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	05/22/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, and misappropriation of property for 2 (Resident #2 and Resident #3) of 3 residents reviewed for abuse. 1. The facility failed to ensure Resident #3 was free from abuse on 01/05/25, when Resident #1 told Resident #3 she would stab her. 2. The facility failed to ensure Resident #2 was free from abuse on 01/07/25, when Resident #1 walked into Resident #2's room and hit her repeatedly in the head, with a pole like object causing her to be sent to the hospital, where she was diagnosed with an eye injury, bruises, and abrasions. An Immediate Jeopardy was identified on 05/21/2025. The IJ template was provided to the facility on [DATE] at 4:38 PM. While the immediacy was removed on 05/22/2025 at 1:35 PM, the facility remained out of compliance at a scope of isolated and severity level of no actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures placed residents at risk of physical or psychosocial harm from physical or verbal abuse. Findings included: Record review of Resident #1's face sheet, dated 05/20/25, reflected a [AGE] year-old female, who admitted to the facility on [DATE]. Resident #1 had diagnoses of Bipolar Disorder (mental health condition with extreme shifts in mood, energy, and activity levels), Major Depressive Disorder (serious mental illness with low mood, loss of interest in activities, and sleep disturbance), Anxiety Disorder (persistent and excessive worry or fear), and Cognitive Communication Deficit (cognitive function issues with memory and functioning) Record review of Resident #1's Quarterly MDS Assessment, dated 10/11/24, reflected Resident #1 had a BIMS score of 15, which indicated Resident #1's cognition was intact. The MDS noted Resident #1 had no issues with mood or behavior. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Care Plan, with an initial date of 06/24/22, reflected the following: Initiated date 02/17/24- Resident is paranoid thinking everyone is against her Record review of Resident #2's face sheet, dated 05/20/25, reflected an [AGE] year-old female, who admitted to the facility on [DATE]. Resident #2 had diagnoses of Dementia (decline in memory, thinking, and reasoning), Major Depressive Disorder (serious mental illness with low mood, loss of interest in activities, and sleep disturbance), Post Traumatic Stress Disorder (mental health condition that develops after experiencing or witnessing a traumatic event, which can be triggered by violence or abuse), and Anxiety Disorder (persistent and excessive worry or fear). The face sheet reflected Resident #2 discharged from the facility on 05/17/25. Record review of Resident #2's Quarterly MDS Assessment, dated 03/26/25, reflected Resident #2 had a BIMS score of 9, which meant Resident #2's cognition was moderately impaired. Record review of Resident #2's Care Plan, with an initial date of 09/03/24, did not address the incident where Resident #1 hit her. Record review of Resident #3's face sheet, dated 05/20/25, reflected a [AGE] year-old female, who admitted to the facility on [DATE]. Resident #3 had diagnoses of Schizoaffective Disorder (combination of a brain disorder that affects thinking, feeling, and behavior along with a mood disorder), Major Depressive Disorder (serious mental illness with low mood, loss of interest in activities, and sleep disturbance), Cerebral Infarction (stroke), and Hemiplegia (paralysis of one side of the body) and Hemiparesis (weakness on one side of the body). Record review of Resident #3's Quarterly MDS Assessment, dated 03/22/25, reflected Resident #3 had a BIMS score of 03, which indicated Resident #3's cognition was severely impaired. Record review of Resident #3's Care Plan, with an initial date of 10/29/24, reflected the following: Resident #3 required 24-hour supervision by ensuring all of Resident #3's needs were met. Record review of the progress notes in Resident #1's electronic record reflected the following: 01/07/25 1:07 AM Late Entry with an original date of 01/05/25 20:30 (8:30 PM) Documented by LPN B This nurse went to resident's room to talk to resident about the C/O made against her by her roommate. Resident refuted all the allegations made against her by roommate. She denied ever touching her roommate and also denied making any threat of stabbing the roommate with any weapon. My supervisor and myself went back to resident room and the only thing we found was a hand held back scratcher which my supervisor took away from the room. [sic] (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	01/07/25 16:52 (4:52 PM) Documented by LPN A This nurse heard screams coming from hall 400. Ran to room [ROOM NUMBER] where I saw resident hitting resident who resides in room [ROOM NUMBER] 'lying' in the bed screaming 'my eye, my eye'. Resident was standing over resident in 410 hitting her repeatedly with a 'poll-like' object with a hood on the end of it. I immediately attempted to take the object from resident who would not let go. I examined the resident who resides in room and noticed her eye was red, around the eye was bruised, dorsal side of both hands were bruised. I called 911 for the police and paramedics. [sic] Record review of Resident #2's hospital record, dated 01/07/25, reflected Resident #2 was diagnosed with assault, abrasion of left cornea (clear domed-shaped front of the eye), and an abrasion of the face. Record review of the Employee Roster dated 05/20/25 reflected LPN A no longer worked at the facility. Record review of emails sent by the Administrator on 05/20/25, reflected the following: (Resident #2) - Both of them have psych issues and were arguing all the time. (Resident #2) was new so we moved her. (Resident #2) would throw stuff in the floor and (Resident #1) would complain about it and they would argue. (Resident #1) was hateful to (Resident #3) and complained about her all the time. It was escalating so we moved (Resident #3). (Resident #1) had a backscratcher she used and mentioned to staff she should hit (Resident #3) with it to shut her up. We moved (Resident #3) to avoid any escalation. I know (Resident #3) moved herself to (room number) on 12/15/2024. (Resident #2) moved to (room number) on 8/28/2024. It seems some of these moves were made at night by staff to de-escalate a situation, but we don't have specific information to be certain. The common denominator in all this was (Resident #1). She made it difficult for the staff and the other residents. When your census is low you are desperate for admissions and more times than not, you admit some you later regret admitting. It is never a dull moment, I can promise you that. A telephone interview with LPN B was attempted on 05/20/25 at 4:20 PM, but there was no answer and no return call during the investigation. In an interview on 05/20/25 at 4:27 PM, Nurse Aide C stated Resident #1 liked her privacy. She stated Resident #1 would always try to fight with staff. She stated Resident #1 would get a little aggressive, and the staff would have to work with her to calm her down. Nurse Aide C stated she was not at work the day Resident #1 hit Resident #2. She stated Resident #1 and Resident #2 had the same type of behaviors. Nurse Aide C stated it was hard when Resident #1 and Resident #2 were roommates, because if she helped one, the other roommate rushed her to get help. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 05/20/25 at 5:01 PM, the ADON stated she was not at the facility during the incident in January when Resident #3 stated Resident #1 threatened her. The ADON stated she did remember Resident #3 moved to a different room that day, but she stated she was not sure if staff moved her or if she moved herself. The ADON stated the nurse supervisor that helped LPN B during that incident currently did not work for the facility. The ADON stated the Administrator, who was the abuse coordinator was the one responsible for completing an investigation of the allegations. In a telephone interview on 05/20/25 at 5:12 PM, LPN A stated she did not feel comfortable discussing the incident over the phone, that the state did not normally make telephone calls during an investigation, and she did not feel safe to discuss the incident with Surveyor. She stated she was not able to meet in person and did not feel comfortable discussing a resident via email. In an interview on 05/20/25 at 5:32 PM, the Administrator stated Resident #3 moved herself from the room with Resident #1. He stated he spoke with Resident #3 on 01/06/25, and she did not tell him that Resident #1 threatened her. The Administrator stated Resident #3 did not tell him she did not feel safe. The Administrator stated Resident #3 was all over the place and you might not know who she was talking about. The Administrator stated he spoke with Resident #1, and she denied threatening Resident #3. The Administrator stated no one in the facility would have dreamed Resident #1 would have grabbed a sticked, walked over to Resident #2's room, and beat the crap out of Resident #2. He stated Resident #1 argued with everyone, and he believed everyone at the facility had just got conditioned to Resident #1' behavior. The Administrator stated no safe surveys were completed after Resident #3 stated Resident #1 threatened to stab her. He stated there was no investigation, because neither resident recalled the threats when he spoke to them. He stated there was no one on one care. He stated the safe surveys were not completed until two days later, on 01/07/25, after Resident #1 hit Resident #2. The Administrator stated he probably should have done more after the allegations were told to staff about Resident #1 threatening Resident #3. He stated even though there was no validity to the allegations at the time, he should have done more at the time. The Administrator stated he did not think doing more at that time would have prevented Resident #1 from physically abusing Resident #2 a couple of days later. He stated Resident #1 knew what she was doing. The Administrator stated Resident #1 was arrested after the incident with Resident #2, and she did not return to the facility. In an interview on 05/21/25 at 11:19 AM, Resident #3 stated Resident #1 was her previous roommate. She stated she was scared of Resident #1, because she was very mean. She stated Resident #1 did not hit her, but Resident #1 threatened to stab her. Resident #3 stated she did not want to cause trouble. Resident #3 stated she told a nurse about Resident #1 threatening her, then she moved herself out of the room with Resident #1 to be safe. In an interview on 05/21/25 at 1:07 PM, Resident #1's Family Member stated Resident #1 had paranoia and delusions regarding Resident #2. The Family Member stated Resident #1 was saying Resident #2 was talking to her through the television. The Family Member stated the facility moved Resident #2 out of the room, and then moved Resident #3 into the room with Resident #1. The Family Member stated Resident #1 had the same delusions and paranoia about Resident #3 like she did with Resident #2. The Family Member stated the Administrator and the DON were aware of the paranoia and delusions. The Family Member stated it was discussed in care plan meetings for Resident #1. The Family Member stated the staff told her they would look into her medications and ensured she continued psych services. Record review of the facility's policy titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, dated 12/2024, reflected the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility will identify events, occurrences, patterns and trends that may constitute: Verbal abuse- means the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Protection: the facility will protect residents from harm during an investigation. The Administrator and ADON were notified of an Immediate Jeopardy (IJ) on 5/21/25 at 4:25 PM, due to the above failures and the IJ Template was provided at 4:38 PM. The facility's Plan of Removal (POR) was accepted on 5/22/25 at 1:35 PM and included: (Facility Name) F-600 Preparation and/or execution of this plan do not constitute admission or agreement by the provider that immediate jeopardy exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and immediate jeopardy removal plan. This immediate jeopardy removal plan is submitted as the facility's immediate actionable plan to remove the likelihood that serious harm to a resident will occur or recur. 1. Identification of Residents Affected or Likely to be Affected: The facility should have taken the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: 5/22/25) The Administrator or designee should have immediately ensured the safety and well-being of the resident who alleged abuse by removing the threatened resident from the shared room and placing her in a private room on a different hall. The Administrator or designee should have immediately initiated abuse investigation into Resident #3's abuse allegation(s). Safe Surveys should have been completed by the Social Worker on all residents with a BIMS score of 8 or higher to identify anyone not feeling safe residing in the facility. Any concerns that are identified should have been addressed immediately. Safe Surveys were completed on all residents by the Social Worker on 5/21/25 . 2. Actions to Prevent Occurrence/Recurrence: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: 5/22/25) All Federal and State protocols will be followed in investigating and reporting any abuse allegation(s). Residents with BIMS scores of 8 or higher will be interviewed/assessed to identify if they feel safe and if they have ever experienced abuse while living at the facility. Concerns were/were not identified. (Provide details if concerns were identified from the interviews). Abuse policies were reviewed by the Administrator, all department managers, and all care staff. Abuse investigation procedure and documentation process were reviewed. The Administrator implemented a new abuse investigation checklist to ensure investigations were initiated and completed thoroughly. All staff were educated on changes. All staff received education on facility abuse policies by the ADON. All staff received education on abuse prevention and reporting by the ADON. Facility abuse policies and procedures will be reviewed with any agency staff prior to their shift, if agency staff are employed. Staff members are not permitted to work a shift until education had been completed. The Administrator, DON, and Social Services Director received education from the SR. VP of Clinicals on timely and thorough abuse investigations and reporting. The regional/corporate staff member will visit the facility weekly for eight (8) weeks to provide oversight, audits, and additional training as needed. The Activities Director held a Resident Council meeting in which the residents were educated on the facility's abuse policies and procedures. The Social Services Director began discussing facility abuse policies with residents and families at the initial care plan conference. The Administrator or designee will continue to interview residents with BIMS scores of 8 or higher monthly to ensure they have not experienced abuse. The findings of these interviews will be presented to the QAPI Committee as a PIP project. On 5/22/25 at 1:35 PM, the investigator began monitoring to determine if the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy with the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 05/22/25 at 1:39 PM, RN D stated she received in-services today, that covered abuse and neglect, resident rights, reporting of abuse and neglect, care plans, suicidal ideations, and reporting of suicidal ideations. She stated the in-service reviewed reporting of abuse, who the abuse coordinator was, the Administrator, and also received an in-service on resident-to-resident aggression. She stated three types of abuse were physical, mental, and emotional. In an interview on 05/22/25 at 1:55 PM, the ADON stated she and the Administrator facilitated the in-services with the staff, on abuse and neglect, resident rights, resident-to-resident aggression, and care planning. She stated she and the Administrator received in-services on those subjects and it was facilitated by the VP from their corporate office. She stated there was an additional in-services on psych services and suicidal ideations facilitated by the behavioral health doctor on site today. In an observation on 05/22/25 at 1:58 PM, an in-service on behavioral health, suicidal ideations, and suicide was observed with over 20 staff members present in the in-service, which was conducted by the Behavioral Health Physician, in the dining hall. In an interview on 05/22/25 at 2:02 PM, RN E stated she received in-services that started yesterday and covered abuse, neglect, resident rights, reporting of abuse and neglect, care plans, suicidal ideations, and reporting when a resident had suicidal ideations. She stated the abuse coordinator was the Administrator. She stated three types of abuse were emotional, sexual, and physical. In an interview on 05/22/25 at 2:18 PM, LVN F stated he received in-services today that covered, abuse and neglect, resident rights, reporting of abuse, neglect and suicidal ideations. He stated it also covered to report any allegations immediately. He stated he also received in-services on care planning, updates to care plans, and resident-to-resident issues and incidents. LVN F stated three types of abuse were verbal, physical, and mental. In an interview on 05/22/25 at 3:09 PM, Nurse Aide G stated she was in the behavioral health in-service today, and she also received an in-service on abuse and neglect, resident rights, care plans, updates with residents, reporting incidents and behaviors of residents to the nursing staff, suicidal ideations heard from residents, suicide attempts, and residents fighting with each other. She stated three types of abuse were physical, psychological, and sexual abuse. She stated if she witnessed any abuse or neglect, she would report it immediately to the Administrator. In an interview on 05/22/25 at 4:01 PM, Nurse Aide H stated she was trained, today, on abuse and neglect, reporting of abuse and neglect, and reporting of suicidal ideations. She stated she would report any of that to the Administrator, who was the abuse coordinator. She stated she was also aware that she could report abuse to HHS. She stated she was also trained on resident rights, resident altercations, care plans, changes in residents, and reporting those changes in residents. She stated three types of abuse were financial, mental, and physical abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 05/22/25 at 4:22 PM, with Spanish Interpreter 2633, the Housekeeper stated she received in-services today on abuse and neglect, resident rights, changes with residents, reporting any issues like behavior or abuse to the nurses or the Administrator. She stated the was in the behavioral health in-service. She stated her in-services are usually given to her in Spanish, so she can understand everything. She stated her supervisor interprets it for her. The Housekeeper stated there was always someone present to interpret the trainings for her. She stated three types of abuse were physical, mental, and sexual. She stated she would report any of that to the Administrator or her supervisor. In an interview on 05/22/25 at 4:41 PM, the Dietary Manager stated she was trained this week on abuse, neglect, resident rights, resident-to-resident altercations, suicide, suicidal ideations, behavioral issues and concerns with residents, resident changes, and reporting of allegations. She stated if she witnessed anything she would immediately tell the Administrator. She stated she in-serviced her staff on all of those subjects this week, and she stated all of her staff attended the in-service on behavioral health today. She stated three types of abuse were neglect, verbal, and sexual abuse. In an interview on 05/2/25 at 4:47 PM, the Receptionist stated she received in-services that started yesterday, and covered, abuse and neglect, resident rights, altercations with residents, changes in residents and reporting suicidal ideations. She stated she attended the in-service on behavioral health. The Receptionist stated three types of abuse were physical, neglect, and sexual. She stated she would report any concerns to the Administrator, who was the abuse coordinator. In an interview on 05/22/25 at 5:02 PM, the ADON stated the DON was still on vacation, but she would be in-serviced by the VP of Clinical Services prior to her working again. She stated all other staff had received in-services on abuse, neglect, resident rights, behavioral health, care plans, suicide prevention, and medication administration. She stated she, the DON, and the Administrator would continue to do routine in-services and audits to ensure there were no more concerns with abuse and neglect in the facility. In an interview on 05/22/25 at 5:10 PM, the VP of Clinical Services stated she in-serviced the Administrator and the ADON on abuse and neglect, resident rights, care planning, resident to resident altercations, medication administration, and managing residents. She stated she would in-service the DON prior to her returning to work from leave. She stated they started audits and will continue to routinely do audits to ensure the staff are following through with all the trainings, as well as the Administrator, ADON, and DON following through with continued training and auditing. In an interview on 05/22/25 at 5:18 PM, the Social Worker stated she attended the behavioral health in-service today. She stated she was also in-serviced on care plans, resident rights, resident altercations, suicidal ideations, reporting abuse and neglect, and investigation of abuse and neglect. She stated she was helping the MDS Nurse audit the care plans today and on-going. She stated she was responsible for completing audits on suicidal ideations and anxiety. The Social Worker stated the residents with behaviors would be checked on twice a week for the next 6-8 weeks, then quarterly afterward. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 05/22/25 at 5:23 PM, the MDS Nurse stated she received an in-service on behavioral health, resident rights, abuse and neglect, care planning, resident altercations, and suicidal ideations. She stated he also received an in-services on reporting abuse, neglect, suicidal ideations. She stated she started auditing all resident MDS assessments to ensure all behaviors were addressed on the MDS, and she would do that for all in-coming residents as well. In an interview on 05/22/25 at 5:58 PM, the Administrator stated he completed in-services this week on abuse and neglect, resident rights, behavioral health, resident altercations, care planning, medication administration, and reporting of anything concerning. He stated they have all started completing the audits and the audits would continue for a while according to the plan. Record review of the following: In-services on abuse and neglect, resident rights, behavioral health, care plans, medication administration, resident-to-resident altercations, reporting of abuse and neglect dated 05/21/25 and 05/22/25. Audit of all resident care plans dated 05/22/25 May Activity Report dated 05/22/25 MDS Nurse Audit of the MDS assessments of residents Audit report of incidents reported, grievances reported, and any allegations of abuse or neglect Resident Council Meeting minutes Abuse Investigation Checklist An Immediate Jeopardy (IJ) was identified on 5/21/25 at 4:25 PM and an IJ Template was provided to the Administrator at 4:38 PM. While the IJ was removed on 5/22/25, the facility remained out of compliance at a scope of isolated with the severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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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 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** Based on interview 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 for 1 (Resident #3) of 3 residents reviewed for abuse. 1. The facility failed to conduct a thorough investigation when Resident #3 told staff her roommate threatened to stab her on 01/05/25. 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: Record review of Resident #3's face sheet, dated 05/20/25, reflected a [AGE] year-old female, who admitted to the facility on [DATE]. Resident #3 had diagnoses of Schizoaffective Disorder (combination of a brain disorder that affects thinking, feeling, and behavior along with a mood disorder), Major Depressive Disorder (serious mental illness with low mood, loss of interest in activities, and sleep disturbance), Cerebral Infarction (stroke), and Hemiplegia (paralysis of one side of the body) and Hemiparesis (weakness on one side of the body). Record review of Resident #3's Quarterly MDS Assessment, dated 03/22/25, reflected Resident #3 had a BIMS score of 03, which indicated Resident #3's cognition was severely impaired. 01/07/25 1:07 AM Late Entry with an original date of 01/05/25 20:30 (8:30 PM) Documented by LPN B This nurse went to resident's room to talk to resident about the C/O made against her by her roommate. Resident refuted all the allegations made against her by roommate. She denied ever touching her roommate and also denied making any threat of stabbing the roommate with any weapon. My supervisor and myself went back to resident room and the only thing we found was a hand held back scratcher which my supervisor took away from the room. (continued on next page)

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	05/22/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/20/25 at 5:32 PM, the Administrator stated Resident #3 moved herself from the room with Resident #1. He stated he spoke with Resident #3 on 01/06/25, and she did not tell him that Resident #1 threatened her. The Administrator stated Resident #3 did not tell him she did not feel safe. The Administrator stated Resident #3 was all over the place and you might not know who she was talking about. The Administrator stated he spoke with Resident #1, and she denied threatening Resident #3. The Administrator stated no safe surveys were completed after Resident #3 stated Resident #1 threatened to stab her. The Administrator stated he probably should have done more after the allegations were told to staff about Resident #1 threatening Resident #3. He stated even though there was no validity to the allegations at the time, he should have completed a more thorough investigation to ensure the safety of Resident #3. The Administrator stated he was the one responsible for completing an investigation of abuse. In an interview on 05/21/25 at 11:19 AM, Resident #3 stated Resident #1 was her previous roommate. She stated she was scared of Resident #1, because she was very mean. She stated Resident #1 did not hit her, but Resident #1 threatened to stab her. Resident #3 stated she did not want to cause trouble. Resident #3 stated she told a nurse about Resident #1 threatening her, then she moved herself out of the room with Resident #1 to be safe. Record review of the facility's policy titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, dated, 12/2024, reflected the following: Compliance Guidelines The facility must develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to ensure that the facility is doing all that is within its control to prevent occurrences. 6. Investigation: The facility will investigate all allegations and types of incidents listed above in accordance to facility procedure for reporting/response as described below. The Administrator should follow up with the government agencies, during business hours, to confirm the report was received and to report the results of the investigation when final as required by state agencies.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 (Resident #1 and Resident #2) of 6 residents, reviewed for care plans. 1. The facility failed to address Resident #1's verbal abuse towards others and threat toward Resident #3, on 01/05/25, on the comprehensive care plan. 2. The facility failed to address Resident #2's suicidal ideations on 09/26/24, 12/11/24, and 01/03/25 on the comprehensive care plan. An Immediate Jeopardy was identified on 05/21/2025. The IJ template was provided to the facility on [DATE] at 4:38 PM. While the immediacy was removed on 05/22/2025 at 1:35 PM, the facility remained out of compliance at a scope of isolated and severity level of no actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place the residents at risk of not receiving the care and services to maintain their highest practicable physical, mental, and psychosocial well-being. Findings included: Record review of Resident #1's face sheet, dated 05/20/25, reflected a [AGE] year-old female, who admitted to the facility on [DATE]. Resident #1 had diagnoses of Bipolar Disorder (mental health condition with extreme shifts in mood, energy, and activity levels), Major Depressive Disorder (serious mental illness with low mood, loss of interest in activities, and sleep disturbance), Anxiety Disorder (persistent and excessive worry or fear), and Cognitive Communication Deficit (cognitive function issues with memory and functioning) Record review of Resident #1's Quarterly MDS Assessment, dated 10/11/24, reflected Resident #1 had a BIMS score of 15, which indicated Resident #1's cognition was intact. The MDS noted Resident #1 had no issues with mood or behavior. Record review of Resident #1's Care Plan, with an initial date of 06/24/22, reflected the following: Initiated date 02/17/24- Resident is paranoid thinking everyone is against her Resident #1's Care Plan did not address Resident #1's verbal abuse or threats toward Resident #3. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the progress notes on Resident #1's electronic record reflected the following: 01/07/25 16:52 (4:52 PM) Documented by LPN A This nurse heard screams coming from hall 400. Ran to room [ROOM NUMBER] where I saw resident hitting resident who resides in room [ROOM NUMBER] 'lying' in the bed screaming 'my eye, my eye'. Resident was standing over resident in 410 hitting her repeatedly with a 'poll-like' object with a hood on the end of it. I immediately attempted to take the object from resident who would not let go. I examined the resident who resides in room and noticed her eye was red, around the eye was bruised, dorsal side of both hands were bruised. I called 911 for the police and paramedics. [sic] 01/07/25 1:07 AM Late Entry with an original date of 01/05/25 20:30 (8:30 PM) Documented by LPN B This nurse went to resident's room to talk to resident about the C/O made against her by her roommate. Resident refuted all the allegations made against her by roommate. She denied ever touching her roommate and also denied making any threat of stabbing the roommate with any weapon. My supervisor and myself went back to resident room and the only thing we found was a hand held back scratcher which my supervisor took away from the room. [sic] Record review of Resident #2's face sheet, dated 05/20/25, reflected an [AGE] year-old female, who admitted to the facility on [DATE]. Resident #2 had diagnoses of Dementia (decline in memory, thinking, and reasoning), Major Depressive Disorder (serious mental illness with low mood, loss of interest in activities, and sleep disturbance), Post Traumatic Stress Disorder (mental health condition that develops after experiencing or witnessing a traumatic event, which can be triggered by violence or abuse), and Anxiety Disorder (persistent and excessive worry or fear). The face sheet reflected Resident #2 discharged from the facility on 05/17/25. Record review of Resident #2's Quarterly MDS Assessment, dated 03/26/25, reflected Resident #2 had a BIMS score of 9, which meant Resident #2's cognition was moderately impaired. Record review of Resident #2's Care Plan, with an initial date of 09/03/24, did not address suicidal ideations, and no interventions were noted regarding suicidal ideations. Record review of Resident #2's progress notes reflected the following: 09/26/24 11:45 AM Signed by ADON (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident by therapy door crying this nurse asked the resident why is she crying and resident stated I want to go heaven, I am tired of this place. This nurse called resident's (Family Member) and notified. (Family Member) said she will be come shortly. Resident cont. on Sertraline 100 mg daily, Clonazepam 0.5mg BID and Quetiapine 25mg BID. Psych Dr. called and left a voice message with call back # awaiting for call back. Resident in her room sitting in her wheel chair water provided by the CNA and resident is drinking at this time. [sic] 12/11/24 13:56 (1:56 PM) Signed by LPN A Resident was having crying outbursts. She stated- 'I want to die' and it would be better if I weren't here. She also said that her daughter committed suicide. She was crying. Resident got a new roommate and feels anxious about it. Physician gave verbal order to give 1 mg Clonazepam now and increase scheduled dose from .5 mg to 1 mg BID. Gave Stat dose. updated order, [sic] 01/03/25 22:02 (10:02 PM) Signed by LPN I Resident got up around 8:45 PM , and tried to exit the building . She wanted to talk to her Pastor but did not know his name or his phone number . Resident grabbed a lamp in the lobby and wanted to hurt herself . This nurse asked resident if she would like to talk to one of our chaplains , then this nurse called Pastor (Pastor Name) and they talked for about one hour and then resident calmed down and she was able to go to sleep . The Chaplain promised resident that he will come to visit her tomorrow afternoon . Scissors which were in her room have been removed and kept in 400 hall cart . Family member (Family Member name) called but was not able to answer the phone call. [sic] 05/17/25 9:33 AM Sign by LPN J right after breakfast about 8 am charge nurse summone this nurse stating that resident was calling the police when spoke to (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident she was saying that last night they didn't give her medication she has to wait a long time to get it. try to explain that this is morning and will give her all her med personally. and did administer her am meds including clonazepam and spoke with the officer that she will be calming after a while instead after they left while trying to get a hold of her daughter resident came to nursing station with scissor on hand pointing it to her neck stating I am going to do it the other nurses took away her scissor from her hand contacted MD on call and received an order to send resident to ER for evaluation. Resident is at nursing station. [sic] 05/17/25 9:44 AM Signed by LPN J Resident locked her self in receptionist room holding a stapler saying she want to be left alone at this time EMT has been notified and able to open the door and get resident, when EMT arrived resident refuse to go with them (Name of City) police department were involved. Resident insist speaking with (Administrator name) (Administrator) and he spoke with her. Even then she refuse to go with them after police spoke with their chief since she was threatening to harm herself and disrupting the facility they lifted her to the stretcher and took her to (Hospital Name). EMT personal said they will take her to (facility name) facility but if they have to use sedation then they have to take her to (hospital name). called daughter and notified her. and told her exactly what the EMT told me. administrator, DON, ADON notified. [sic] Record review of Resident #2's hospital record, dated 01/07/25, reflected Resident #2 was diagnosed with assault, abrasion of left cornea (clear domed-shaped front of the eye), and an abrasion of the face. Record review of emails sent by the Administrator on 05/20/25, reflected the following: (Resident #2) - Both of them have psych issues and were arguing all the time. (Resident #2) was new so we moved her. (Resident #2) would throw stuff in the floor and (Resident #1) would complain about it and they would argue. (Resident #1) was hateful to (Resident #3) and complained about her all the time. It was escalating so we moved (Resident #3). (Resident #1) had a backscratcher she used and mentioned to staff she should hit (Resident #3) with it to shut her up. We moved (Resident #3) to avoid any escalation. I know (Resident #3) moved herself to (room number) on 12/15/2024. (Resident #2) moved to (room number) on 8/28/2024. It seems some of these moves were made at night by staff to de-escalate a situation, but we don't have specific information to be certain. The common denominator in all this was (Resident #1). She made it difficult for the staff and the other residents. When your census is low you are desperate for admissions and more times than not, you admit some you later regret admitting. It is never a dull moment, I can promise you that. (continued on next page)

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	675453	A. Building B. Wing	05/22/2025

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a received email on 05/21/25 at 10:06 AM, the Administrator stated the following: The incident this past weekend with (Resident #2) resulted in her being sent to the hospital for evaluation and treatment. It started with her being confused as to the time and was thinking staff 'hadn't given her the medications she needed. She called the police, and staff explained the time and administered her medications as scheduled. She was at the nurse's station, and they were in the process of sending her to the hospital when she wheeled herself to the receptionist area and locked the door behind her keeping staff out. She grabbed the stapler and wanted everyone to leave her alone. Staff were able to get inside the door when the receptionist returned. The EMTs were here and assisted with this. The receptionist had gone to get a resident some water and was just returning. I spoke with her by phone and was encouraging her to go with them, reminding her they were only here to help. She was still refusing to go and eventually allowed them to take her to the hospital. The staff did everything they could in this situation to protect her. They removed the scissors and were in the process of sending her to the hospital for treatment. This is the first time Resident #2 has given any indication of self-harm. She has expressed her wishes that she would die but has never done anything to facilitate this. The staff ensured she did not hurt herself and assisted the EMTs in her transportation to the hospital. No in-services or investigations were done during this time. In an interview on 05/20/25 at 4:27 PM, Nurse Aide C stated Resident #1 was always needed her privacy and always fought with people. She stated Resident #1 got aggressive with staff at times and they would have to work with her to calm her down. Nurse Aide C stated Resident #2 was the same way as Resident #1, and she stated it was hard to work with both of them when they were roommates. She stated she let the DON know whenever she had a hard time with either resident. In an interview on 05/2025 at 4:37 PM, the MDS Nurse stated the ADON and DON were responsible for changes on the care plan regarding acute issues like suicidal ideations and abuse. She stated the nursing team was responsible for adding those interventions to the care plan. She stated the DON was responsible for signing off on changes on the care plan for acute issues. The MDS Nurse stated the Social Worker might also be responsible for adding interventions for suicidal ideations. In an interview on 05/20/25 at 5:01 PM, the ADON stated the DON was on vacation. She stated the MDS nurse was responsible for ensuring the interventions were added to the care plan after a significant event. She stated the MDS Nurse was responsible for adding interventions related to suicidal ideations and verbal threats from one resident to another. The ADON stated the risk of not updating the care plan was the resident would not be monitored properly. In an interview on 05/20/25 at 5:32 PM, the Administrator stated Resident #1 argued with everyone. The Administrator stated ultimately, the MDS Nurse was responsible for ensuring the care plans were updated when it came to changes. He stated the ADON, DON, Social Worker, and the MDS Nurse all worked together to ensure the care plans were completed, but he stated they would all revisit the responsibilities to ensure everyone was aware who was responsible for what when he came to care plans. The Administrator stated it would be revisited so there was not a mishap. The Administrator stated the risk of not updating the care plan or adding interventions was that staff could not keep tabs on the residents. He stated the care staff would have a harder time, because it would not be noted exactly what the staff should look for when assisting certain residents. Record review of the facility's policy, titled, Care Plans, Comprehensive, dated 12/2024, reflected the following: (continued on next page)

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	675453	A. Building B. Wing	05/22/2025

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation I. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 1. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 2. The IDT includes: a. The Attending Physician; b. A registered nurse who has responsibility for the resident; c. A nurse aide who has responsibility for the resident; d. A member of the food and nutrition services staff; e. The resident and the resident's legal representative (to the extent practicable); and f. Other appropriate staff or professionals as determined by the resident's needs or as requested by the resident. 3. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. Participate in the planning process; b. Identify individuals or roles to be included; c. Request meetings; d. Request revisions to the plan of care; e. Participate in establishing the expected goals and outcomes of care; f. Participate in determining the type, amount, frequency and duration of care; g. Receive the services and/or items included in the plan of care; and h. See the care plan and sign it after significant changes are made. 4. The resident will be informed of his or her right to participate in his or her treatment. 5. An explanation will be included in a resident's medical record if the participation of the resident and his/her resident representative for developing the resident's care plan is determined to not be practicable. 6. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The care planning process will: a. Facilitate resident and/or representative involvement; b. Include an assessment of the resident's strengths and needs; and c. Incorporate the resident's personal and cultural preferences in developing the goals of care. 7. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; d. Describe any specialized services to be provided as a result of PASARR recommendations; e. Include the resident's stated goals upon admission and desired outcomes; f. Include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire; g. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Incorporate identified problem areas; continues on next page h. Incorporate risk factors associated with identified problems; i. Build on the resident's strengths; j. Reflect the resident's expressed wishes regarding care and treatment goals; k. Reflect treatment goals, timetables and objectives in measurable outcomes; l. Identify the professional services that are responsible for each element of care; m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and o. Reflect currently recognized standards of practice for problem areas and conditions. 8. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. 9. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. a. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	No single discipline can manage an approach in isolation. b. The resident's physician (or primary healthcare provider) is integral to this process. 10. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. a. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. b. Care planning individual symptoms in isolation may have little, if any, benefit for the resident. 11. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment. 12. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 13. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. When the resident has been readmitted to the facility from a hospital stay; and d. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At least quarterly, in conjunction with the required quarterly MDS assessment. 14. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals will be documented in the resident's clinical record in accordance with established policies. The Administrator and ADON were notified of an Immediate Jeopardy (IJ) on 5/21/25 at 4:25 PM, due to the above failures and the IJ Template was provided at 4:38 PM. The facility's Plan of Removal (POR) was accepted on 5/22/25 at 1:35 PM and included: (Facility Name) F-656 Preparation and/or execution of this plan do not constitute admission or agreement by the provider that immediate jeopardy exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and immediate jeopardy removal plan. This immediate jeopardy removal plan is submitted as the facility's immediate actionable plan to remove the likelihood that serious harm to a resident will occur or recur. 1. Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: 5/22/25) Resident directly involved in this deficient practice had their care plan reviewed by the DON or designee and updated to reflect current /past verbal abuse, threatening to harm self and other residents and aggression towards others. The MDS Coordinator reviewed Section D & E of the MDS and associated CAA for all residents. Care plans were reviewed and updated to ensure they reflect audit findings. Any concerns identified will be addressed immediately. Residents at risk for verbal abuse and/or aggressive behavior were re-evaluated using a PQH-9. All nursing staff on all shifts received education by the ADON on the importance of care plan reflecting residents' accurate behavior (ex. Verbal and physical aggression etc.) Any staff on leave will receive education on their next scheduled workday. The DON will be in-serviced prior to her return to work by the SR. VP. Of Clinicals. 2. Actions to Prevent Occurrence/Recurrence: (continued on next page)

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	05/22/2025

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

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: (5/22/25) The Managing Residents with Aggressive Behaviors policy was reviewed by department managers and all care staff. The DON or designee will audit new admissions for aggressive behavior risk and ensure appropriate interventions are in place. The DON or designee will audit completed MDS's to ensure the care plan reflects concerns identified in the CAAs. New hires will receive education from Nurse Management on dealing with residents with aggressive behaviors, and resident safety at orientation. A Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) was implemented to review and interpret all audit findings. All findings will be discussed at the monthly QAPI meeting for a minimum of three months or until the pattern of compliance is maintained. Date Facility Asserts Likelihood for Serious Harm No Longer Exists: (5/22/25) On 5/22/25 at 1:35 PM, the investigator began monitoring to determine if the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy: In an interview on 05/22/25 at 1:39 PM, RN D stated she received in-services today on care plans and following interventions put into place for residents. In an interview on 05/22/25 at 1:55 PM, the ADON stated she and the Administrator facilitated the in-services with the staff, on abuse and neglect, resident rights, resident-to-resident aggression, and care planning. She stated she and the Administrator received in-services on those subjects and it was facilitated by the VP from their corporate office. She stated there was an additional in-service on psych services and suicidal ideations facilitated by the behavioral health doctor on site today. In an interview on 05/22/25 at 2:02 PM, RN E stated she received in-services today on care plans and following interventions put into place for residents. In an interview on 05/22/25 at 2:18 PM, LVN F stated he received in-services today on care planning, updates to care plans, and following interventions on the care plans. In an interview on 05/22/25 at 3:09 PM, Nurse Aide G stated today she in-serviced on care plans, updates with residents, reporting incidents and behaviors of residents and following interventions set for those residents. In an interview on 05/22/25 at 4:01 PM, Nurse Aide H stated she was trained, today on changes with residents, reporting those changes in residents, and following-up to see if new interventions were set by reviewing the care plans or asking the nurses. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 05/22/25 at 4:22 PM, with Spanish Interpreter 2633, the Housekeeper stated she received in-services on changes with residents, reporting any issues like behavior or abuse to the nurses or the Administrator, and following-up with the nurses on what the resident needs. In an interview on 05/22/25 at 4:41 PM, the Dietary Manager stated she was trained this week on behavioral issues and concerns with residents, resident changes, and knowing to look at resident information or get with the nurses to know what the needs of the resident are at that time. In an interview on 05/2/25 at 4:47 PM, the Receptionist stated she received in-services that started yesterday on changes in residents and reporting those changes. She stated she also received an in-service on getting updates from the nurse or in the meetings on new interventions for certain residents. In an interview on 05/22/25 at 5:02 PM, the ADON stated the DON was still on vacation, but she would be in-serviced by the VP of Clinical Services prior to her working again on care plans and interventions. She stated all care staff had received in-services on care plans and interventions. She stated she, the DON, the Social Worker, the MDS Nurse, and the Administrator would continue to do routine in-services and audits to ensure there were no more concerns with care planning in the facility. She stated they were all responsible for ensuring the care plans were updated when needed. In an interview on 05/22/25 at 5:10 PM, the VP of Clinical Services stated she in-serviced the Administrator and the ADON on abuse and neglect, resident rights, care planning, resident to resident altercations, medication administration, and managing residents. She stated she would in-service the DON prior to her returning to work from leave. She stated they started audits and will continue to routinely do audits to ensure the staff are following through with all the trainings, as well as the Administrator, ADON, and DON following through with continued training and auditing. In an interview on 05/22/25 at 5:18 PM, the Social stated she received in-services on care plans and interventions. She stated she was helping the MDS Nurse audit the care plans today and on-going. The Social Worker stated the residents with behaviors would be checked on twice a week for the next 6-8 weeks, then quarterly afterward. In an interview on 05/22/25 at 5:23 PM, the MDS Nurse stated she received an in-service on care planning, resident changes and interventions. The MDS Nurse stated she was auditing care plans to ensure all addressed the needs of all residents. She stated she would do the same for all newly admitted residents. In an interview on 05/22/25 at 5:58 PM, the Administrator stated he completed in-services care planning and updating interventions for all residents. He stated they have all started completing the audits and the audits would continue for a while according to the plan. Record review of the following: In-services on abuse and neglect, resident rights, behavioral health, care plans, medication administration, resident-to-resident altercations, reporting of abuse and neglect dated 05/21/25 and 05/22/25. Audit of all resident care plans dated 05/22/25 (continued on next page)

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	675453	A. Building B. Wing	05/22/2025

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	May Activity Report dated 05/22/25 MDS Nurse Audit of the MDS assessments of residents Audit report of incidents reported, grievances reported, and any allegations of abuse or neglect. An Immediate Jeopardy (IJ) was identified on 5/21/25 at 4:25 PM and an IJ Template was provided to the Administrator at 4:38 PM. While the IJ was removed on 5/22/25, the facility remained out of compliance at a scope of isolated with the severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being, for one (Resident #2) of six residents reviewed for behavioral health services. 1. The facility failed to ensure Resident #2 was not roommates with another resident who affect her diagnoses of anxiety and PTSD, when she told staff she felt anxious about the new roommate, Resident #1. 2. The facility failed to ensure Resident #2 was immediately provided behavioral health services or put interventions in place after having suicidal ideations and threatening to harm herself. An Immediate Jeopardy was identified on 05/21/2025. The IJ template was provided to the facility on [DATE] at 4:38 PM. While the immediacy was removed on 05/22/2025 at 1:35 PM, the facility remained out of compliance at a scope of isolated and severity level of no actual harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could put residents at risk of not receiving behavioral health services and a decline in quality of life. Finding Included: Record review of Resident #2's face sheet, dated 05/20/25, reflected an [AGE] year-old female, who admitted to the facility on [DATE]. Resident #2 had diagnoses of Dementia (decline in memory, thinking, and reasoning), Major Depressive Disorder (serious mental illness with low mood, loss of interest in activities, and sleep disturbance), Post Traumatic Stress Disorder (mental health condition that develops after experiencing or witnessing a traumatic event, which can be triggered by violence or abuse), and Anxiety Disorder (persistent and excessive worry or fear). The face sheet reflected Resident #2 discharged from the facility on 05/17/25. Record review of Resident #2's electronic record, reflected a hospital document, titled, Discharge Clinical and Scripts, dated 08/27/24, and it reflected Resident #2 was admitted to the hospital for suicidal ideations on 08/02/24 from another facility. The document noted Resident #2 tried to use a knife to cut her neck. It noted Resident #2 told staff at the previous facility that she was going to kill herself. Record review of Resident #2's Quarterly MDS Assessment, dated 03/26/25, reflected Resident #2 had a BIMS score of 9, which meant Resident #2's cognition was moderately impaired. (continued on next page)

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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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's Care Plan, with an initial date of 09/03/24, did not address suicidal ideations, and no interventions were noted regarding suicidal ideations. In a received email on 05/21/25 at 10:06 AM, the Administrator stated the following: The incident this past weekend with (Resident #2) resulted in her being sent to the hospital for evaluation and treatment. It started with her being confused as to the time and was thinking staff 'hadn't given her the medications she needed. She called the police, and staff explained the time and administered her medications as scheduled. She was at the nurse's station, and they were in the process of sending her to the hospital when she wheeled herself to the receptionist area and locked the door behind her keeping staff out. She grabbed the stapler and wanted everyone to leave her alone. Staff were able to get inside the door when the receptionist returned. The EMTs were here and assisted with this. The receptionist had gone to get a resident some water and was just returning. I spoke with her by phone and was encouraging her to go with them, reminding her they were only here to help. She was still refusing to go and eventually allowed them to take her to the hospital. The staff did everything they could in this situation to protect her. They removed the scissors and were in the process of sending her to the hospital for treatment. This is the first time Resident #2 has given any indication of self-harm. She has expressed her wishes that she would die but has never done anything to facilitate this. The staff ensured she did not hurt herself and assisted the EMTs in her transportation to the hospital. No in-services or investigations were done during this time. Record review of Resident #2's progress notes reflected the following: 09/26/24 11:45 AM Signed by ADON Resident by therapy door crying this nurse asked the resident why is she crying and resident stated I want to go heaven, I am tired of this place. This nurse called resident's daughter and notified. Daughter said she will be come shortly. Resident cont. on Sertraline 100mg daily, Clonazepam 0.5mg BID and Quetiapine 25mg BID. Psych Dr. called and left a voice message with call back # awaiting for call back. Resident in her room sitting in her wheel chair water provided by the CNA and resident is drinking at this time. [sic] Record review of Resident #2's electronic record reflected Resident #2 did not receive any psychiatric, psychological, or behavioral assessment immediately following the staff noting the suicidal ideations on 09/24/24. 12/11/24 13:56 (1:56 PM) (continued on next page)

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	675453	A. Building B. Wing	05/22/2025

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Signed by LPN A Resident was having crying outbursts. She stated- 'I want to die' and it would be better if I weren't here. She also said that her daughter committed suicide. She was crying. Resident got a new roommate and feels anxious about it. Physician gave verbal order to give 1 mg Clonazepam now and increase scheduled dose from .5 mg to 1 mg BID. Gave Stat dose. updated order, Record review of Resident #2's electronic record reflected Resident #2 did not receive any psychiatric, psychological, or behavioral assessment immediately following the staff noting the suicidal ideations on 12/11/24. 01/03/25 22:02 (10:02 PM) Signed by LPN I Resident got up around 8:45 Pm , and tried to exit the building . She wanted to talk to her Pastor but did not know his name or his phone number . Resident grabbed a lamp in the lobby and wanted to hurt herself . This nurse asked resident if she would like to talk to one of our chaplains , then this nurse called Pastor (Pastor Name) and they talked for about one hour and then resident calmed down and she was able to go to sleep . The Chaplain promised resident that he will come to visit her tomorrow afternoon . Scissors which were in her room have been removed and kept in 400 hall cart . Family member (Family Member name) called but was not able to answer the phone call. Per the Progress Notes, Resident #2 did see a Psychiatrist on 01/03/25 at 00:02 (1:02 AM) on 01/03/25. Resident #2 did not receive any psychiatric, psychological, or behavioral assessment immediately following the staff noting the suicidal ideations that occurred on 01/03/25. Per the Progress Notes, Resident #2 did see a Psychiatrist on 01/03/25 at 00:02 (1:02 AM) on 01/03/25. Resident #2 did not receive any psychiatric, psychological, or behavioral assessment immediately following the staff noting the suicidal ideations that occurred on 01/03/25. 05/17/25 9:33 AM (continued on next page)

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	675453	A. Building B. Wing	05/22/2025

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Sign by LPN J right after breakfast about 8 am charge nurse summone this nurse stating that resident was calling the police when spoke to resident she was saying that last night they didn't give her medication she has to wait a long time to get it. try to explain that this is morning and will give her all her med personally. and did administer her am meds including clonazepam and spoke with the officer that she will be calming after a while instead after they left while trying to get a hold of her daughter resident came to nursing station with scissor on hand pointing it to her neck stating I am going to do it the other nurses took away her scissor from her hand contacted MD on call and received an order to send resident to ER for evaluation. Resident is at nursing station. [sic] 05/17/25 9:44 AM Signed by LPN J Resident locked her self in receptionist room holding a stapler saying she want to be left alone at this time EMT has been notified and able to open the door and get resident, when EMT arrived resident refuse to go with them (City Name) police department were involved. Resident insist speaking with (Administrator name) (Administrator) and he spoke with her. Even then she refuse to go with them after police spoke with their chief since she was threatening to harm herself and disrupting the facility they lifted her to the stretcher and took her to (Hospital Name). EMT personal said they will take her to (facility name) facility but if they have to use sedation then they have to take her to (hospital name). called daughter and notified her. and told her exactly what the EMT told me. administrator, DON, ADON notified. [sic] Record review of Resident #2's electronic record reflected the resident saw the Behavioral Health Doctor on 01/02/25, but per the doctor's notes, Resident #2 denied any suicidal or homicidal ideations. The treatments listed on the document were: Psychosocial & Supportive Interventions Referral to Counseling/Therapy: Arrange for a counselor to provide regular one-on-one sessions to address her loneliness, potential family dysfunction, and coping skills. Staff Education: Encourage staff to respond promptly to her call light, ensure her immediate requests are met when feasible to reduce triggers for agitation. Activity Engagement: Suggest low-impact group or one-on-one recreational therapy to increase social interaction and reduce idle time. Medication Review (continued on next page)

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	675453	A. Building B. Wing	05/22/2025

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Current Regimen: She is on multiple agents (sertraline, quetiapine, clonazepam) for mood/anxiety/psychosis. Continue to monitor sedation, cognitive impact, and overall efficacy. Possible Adjustments: If depression persists, consider evaluating the dose of sertraline (currently 100 mg daily) for potential titration, or add a mood stabilizer carefully if indicated. In an interview on 05/20/25 at 4:27 PM, Nurse Aide C stated Resident #1 was always needed her privacy and always fought with people. She stated Resident #1 got aggressive with staff at times and they would have to work with her to calm her down. Nurse Aide C stated Resident #2 was the same way as Resident #1, and she stated it was hard to work with both of them when they were roommates. She stated she let the DON know whenever she had a hard time with either resident. She stated staff were trained to let the DON or Administrator know if any resident had suicidal ideations. In an interview on 05/20/25 at 4:37 PM, the MDS Nurse stated the DON and ADON were responsible for putting interventions in place for suicidal ideation concerns. She stated the nursing staff were the ones responsible for the more acute situations like suicidal ideations. In an interview on 05/20/25 at 5:01 PM, the ADON stated certain interventions would be updated by the nursing staff, such as herself or the DON, but certain interventions, like adding interventions to the care plan was the responsibility of the MDS Nurse. The ADON stated her nursing staff were monitoring Resident #2 for behaviors. In a telephone interview on 05/20/25 at 5:12 PM, LPN A stated she did not feel comfortable discussing the incident over the phone, that the State did not normally make telephone calls during an investigation, and she did not feel safe to discuss the incident with Surveyor. She stated she was not able to meet in person and did not feel comfortable discussing a resident via email. In an interview on 05/20/25 at 5:32 PM, the Administrator stated he was aware of the incident with the scissors, but he stated he was not aware of any incident where Resident #2 picked up a lamp to harm herself. He stated he did not recall a time where she actually harmed herself. He stated she refused to go to the hospital on a few occasions. The Administrator stated he refused her medications at time. He stated with putting interventions in place, it was a collaborative effort between the ADON, DON, the Social Worker, and the MDS Nurse. He stated they usually worked together. The Administrator stated he will revisit exactly whose duty it was when it came to putting interventions in place. The Administrator stated there were risks of not having interventions in place for Resident #2, and that was the staff, nurses, and caregivers not being alerted on behaviors and knowing what to look for to report to management. In an interview on 05/21/25 at 11:29 AM, the Social Worker stated her primary responsibilities were MDS admission assessments, care plans, discharges, coordination of services like transportation and insulary things like seeing specialists. She stated Resident #1 and Resident #2 were good roommates as first. She stated they got along well together. She stated something changed, and Resident #2 was moved to another room. The Social Worker stated she is not sure how long the two were roommates, but it was not long. The Social Worker stated, regarding suicidal ideations, that would be added to the care plan by the nurses. (continued on next page)

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	675453	A. Building B. Wing	05/22/2025

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's undated policy, titled, Suicide Prevention, reflected the following: The facility designs and implements processes that strive to provide physical and psychosocial services that adequately care for all residents/patients admitted to the facility. In an attempt to identify and prevent psychosocial dysfunction, the staff will observe the physical and functioning psychosocial of the resident/patient. This process allows the staff to detect early warning signs of major mood changes and/or possible suicidal ideation and obtain and provide appropriate interventions. 1. Report any of the following warning signs immediately to your immediate supervisor: a. Resident/patient expresses feelings of worthlessness, hopelessness or helplessness b. Outbursts of anger, mood swings, and drastic changes in behavior c. Experienced a recent significant loss d. Direct and indirect statements such as, I wish I were dead, I'm going to kill myself, I'm useless, and I can't go on living like this 2. Provide a quiet, calm atmosphere to decrease anxiety/agitation. 3. Express care and concern while allowing resident/patient to express emotions. 4. Evaluate resident/patient's environment for safety and remove and store objects which could be used for self-harm. 9. Initiate a Plan of Care meeting and determine the appropriate interventions and goals. (continued on next page)

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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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Administrator and ADON were notified of an Immediate Jeopardy (IJ) on 5/21/25 at 4:25 PM, due to the above failures and the IJ Template was provided at 4:38 PM. The facility's Plan of Removal (POR) was accepted on 5/22/25 at 1:35 PM and included: (Facility Name) F-742 Preparation and/or execution of this plan do not constitute admission or agreement by the provider that immediate jeopardy exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and immediate jeopardy removal plan. This immediate jeopardy removal plan is submitted as the facility's immediate actionable plan to remove the likelihood that serious harm to a resident will occur or recur. 1. Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: 5/22/25). All staff were educated by, Dr. (doctor name), a Licensed Clinical Social Worker (LCSW), who specializes in mental health and behavior management, on suicide, self-harm, and recognizing triggers/indicators of resident distress. The LCSW provided detailed education to all social services staff members on conducting resident suicide screenings/assessments successfully. The DON/ADON educated nursing staff on meeting the resident's behavioral health and psychosocial needs based upon current standards of practice, the principals of person-centered care, and the resident's goals. Social Service Director to meet with resident two times weekly indefinitely, to assess for suicidal ideation, intent, and/or plan. Resident #2 is no longer in the facility All charts were audited the Administrator, ADON, MDS, and Social Worker, to ensure that care plan interventions were in place for any residents with mood, behavior, or psychosocial indicators. 2. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: 5/22/25). All facility policies and procedures regarding behavioral health services, and suicide assessment and prevention, were reviewed by the department managers as well as all care staff. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All nursing and social services staff members were educated by the ADON regarding facility policy and procedures on behavioral health services, and suicide assessment and prevention. Changes in resident mood and behavior will be discussed by the IDT at the daily stand-up meeting. Interventions will be developed, care planned, and implemented with front line staff involvement. The facility has contracted with a new mental health company that employs Psychiatrists who make facility visits. This will improve medication management for residents with mental illnesses and behavioral health needs. The Social Services Director will conduct chart audits to continually ensure that care plan interventions are in place for any residents with mood, behavior, or psychosocial indicators. Audits occur: o Weekly for 4 weeks and then. o Monthly for 3 months and then. o Quarterly The Social Services Director implemented a QAPI PIP to gather and process information from the audits. Findings will be reported at the monthly QAA meeting for a minimum of 3 months. Date Facility Asserts Likelihood for Serious Harm No Longer Exists: 5/22/25 On 5/22/25 at 1:35 PM, the investigator began monitoring to determine if the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy: In an interview on 05/22/25 at 1:39 PM, RN D stated she received in-services today, suicidal ideations, and reporting of suicidal ideations. In an interview on 05/22/25 at 1:55 PM, the ADON stated she and the Administrator facilitated the in-services with the staff, on abuse and neglect, resident rights, resident-to-resident aggression, and care planning. She stated she and the Administrator received in-services on those subjects and it was facilitated by the VP from their corporate office. She stated there was an additional in-services on psych services and suicidal ideations facilitated by the behavioral health doctor on site today. On 05/22/25 at 1:58 PM, an in-service on behavioral health, suicidal ideations, and suicide was observed with over 20 staff members present in the in-service, which was conducted by the Behavioral Health Physician, in the dining hall. (continued on next page)

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	675453	A. Building B. Wing	05/22/2025

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

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 05/22/25 at 2:02 PM, RN E stated she received in-services that started yesterday and covered abuse, neglect, today on suicidal ideations, and reporting when a resident had suicidal ideations. She stated the abuse coordinator was the Administrator. In an interview on 05/22/25 at 2:18 PM, LVN F stated he received in-services today that covered, abuse and neglect and suicidal ideations. In an interview on 05/22/25 at 3:09 PM, Nurse Aide G stated she was in the behavioral health in-service today, reporting incidents and behaviors of residents to the nursing staff, suicidal ideations heard from residents, suicide attempts, and residents fighting with each other. In an interview on 05/22/25 at 4:01 PM, Nurse Aide H stated she received training today on reporting of suicidal ideations by residents. She stated she would report that to the Administrator, who was the abuse coordinator. In an interview on 05/22/25 at 4:22 PM, with Spanish Interpreter 2633, the Housekeeper stated she received in-services today on changes with residents, reporting any issues like behavior or abuse to the nurses or the Administrator. She stated the was in the behavioral health in-service. She stated her in-services are usually given to her in Spanish, so she can understand everything. She stated her supervisor interprets it for her. The Housekeeper stated there was always someone present to interpret the trainings for her. In an interview on 05/22/25 at 4:41 PM, the Dietary Manager stated she was trained this week on resident suicide, suicidal ideations, behavioral issues and concerns with residents, resident changes, and reporting of allegations. She stated if she witnessed anything she would immediately tell the Administrator. She stated she in-serviced her staff on all of those subjects this week, and she stated all of her staff attended the in-service on behavioral health today. In an interview on 05/2/25 at 4:47 PM, the Receptionist stated she received in-services on changes in residents and reporting suicidal ideations. She stated she was getting the in-service on behavioral health after the other staff, because she had to cover the front desk during the larger in-service. In an interview on 05/22/25 at 5:02 PM, the ADON stated the DON was still on vacation, but she would be in-serviced by the VP of Clinical Services prior to her working again. She stated all other staff had received in-services on abuse, neglect, resident rights, behavioral health, care plans, suicide prevention, and medication administration. She stated she, the DON, and the Administrator would continue to do routine in-services and audits to ensure there were no more concerns with abuse and neglect in the facility. She stated the IDT was working together to ensure all residents with behavioral issues had interventions in place and the care that was needed to ensure their safety. In an interview on 05/22/25 at 5:10 PM, the VP of Clinical Services stated she in-serviced the Administrator and the ADON on abuse and neglect, resident rights, care planning, resident to resident altercations, medication administration, and managing residents. She stated she would in-service the DON prior to her returning to work from leave. She stated they started audits and will continue to routinely do audits to ensure the staff are following through with all the trainings, as well as the Administrator, ADON, and DON following through with continued training and auditing. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 05/22/25 at 5:18 PM, the Social Worker stated she attended the behavioral health in-service today. She stated she was helping the MDS Nurse audit the care plans today and on-going. She stated she was responsible for completing audits on suicidal ideations and anxiety. The Social Worker stated the residents with behaviors would be checked on twice a week for the next 6-8 weeks, then quarterly afterward. She stated she was working with the nursing team, and the MDS Nurse to ensure interventions were in place for residents with behavioral concerns. In an interview on 05/22/25 at 5:23 PM, the MDS Nurse stated she received an in-service on behavioral health, resident rights, abuse and neglect, care planning, resident altercations, and suicidal ideations. She stated he also received an in-services on reporting abuse, neglect, suicidal ideations. She stated she started auditing all resident MDS assessments to ensure all behaviors were addressed on the MDS, and she would do that for all in-coming residents as well. She stated she was working with other department heads like the Social Worker and ADON to ensure interventions were in place for residents with behavioral issues. In an interview on 05/22/25 at 5:58 PM, the Administrator stated he completed in-services this week on abuse and neglect, resident rights, behavioral health, resident altercations, care planning, medication administration, and reporting of anything concerning. He stated they have all started completing the audits and the audits would continue for a while according to the plan. The Administrator stated all department heads were working together to ensure the safety of all residents and to ensure their needs were met. Record review of the following: In-services on abuse and neglect, resident rights, behavioral health, care plans, medication administration, resident-to-resident altercations, reporting of abuse and neglect dated 05/21/25 and 05/22/25. Audit of all resident care plans dated 05/22/25 May Activity Report dated 05/22/25 MDS Nurse Audit of the MDS assessments of residents Audit report of incidents reported, grievances reported, and any allegations of abuse or neglect. An Immediate Jeopardy (IJ) was identified on 5/21/25 at 4:25 PM and an IJ Template was provided to the Administrator at 4:38 PM. While the IJ was removed on 5/22/25, the facility remained out of compliance at a scope of isolated with the severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access for one (Treatment Cart #1) of one treatment cart reviewed. The facility failed to ensure Treatment Cart #1 was locked when unattended on 05/21/25. This failure could place residents at risk of having access to unauthorized medications and/or lead to possible harm or drug diversion. Findings included: In an observation and interview on 05/21/25 at 9:23 AM, Treatment Cart #1 was observed unlocked and unattended, near the nurses' station, against the wall between the 500 wing and 600 wing. All drawers were unlocked, and there were bandages and prescription creams on the cart. There were residents in the immediate area and no staff at the nurses' station. The treatment cart was unlocked and unattended for at least 5 minutes. The items on the cart were scissors, gauze, iodine, honey patches, and saline. The Administrator stated the treatment cart should be locked all the times. The Administrator stated he would go find out who left the treatment cart unlocked and unattended. The Administrator did not locate a nurse, so the ADON went to the treatment cart and locked it. The ADON stated she was not sure who left the cart unlocked and unattended. The ADON stated all nurses were responsible for ensuring the treatment cart was locked. The ADON stated she would research to see who the last nurse was to use the cart. In an interview on 05/22/25 at 5:02 PM, the ADON stated she never figured out which nurse was responsible for the unlocked treatment cart. She stated all nurses were in-serviced on the importance of locked treatment carts. She stated the risk of an unlocked treatment cart was confused patients could open the cart and get items of the cart that were dangerous. In an interview on 05/22/25 at 5:58 PM, the Administrator stated the risk of the unlocked treatment cart was residents had access to scissors, medications, and fingernail clippers. He stated his nurses knew better than to leave the treatment cart unlocked. Record review of the facility's undated policy titled, Medication Administration General Guidelines, reflected the following: 1. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications when unlocked. Record review of the in-service, titled, Should Not Leave Med Carts Open Tx Cart, dated 05/21/25, reflected the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication carts should be kept locked and secured at all times when not in use to prevent unauthorized access and potential med errors.