

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675563	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/10/2024
NAME OF PROVIDER OR SUPPLIER  Colonial Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  508 Pierce St Lindale, TX 75771	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49019</p> <p>Based on interview and record review, the facility failed to ensure residents were secure during transportation to prevent accidents for 1 of 3 residents reviewed for accidents. (Resident # 12)</p> <p>The facility did not ensure a wheelchair was secured while transporting Resident #12 which caused . Resident #12 to slide out of the wheelchair during transportation from the hospital.</p> <p>This failure could place residents who travel in the facility van at risk of injuries.</p> <p>Findings included:</p> <p>During record review of a face sheet dated 6/23/2024 indicated Resident # 12 was [AGE] years old female and admitted on [DATE]. Resident #12's diagnoses included: Sepsis (An infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever), Acute on chronic diastolic congestive heart failure ( condition in which your heart's main pumping chamber (left ventricle) becomes stiff and unable to fill properly), Type II Diabetes (Type 2 diabetes is a chronic condition that happens when you have persistently high blood sugar levels (hyperglycemia).) acquired absence of right below the knee and acquired absence of left leg above the knee (a medical condition that indicates the loss or amputation of the right leg below the knee and left leg above the knee), and cognitive communication deficit (communication deficit is a problem with one or more cognitive skills involved in communication such as attention, memory or reasoning).</p> <p>During record review of a MDS dated [DATE] revealed Resident #12's BIMs (Brief Interview for Mental Status) score was a 08 indicating Resident #12's cognition was moderately impaired. Resident # 12 was dependent on 2 or more persons to transfer from the chair to the bed and toilet transfers. She used a manual wheelchair as a mobility device.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During record review of a care plan dated 5/17/2024 indicated Resident # 12 was a resident at risk for falls related to balance problems, incontinence, weakness and bilateral (pertaining to, involving, or affecting two or both sided) lower extremity amputee with a goal to be free of fall. Interventions reflected to anticipate and meet Resident #12's needs, keep call light within reach and remind resident what to do if a fall occurs, encourage to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Resident #12's care plan indicated she had limited physical mobility related to double lower extremity amputee with a goal to demonstrate the appropriate use of electric wheelchair to increase mobility and maintain current level of mobility. Interventions reflected to provide supportive care, assistance with mobility as needed and physical therapy and occupational referrals as ordered. Resident #12's care plan indicated she had ADL self-care deficits and required a mechanical lift with 2 staff for transfers to and from the shower chair and may use sliding board from bed to chair or chair to bed.</p> <p>During an interview on 6/22/2024 at 3:12 PM, Resident #12 denied any falls or injuries while at the facility. Resident #12 said she had used the transportation at the facility and said she was buckled in securely and felt safe during transportation to and from hospital.</p> <p>During record review of incident report dated 6/10/2024, Transportation driver indicated Resident #12 slid from her wheelchair onto the floor in the van. The incident report indicated upon assessment; Resident #12 was observed laying on the floor of the van with a pillow under her head. When attempted to move Resident #12, she screamed out in pain while grabbing her hips. Emergency services notified and Resident #12 was transported to hospital.</p> <p>During an interview on 6/22/2024 at 4:43 PM, the DON and the Assistant ADM said Resident #12 slid from her wheelchair during van transportation on 6/10/2024. The DON said the fall occurred as the van was pulling into the driveway at the facility.</p> <p>During an interview on 6/22/2024 at 4:48 PM, the Transportation Driver said she placed Resident #12 in the van and Resident #12. The Transportation driver said Resident #12 kept sliding out of her wheelchair prior to transport from the hospital The Transportation Driver said about half-way back and approximately 12 miles from the facility, the resident said she was sliding. The Transportation driver pulled over and assisted Resident #12, by lowering her to the floor of the van and placed 2 wheelchair cushions under her head and under Resident #12's bottom. She called the ADM of the facility and the phone hung up. The Transportation Driver said she made the decision to strap the resident down on the floor with the straps and transport her back to the facility. The Transportation Driver said the ADM asked her why she did not call 911. The Transportation Driver said she was never trained on what to do in the event of an accident. The Transportation Driver said when she returned to the facility, staff members came out to the van to assess Resident #12 and Emergency Medical Services were notified and Resident #12 was transported to the hospital for further evaluation. The Transportation Driver said she was not suspended after the incident .</p> <p>During an interview on 6/22/2024 at 5:29 PM, the Director of Rehab said he trained the Transportation Driver on proper seating in the wheelchair and wheelchair on the van on 12/18/2023. The Director of Rehab said Resident #12 was a double amputee and Resident #12 required a manual wheelchair to transport. The Director of Rehab said he demonstrated to the Transportation Driver how to get a resident in and out of van and strap securement on the wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/22/2024 at 5:44 PM, the Transportation Driver was contacted for further information. The Transportation Driver said Resident #12 would normally use her powerchair during transportation but was in a regular manual wheelchair on the day of the incident. The Transportation Driver said she was not allowed to transfer residents due to her not being a CNA.</p> <p>During an interview on 6/23/2024 at 4:40 PM Activity Director said she had never observed Resident #12 sliding from her wheelchair. The Activity Director said Resident #12 did not require anything to keep her in her wheelchair. The Activity Director said a resident having issues with wheelchair would be on the care plan.</p> <p>During an interview on 6/23/2024 at 4:50 PM, CMA K said CNAs did not assist during transportation with residents in wheelchairs. She said the transportation driver and residents were the only ones on the van.</p> <p>During an interview on 6/23/2024 at 5:23 PM, the DON said securing a resident on the floor of the van and transporting them back to the facility was appropriate, but the Transportation Driver should have called Emergency Medical Services (EMS) for assistance. The DON said she was going to investigate the incident and the Transportation Driver would be re-educated and have a vehicle checklist. The DON said a resident sliding out of from a wheelchair should be care planned. The DON said there should be another person on the van with Resident #12 since she had an issue with sliding out of her wheelchair.</p> <p>During an interview on 6/23/2024 at 5:38 PM, the Assistant ADM said the Transportation Driver should make sure the residents are properly secured in van before transport. The Assistant ADM said he would have pulled over and called first responders and he expected the Transportation Driver to call for help because she was not a nurse aid. The Assistant ADM said a resident sliding out of wheelchair should be care planned and would be care planned to move forward to prevent incidents.</p> <p>During record review of the facility's in-service training report dated 12/18/2023 indicated the Transportation Driver was trained on following:</p> <p>Van and Car transfers including seating and positioning of resident in wheelchair, locking brakes, seat belts, loading and unloading via lift and down, adding or removing wheelchair leg rest, use of oxygen and proper placement on wheelchair conducted and signed by Director of Rehab. The Director of Rehab indicated in his evaluation, comments the Transportation Driver was able to demonstrate proper use of wheelchair and oxygen tanks. He noted she was able to safely load and unload resident's using the van lift and able to use seat belt and lock wheelchair correctly. The Director of Rehab indicated she was instructed to make sure residents had leg rest and buckled properly.</p> <p>Record review of the facility's Transportation Policy dated 6/3/2023 indicated .Purpose: The transportation policy of residents of facility, whether conducted by facility-employed or contracted transportation services . Any accidents or incidents during transportation must be reported immediately to the facility's designated personnel and documented per facility procedures .8. Emergency procedures: Drivers must be trained in emergency procedures specific to transportation incidents, including medical emergencies, accidents, and adverse weather conditions .Emergency contact information for residents and facility staff must be readily available and accessible during transport .</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49019</p> <p>Based on interview and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 of 5 residents reviewed for pharmacy services (Resident #24)</p> <p>1. The facility failed to keep a record receipt of Resident #24's-controlled medication Hydrocodone.</p> <p>The failures could place residents at risk of inadequate pain control, not receiving the intended therapeutic dose to alleviate moderate to severe pain as ordered and not having accurate records of medication administration which could result in diminished health and well-being.</p> <p>Findings included:</p> <p>1. Record review of the undated face sheet for Resident #24 indicated she was a [AGE] year old female that readmitted [DATE] with diagnoses that included: Orthopedic aftercare following surgical amputation (surgical procedure of a removal of body part such as arm, foot, toe or leg), Atherosclerosis of native arteries of extremities with rest pain, right leg (a disease of the peripheral blood vessels that is characterized by narrowing and hardening of the arteries that supply the legs and feet), peripheral vascular disorder (a circulatory condition in which narrowed blood vessels reduce blood flow to limbs).</p> <p>Record review of the MDS assessment dated [DATE] indicated Resident # 24 had clear speech, usually understood others, and usually understood by others. She had a BIMS of 15 indicating she was cognitively intact.</p> <p>Record review of the care plan revised on 4/29/2024 revealed Resident #24 had acute and chronic pain related to peripheral vascular disease and post-surgery to right femoral bypass grafts and takes pain medication. The goal was Resident #24 would be free of any discomfort or adverse side effects from pain medication. Interventions included to administer analgesic medications as ordered by physician. Monitor and document side effects and effectiveness every shift and notify MD PRN. Review for pain medication efficacy, assess whether pain intensity was acceptable to resident.</p> <p>Record review of physician's orders for Resident #24 indicated:</p> <p>1. Hydrocodone 5-325 mg (120 quantity) was filled on 4/19/2024. The pharmacist confirmed order written for Hydrocodone 5-325 mg 1 tablet every 6 hours scheduled for 30 days.</p> <p>2. Hydrocodone 5-325 mg (180 quantity) was filled on 5/20/2024 and receipted at the facility. The pharmacist confirmed the order was for Hydrocodone 5-325 mg 1 tablet four times daily and every 6 hours as needed for pain.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a hospital discharge date d 6/20/2024 indicated Resident #24 was hospitalized from 6/11/2024- 6/20/2024 for Right AKA (above the knee amputation). Resident #24 was discharged from hospital with a new prescription of Hydrocodone-acetaminophen 5-325 mg 1 tablet every 4 hours if needed for moderate pain (4-6) or severe pain (7-10). Resident #24 would have remaining Hydrocodone previously prescribed to her on 5/20/2024 for Hydrocodone 5-325 mg (180 dispensed) 1 tablet every 4 hours and every 6 hours as needed for pain. The facility was unable to locate remaining Hydrocodone prescribed and delivered on 5/20/2024.</p> <p>During an interview on 6/23/2024 at 12:50 PM, LVN C and the DON said the facility could not locate Resident #24's Hydrocodone 5-325 mg 4 x daily and every 6 hours prn for pain that was delivered on 5/20/2024 . The DON and LVN C said Resident #24 was prescribed Oxycodone 5-325 mg 1 tablet every 4 hours as needed for moderate pain on 5/15/2024 and was completed on 5/22/2024.</p> <p>During record review of delivery receipt dated 5/15/2024, indicated Resident #24's Oxycodone/APAP 5-325 mg tablet quantity 30 was delivered on 5/15/2024 and completed on 5/22/2024 indicated on the individual control drug record.</p> <p>During an interview on 6/23/2024 at 12:56 PM LVN C said there was not another prescription or delivery for Hydrocodone on 5/20/2024.</p> <p>During a phone interview on 6/23/2024 at 1:42 PM, with Pharmacist G, said the Hydrocodone 5-325 mg was delivered on 5/20/2024 (180 dispensed) and was signed by LVN D. The remaining Hydrocodone from dispensed date 5/20/2024 was not located at the facility.</p> <p>During an interview on 6/23/2024 at 1:48 PM, the DON said LVN D worked on 5/20/2024 on the 6pm-6am shift and was scheduled.</p> <p>During an interview on 6/23/2024 at 2:16 PM LVN A said narcotics were always counted before and after shift change. LVN A denied any counts being off. LVN A said she would call the DON if counts were off. LVN A said the medications remained on the cart when a resident went to the hospital. She said they would not send Resident #24 with medications. LVN A said discontinued medication count sheets go to the DON for her and the pharmacist to destruct medications.</p> <p>During an interview on 6/23/2024 at 2:43 PM Resident #24 said she received her routine medications on time as scheduled and wound care daily as ordered. Resident #24 said recently she had to wait 24 hours to receive her pain medication after returning from the hospital on 6/20/2024 and said she had to wait for the pharmacy to deliver her pain medications. Resident #24 said she only received Hydrocodone 5-325 mg 1 tablet of her pain medication scheduled every 4 hours.</p> <p>During an interview on 6/23/2024 at 4:10 PM the DON said she was on vacation on 6/10/2024-6/16/2024. The DON said prior to her vacation, the Hydrocodone prescribed on 4/19/2024 was dated completed on 6/6/2024 and she reviewed Resident #24's Hydrocodone prescription to ensure she needed a new prescription on 6/20/2024. The DON said the Hydrocodone had been called in for Resident #24 from the hospital prior to her discharging. The DON said she was not aware of the missing count sheet or Hydrocodone. The DON said it would be a reportable incident if medication was missing. The DON said she was going to in-service staff on narcotic delivery and would start having 2 nurses sign when the pharm dropped off narcotics.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/23/2024 at 4:55 PM, RN B said she had only been at the facility for 2 days and she did not administer medications and said she had not received report from any staff that narcotic counts were off and would recount if counts were ever off.</p> <p>During an interview on 6/23/2024 5:05 PM LVN C said she was currently the new MDS nurse was previously the ADON about 1 month ago. LVN C said she was not aware of missing narcotics.</p> <p>During an interview on 6/23/2024 5:23 PM, the DON said she expected the nurses to report any missing medications. The DON said she was not aware of Resident #24's missing count sheet or Hydrocodone. She said missing medication was reportable. The DON said that was the first time a medication had not been located.</p> <p>During an interview on 6/23/2024 at 5:38 PM, the Assistant ADM he it was not reported that Resident #24 was missing her Hydrocodone or count sheet, expected nursing staff to report any medication counts off or missing narcotics immediately.</p> <p>During an interview on 6/23/2024 6:20 PM, LVN D said she received the Hydrocodone on 5/20/2024 between 10 PM and 11 pm. LVN D said she signed for the medication and placed it in the med cart. LVN D said no other nurses witnessed the medications dropped off. LVN D said there were 180 pills of Hydrocodone delivered for Resident #24 on 5/20/2024. LVN D said she signed the individual control drug record and documented the quantity and placed the form in the narcotic book at station 1 cart. LVN D said the medications were routine .</p> <p>During record review of the facility's individual control drug record dated 5/15/2024 indicated Oxycodone/APAP 5-325 mg in the quantity of 30 pills dispensed for Resident #24 to be administered 1 tablet by mouth every 4 hours as needed for moderate pain for up to 7 days and was started on 5/16/2024-5/22/2024. Resident #24 received her pain medication and completed them on 5/22/2024.</p> <p>During the record review of the facility's individual control drug record dated 4/19/2024 indicated Resident #24's Hydrocodone 5-325 mg 1 tablet by mouth every 6 hours and quantity of 120 dispensed and signed off on starting on 4/20/2024- 5/24/2024 on 1 of 2 drug records and 5/24/2024 -6/6/2024 on page 2 of 2 drug records.</p> <p>During record review of the facility's individual control drug record dated 6/20/2024 indicated Hydrocodone 5-325 mg 1 tablet by mouth every 4 hours as needed for moderate to severe pain and a quantity of 40 pills started on 6/20/2024 at 11:00 PM through 6/24/2024 was still available and administered as ordered with 16 tablets remaining.</p> <p>During record review and interview on 6/23/2024 at 1:54 PM the DON presented a pharmacy delivery requisition form dated 5/20/2024, Resident #24's Hydrocodone 5-325 mg in quantity of 180 pills filled and delivered on 5/20/2024 was not accounted for. The DON said she could not locate the individual control drug record with the counts for the Hydrocodone 5-325 mg delivered on 5/20/2024. The DON said the medications were not located in the medication destruction storage.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During record review of the facility 's policy dated April 2019 titled Discarding and Destroying Medications, indicated .Medications will be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste, and controlled substances . Policy Interpretation and Implementation .1. All unused controlled substances shall be retained in a securely locked area with restricted access until disposed of .11. The medication disposition record will contain the following information . a. The resident's name b. Date medication disposed c. The name and strength of the medication d. The name of the dispensing pharmacy e. The quantity disposed f. Method of disposition g. Reason of disposition h. signature of witnesses .12. Completed medication disposition records shall be kept on file in the facility for at least two (2) years, or as mandated by state law governing the retention and storage of such records.</p> <p>During record review of the facility 's policy titled Storage of Medication dated April 2019 indicated .the facility stores all drugs and biologicals in a safe, secure, and orderly manner .Policy Interpretation and Implementation . 5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed . 13. Schedule II-V controlled medications are stored in separately locked, permanently affixed compartments. Security access to controlled medication is separate from access to non-controlled medications .14. Access to controlled medications are limited to authorized personnel. Personnel access to controlled medications is recorded .</p>