quarterly MDS (tool used to assess resident's health status and needs) Assessment, dated 12/08/2024, revealed a BIMS (test to assess cognitive status) Assessment was not conducted for Resident #12. Resident #12's Quarterly MDS Assessment reflected physical therapy and occupational therapy services were provided. Medication was administered for a diagnosis of depression. Review of Resident #12's Comprehensive Care Plan, dated 10/31/2024, reflected Resident #12 received Cymbalta (medication used to treat depression and anxiety) for depression. Some interventions included Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 12/14/24 at 04:00 PM, the Social Worker stated the incident should have been reported to State because Resident #12 could have followed through with it. She stated Resident #12's physician, and the facility psych services following the resident, were immediately notified. The Social Worker stated the facility attempted to send Resident #12 out via 911, but the resident refused transport. The Social Worker stated she obtained a mental health warrant and the local police department was involved. She stated the resident was sent out and admitted to a behavioral unit on 12/11/24. The Social Worker stated the administrator or whoever was acting in that role should have investigated and reported the incident as soon as possible or within 2 hours. In an interview 12/14/24 at 04:10 PM, the VP of Clinical Services stated the administrator, social worker, or herself should have reported the incident to State within 24 hours. She stated she was filling the role of Director of Nursing until the new DON started January 1st. She stated the new administrator's first day would be Monday. She stated the abuse coordinator was social services at that time but normally the administrator filled the role of abuse coordinator. She stated Resident #12's physician and the facility psych service was immediatley notified. She stated Resident #12 was immediately placed on one-on-one monitoring with facility staff, including a staff member from the facility psych service, until Resident #12 was sent out on 12/11/24. She stated the incident was not investigated and was not reported to State. She stated that it should have been investigated and reported to State. She stated it was important to report incidents to be sure no abuse was allowed to go on and residents were safely cared for. The facility provided monitoring sheets reflecting Resident #12 was monitored one one one by facility staff, including a staff member of the facility psych sevice, until she transferred to a behavioral unit on 12/11/24. Record review 12/14/24 reflected there was no progress note stating a staff member was told by a visitor that Resident #12 tried to harm herself. Record review of Resident #12's progress notes, dated 12/11/24, reflected the resident was already under care of facility psych services and received medication for depression. Review of facility policy Abuse, Neglect, and Exploitation: Reporting/Response, revised December 2023, reflected The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes .Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury . focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and providing complete and thorough documentation of the investigation

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444 Based on observation, interviews, and record review the facility failed to thoroughly investigate and report findings to the State Survey Agency within 5 working days of the incident and the corrective action taken if the alleged violation was verified. The facility failed to conduct a thorough investigation when Resident #12 told staff she had wrapped her call light around her neck to kill herself on 12/10/24. This failure could place residents at risk of not having allegations of abuse, neglect, and neglect investigated and reported to the State Agency. Findings included: Review of Resident #12's Face Sheet, dated 12/14/2024, reflected the resident was a [AGE] year-old female admitted on [DATE]. Resident #12 was diagnosed with chronic respiratory failure (airway to lungs because narrow and damaged), anxiety disorder (intense feelings of fear or worry that recur for 6 months or longer), post-traumatic stress disorder (mental health condition caused by an extremely stressful or terrifying event), major depressive disorder (persistent feeling of sadness and loss of interest), and Asperger syndrome (disorder that impacts how a person perceives and socializes with others). Review of Resident #12's Quarterly MDS (tool used to assess resident's health status and needs) Assessment, dated 12/08/2024, revealed a BIMS (test to assess cognitive status) Assessment was not conducted for Resident #12. Resident #12's Quarterly MDS Assessment reflected physical therapy and occupational therapy services were provided. Medication was administered for a diagnosis of depression. Review of Resident #12's Comprehensive Care Plan, dated 10/31/2024, reflected Resident #12 received Cymbalta (medication used to treat depression and anxiety) for depression. Some interventions included Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. Review of a progress note by the facility social worker, dated 12/10/24 reflected SW and ADON spoke with resident about making suicidal statements; resident stated that she wants to kill herself rather than live in a place like this; resident has a bruise on right side of neck; resident told staff that she tried to harm herself; resident stated that she would like to speak with a chaplain; SW suggested resident's pastor; resident stated that it has been two years since she has spoken with her pastor and stated that the church has been paying her rent for eight months; resident stated that she doesn't want SW to call her pastor because she only calls when she needs something; SW explained to resident that she would have to go to the ER to be assessed for inpatient psych resident began to yell, scream, and cursing at SW; resident already followed by Psych Services; SW to assist as needed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 12/14/24 at 04:10 PM, the Social Worker stated she received the information third hand and did not know who Resident #12's friend reported the incident to. The Social Worker stated she found out on Tuesday 12/10/24 Resident #12 told a friend she pulled her call light cord around her neck because she wanted to kill herself. The friend reported this to someone at the facility. The Social Worker stated this was immediately reported to Resident #12's physician and the facility psych services. The Social Worker stated she went to Resident #12's room to talk to her, but Resident #12 became upset and dismissed her from the room. She stated Resident #12 was originally scheduled to discharge home 12/09/24. She stated the facility attempted to send the resident out via 911, however the resident refused transport. She stated the facility obtained a mental health warrant, and the local police department was involved. She stated Resident #12 was sent out and was admitted to a behavioral unit on 12/11/24. The Social Worker stated she did not know if an incident report should have been filled out. She said that was nursing judgment. She stated it was important for nursing staff to know so they could provide the appropriate care and in-service staff. In an interview on 12/14/24 at 04:10 PM, the VP of Clinical Services stated if a resident tells us they are going to harm themselves, we interview them. We ask what is troubling you and do you have a plan? She stated if a resident verbalizes I want to harm myself and they have a plan, we have psychiry see them. We make sure they are taking medications as ordered. She stated she looked through the incident reports but there was no report about it. She stated staff was not required to fill out an incident report if someone stated they wanted to hurt their self. She stated an incident report was not required for one-to-one observation of a resident. She stated Resident #12 did not tell anyone at the time of the incident. She stated a visitor reported it later. She stated that arrangements were made to discharge the resident to get appropriate care. She stated staff members at the facility monitored Resident #12 vigilantly until she left the facility. She stated the incident was not investigated and was not reported to State. She stated that it should have been investigated. She stated it was important to investigate and report incidents to be sure no abuse was allowed to go on and residents were safely cared for. The facility provided monitoring sheets reflecting Resident #12 was monitored one one one by facility staff, including a member from the facility psych service, until she transferred to a behavior unit on 12/11/24. Record review 12/14/24 reflected there was no progress note stating a staff member was told by a visitor that Resident #12 tried to harm herself. Record review of progress notes reflected Resident #12 was already receiving psych services and taking medication for depression. Review of Facility Policy Investigation of Alleged Abuse, Neglect and Exploitation, revised December 2023, reflected Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and providing complete and thorough documentation of the investigation.