STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675563	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Nursing & Rehabilitation Center	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 19401 Based on observation, record review and interview the facility failed to ensure residents had the right to be free from abuse and neglect for 5 of 11 residents reviewed for abuse and neglect. (Resident #1 #2, #4, #5, and #8) 1. The facility failed to ensure Resident #2 was free from abuse after Resident #2 indicated MA B physically assaulted her on 11/9/24. The facility failed to address the abuse, report/investigate the allegations of abuse or suspend the alleged perpetrator. 2. The facility failed to provide assistance and supervision for Resident #1 between the hours of 12:20 am and 5:30 am on 6/2/24. Resident #1 rolled out of bed and was not checked on during this time. 3. The facility failed to ensure residents were free from abuse from Resident #7. a. Resident #7 was in Resident #8's room and was found touching Resident #8's genital area. Resident #8 had no pants on. b. Resident #7 pushed Resident #1 down on 10/3/24. c. Resident #7 choked Resident #8 on 10/4/24. d. Resident #7 had additional incidents of aggressive behaviors per nursing notes dated 10/16/24 with no detailed information. 4. The facility failed to ensure residents were free from abuse from Resident #3. a. Resident #3 grabbed a female resident by the wrist and would not let go on 10/28/24. b. Resident #3 hit Resident #4 in the mouth on 10/31/24. c. Resident #3 hit Resident # 5 in the head several times on 11/16/24 and was transferred to a behavioral unit. (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Immediate Jeopardy (IJ) situation was identified 12/19/24 at 4:50 p.m. While the IJ was removed on 12/22/24 at 2:32 p.m., the facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as a pattern due to the facility's need to evaluate the effectiveness of the corrective systems. The facility failures could have caused residents serious physical injury, and emotional abuse due to neglect and continued abuse. Findings Included: 1. Record review of Resident #2's face sheet indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Some of her diagnoses were unsteadiness on feet, dementia (general memory loss) mild with anxiety (feelings of fear, dread, and uneasiness that may occur as a reaction to stress), nicotine dependence, post-traumatic stress disorder (difficulty recovering after experiencing or witnessing a terrifying event) and borderline personality disorder (mental disorder characterized by unstable moods, behavior, and relationships). Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated her BIMS score was a 13 indicating she was cognitively intact. The MDS indicated Resident #2 required set up assistance only with all ADLs. Record review of Resident #2's care plan indicated a Focused area with an initiation date of 5/15/24 that she was a smoker. She was noncompliant with the safe smoking policy. She hid cigarettes and smoking material in her room and was educated repeatedly on these issues. She became confrontational with other residents, staff and visitors during smoke times for no apparent reason. Resident #2 had a Focused area of behavior problems related to smoking and smoking times. One of the interventions was care givers were to provide an opportunity for positive interaction, and attention. Record review of an incident report dated 11/9/24 at 10:10 p.m. indicated this nurse was called by nurse in the front station to report that Resident #2 had been physically aggressive towards MA B. As per front nurse, MA B was just asking Resident #2 to back up a little bit since she was already inside the nurse's station and was in the way of one of the cabinets she needed to open. When MA B pushed her wheelchair back, that was when the resident grabbed the MA's left arm and caused a scratch. Resident #2 called for police assistance without anyone's knowledge. Both parties were interviewed by the police. The nurse talked to the resident, and she claimed MA B grabbed her arm and assaulted her. Resident #2's mental status was oriented to person, place, time, and situation. There was a section for statements and the comment that indicated there were no statements found. There were no injuries noted post incident. Other information was the residents' smoke schedule changed recently and that did not make her happy. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's nursing note dated 11/9/24 at 10:23 p.m. indicated the nurse was called by nurse in the front station to report Resident #2 had been physically aggressive towards the MA B. As per front nurse, MA B was asking resident to back up a little bit since she was already inside the nurse's station and was in the way of one of the cabinets that she needed to open. When MA B pushed her wheelchair back, that was when the resident grabbed the MA's left arm and caused a scratch. This nurse talked to Resident #2 and calmed her down. And she verbalized that the MA had assaulted her. This nurse talked to both sides and agreed amicably and just escalated out of proportion. When the police arrived, the resident was in her room resting. Both parties were interviewed by the police. The Resident was sent to the hospital for an evaluation. Signed by LVN C Record review of Resident #2's nursing notes dated 11/9/24 at 11: 45 p.m. indicated the resident came back from the hospital with no new orders. She was sent out to a psychiatric evaluation due to an earlier incident. The resident is resting in bed with no behaviors. Record review of Resident #2's After Visit Summary dated 11/9/24 indicated the reason for visit was a psychiatric evaluation with a diagnosis of physical assault, left upper arm pain, and speech impairment. There were instructions to schedule an appointment for neurology and a family practitioner. Record review of Resident #2's nursing noted dated 11/12/24 indicated she was transferred to another facility. Record Review of Resident #2's hospital records obtained from the facility on 12/18/24 at 12:31 p.m. indicated Resident #2 was sent to the hospital on 11/9/24 for a psychiatric evaluation. The resident reportedly got into a physical altercation with of the caregiver at the facility. The patient stated she got into an argument with a staff member that she did not get along with. She stated the worker grabbed her left forearm and refused to let go despite the patient asking her to, so she pulled away violently. Resident #2 reported bruising to her left arm and some pain with movement of the left wrist, left elbow, and left shoulder. She remembered the incident fully. She stated she did this to get away from her. She stated they keep telling her that she had dementia, and she did not believe them. She was able to answer the month, year, date of birth, location, and identified the situation without significant difficulty. Comments were mild bruising noted to the left distal bicep, left distal forearm, mild pain with range of motion of the wrist and elbow and shoulder. The Clinical Impression on 11/10/24 at 12:35 a.m. was physical assault and left arm pain. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a Provider Investigation Report indicated HHSC was notified on 12/19/24 at 3:30 p.m. after surveyor intervention. The report contained statements from LVN C (with no date) said LVN M told her she had seen Resident #2 had jumped up and grabbed MA Bs hand causing a skin tear. (There was no statement from LVN M). LVN C said both parties claimed they were grabbed by the arm. She said Resident #2 insisted she was assaulted. LVN C said she checked both of their arms and neither had any visible marks. She said she was preparing to send the resident out to the ER for an evaluation as ordered by her supervisor. Resident #2 had called the police and they showed up. The resident went to the ER for a couple of hours. There were no new orders given to the nurse in report. There was no mention of any injury. When Resident #2 came back from the hospital Resident #2 said she was just tired. A statement dated 12/19/24 from MA B said on the second time she found Resident #2 behind the nursing station on 11/9/24 and told her she was going to move her. MA B said in her statement when she moved Resident #2 back, she jumped up and swung at her barley grazed her. (She did not say she grabbed her.) She said she went and talked to a LVN M who was in the room with a resident. She then said she went and found LVN C and told her Resident #2 was mad about her cigarettes. She said she avoided Resident #2 all night. She said another staff member reported to her that Resident #2 was telling other residents she was going to call the police and tell them she hit her. She said later an officer came and took her statement. Record review of MA B's personnel file indicated she worked double weekends as an MA. Review of her time sheet indicted she last worked Sunday, 12/15/24; her regular scheduled day. During a telephone interview with the hospital ER doctor on 12/18/24 at 11:54 a.m., he said he needed to review the ER notes from 11/9/24. He said the facility had sent Resident #2 to the hospital on 11/9/24. The report he received from the facility was Resident #2 had dementia. He said there was nothing wrong with Resident #2's cognitive recall. She did not have a diagnosis of dementia. He said Resident #2 told him the staff member that abused her did not like her and Resident #2 had words with that staff on several occasions. He said Resident #2 said the staff member grabbed her arm and would not let go despite her asking her to let go. He said they did an assessment of Resident #2 and determined bruising on her left distal forearm and left distal bicep were consistent with her story and she was indeed assaulted. He said again after reviewing Resident #2's chart there was no indication she had dementia from their testing. He said they usually sent the ER report with the resident back to the facility, but he could not be sure. During an interview on 12/18/24 at 12:29 p.m., the Marketing Director said the hospital usually sent the ER records back with the residents when they came from the hospital. She said Resident #2's ER or After Visit Summary records were already uploaded to the facility digital file. However, it took a few days for the physician report to generate. The Hospital records for Resident #2's was uploaded today into the facility's digital system. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 12/18/24 at 4:00 p.m., LVN C said when she arrived at the nursing station on 11/9/24 Resident #2 was in there in a Wheelchair at the nursing station. She said there may have been another resident that witnessed the incident. She said the facility had cameras. LVN C said when she arrived, she listened to both MA B and Resident #2. She said the MA B said Resident #2 got too close in the nursing station and she asked Resident #2 to move, and the resident would not. She said the aide told her she had pushed Resident #2's wheelchair back. The LVN said the MA B told her Resident #2 had clawed her on the arm. LVN C said Resident #2 said she was assaulted. LVN C said they were arguing back and forth exchanging words and accusations. She said she got them separated and Resident #2 went to her room and apparently called the police. The nurse said she did not call the police. She said the police came and talked to both the MA B and Resident #2. LVN C said she had called the former ADON and was told to send the resident to the hospital for an evaluation. She said she had only looked at Resident #2's hand/ wrist area where she said the aide had grabbed her and she did not see any bruising. She did not do a full body assessment. LVN C said she did not write a statement, and as far as she knew the incident was resolved. She said when the police came, they mentioned the word assault but she had called her supervisor and done what she was told. She said she knew what abuse was and did not believe any abuse had occurred. She said when the resident came from the hospital there were no new orders on her paperwork, and she did not see anything else. During a telephone interview on 12/18/24 at 4:30 p.m. MA B said there were two incidents that occurred with Resident #2 on 11/9/24. She said the first incident Resident #2 was behind the nurse's station in one of the employee bags, and she asked her to back up. MA B said she pulled Resident #2's wheelchair back and the resident was upset. She said Resident #2 grabbed her on the forearm on that occasion. MA B said the second time she came back to the nurse's station again, and Resident #2 was back at the nursing station trying to open the cigarette box. She said she told Resident #2 she was going to have to move her back. MA B said Resident #2 went on about her cigarettes. She said she told her she was going to pull back the wheelchair, and Resident #2 jumped out of the chair and was trying to hit her. She said this happened right at shift change, but she could not say anyone witnessed the incidents. She said she had heard staff saying Resident #2 said she had assaulted her. MA B said that night about an hour and half later, the police came, and she told them what happened. She said she had a scratch on her hand, and they took a picture her hand. She said Resident #2 had swung at her, but she barely scratched her. MA B said Resident #2 was mad at her because, previously, they had words about the cigarettes. She said Resident #2 would want to go and smoke and demand to be smoked. MA B said they sent Resident #2 to the hospital to be evaluated. The MA said she did not touch Resident #2 she only touched her wheelchair. The MA said Resident #2 accused her of assault; she was telling the aides on the floor, and police. MA B said she did feel like she was accused of abuse. MA B said no one asked her questions other than the LVN C at that time and no one asked questions after. She said no one asked her to write a statement. During an interview on 12/19/24 at 2:35 p.m., the Director of Operations said they were not aware Resident #2 had a diagnosis of physical assault. They did not have the hospital records uploaded into the computer until today. He said at the time of the incident the former Administrator had turned in her notice a few days before effective immediately and the DON had left without notice on 11/8/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 12/20/24 at 4:16 p.m., the Administrator said that LVN C and MA B had written their statements on yesterday, 12/19/24. She stated she called the allegation of abuse into the state on 12/19/24 regarding Resident #2 that occurred on 11/9/24. She said MA B had come to the facility long enough for the in service and to write her statement and left on 12/19/24. The Administrator said she was not employed at the facility at the time of the incident. Record review of the facility census report dated 12/17/24 indicated the census on the unit was 13. It also indicated Resident #1, Resident #3, Resident #4, Resident #7, and Resident #8 all resided on the locked unit. 2. Record review of Resident #1 face sheet indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Some of her diagnoses were vascular Dementia (brain damage caused by multiple strokes which caused memory loss), assistance with personal care, unsteadiness on feet, muscle weakness, and lack of coordination. Record review of Resident #1's quarterly MDS dated [DATE] indicated a BIMS score of 2 which indicate severe cognitive impairment. The resident had behaviors of disorganized thinking or incoherent rambling, or irrelevant conversations, which could be unclear or illogical. The MDS indicated she required touching assistance with eating, and putting on and taking off footwear, and dressing. She was independent with transfers, sit to stand, and walking. Record review of Resident #1's care plan with an initiation date 9/6/23 indicated a Focus area of at risk for wandering or elopement. She resided on the secure unit. Resident #1 had a Focused area of communication deficit related to dementia. One of the interventions was to provide a safe environment, with call light within reach, and the bed in the lowest position. Resident #1 had a Focus area of episodes of aggression and resistant with care. The resident preferred her door shut. She kept her door closed and did not like anyone in her space/room. She was very anti-social and preferred to stay to herself in her room. Resident #1 had a Focused care area of ADL self-care performance deficit related to dementia and altered thought process. Record review of Resident #1's computerized physician orders indicted an order to admit to the secured unit for exit seeking behaviors with a revision date of 11/23/24. Record review of a Provider Investigation Report indicated on 7/2/24 indicated CNA A was working the 10p to 6 a shift. She failed to check on Resident #1 between 12:20 a.m. and 5:30 a.m. Resident #1 rolled out of bed and was on the floor close to 4.5 hours. CNA A took her break around 3:00 a.m. and notified the charge that she had checked all residents, however that was not true. The family had 2 cameras in Resident #1's room and were aware of what happened. The report indicated CNA A failed to check on Resident # 1. The report stated if CNA A had rounded frequently, Resident #1 would not have been left on the floor for an extended period without attention. Based upon the film recording of the incident CNA A failed to care for Resident #1. The allegation of neglect was confirmed, and CNA A was terminated. During an observation on 12/17/24 at 10:17 a.m., Resident #1 sitting at the table and did not respond when spoken to but was noted to be ambulatory. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview 12/18/24 at 11:17 a.m., LVN H said on 7/2/24, CNA A said she was going on break around 3:00 a.m. LVN H said CNA A said she had just completed rounds on everyone on the unit, and everything was good. LVN H said when CNA A was doing her last round about 5:30 a.m. she found Resident #1 on the floor. She said she was informed by the family the resident had been on the floor for hours. She then asked CNA A if she had checked on Resident #1 at 3:00 a.m. and she said she was not sure. During a telephone interview on 12/18/24 at 2:27 p.m., CNA A said she did not remember if she had checked on Resident #1 on the night of 7/2/24. She said it had been a while and she was not sure. 3. Record review of Resident #7's face sheet indicted he was an [AGE] year-old male admitted to the facility on [DATE]. Some of his diagnoses were dementia (general memory loss), cognitive communication deficit, lack of coordination, and generalized muscle weakness. Record review of Resident #7's quarterly MDS dated [DATE] indicated his BIMS score was 1 indicated severe cognitive impairment. The only behavior he had listed on the MDS was rejection of care which occurred one to three days a week. He required setup and cleaned up help with most ADLs and he was independent with transfers and walking. Review of Resident #7's care plan indicated a Focused area of diagnosis of dementia with agitation and delirium secondary to alcohol abuse with an initiation date of 9/6/23 and a revision date of 12/17/24. Some of the approaches were to acknowledge moods in one-to-one interventions as needed, monitor for changes in mood and behaviors. A Focused area of Resident #7 had the potential to be physically and verbally aggressive related to dementia and poor impulse control. On 5/1/24, he was verbally and physical aggressive to staff. The care plan indicated on 7/28/24, he was physically aggressive a resident tapped on the arm. On 10/3/24, he had physical aggression toward a resident. On 10/4/24, he had physical aggression towards a resident. Some of the interventions were to administer medications, analyze times of day, circumstances, triggers, and de-escalate the behavior and document, send to acute hospital as needed, when he became agitated, intervene before the agitation escalates. (There was no mention of sexually in appropriate behaviors. There was no mention of aggression after 10/4/24.) Record review of Resident #7's physician orders indicated on Order dated 12/7/24 for Lorazepam 0.5 mg to give 1 tablet by mouth every 12 hours as needed for anxiety related to a diagnosis of dementia. An order dated 12/9/24 revealed an order for Depakote 500 mg delayed release. Give 1 tablet by mouth two times a day related to unspecified dementia. Record review of Resident #7's computerized physician's orders indicated an order for medication management may provide psychiatric services dated 9/8/23. Record review of Resident #8's face sheet indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Some of her diagnoses were Alzheimer's Disease (a progressive disease that destroys memory and important mental functions), and adjustment disorder (a mental disorder that involves and intense emotional or behavioral response to a stressful event or life change.) Record review of Resident #8's quarterly MDS dated [DATE] indicated a BIMS score of 9 which indicated moderate cognitive impairment. Resident #8's functional status was she was independent with toileting hygiene and dressing. She was independent with bed mobility, transfers, walking/ambulation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #8' s care plan indicated a focused area of ADL care performance deficit related to dementia, with an initiation date of 5/10/24. Some of the interventions were the resident required one person assist with bathing, hygiene, dressing and transfers. (No mention of behaviors or an inappropriate relationship) Record review of an incident report dated 6/23/24 at 10:26 a.m. indicated Resident #8 was found lying in her bed without any pants/underwear while being touched in her private area (vaginal) by Resident #7. The residents were unable to give a description. Residents were asked to stop and were separated. There were no injuries at the time of the incident. The residents thought they were married to each other. Record review of a nursing note dated 6/24/24 at 2:35 a.m. indicated the resident was found by nurse doing rounds lying in her bed with no pants/underwear while being touched in her private parts by Resident #7. The residents were told to stop and separated. Notified all parties. Record review of Resident #8's nursing notes dated 6/24/24 at 8:15 a.m. day one of three monitoring due to inappropriate sexual behaviors will continue to monitor. Record review of Resident #8's nursing notes dated 6/25/24 at 8:51 a.m. day two of three monitoring due to inappropriate sexual behaviors will continue to monitor. Record review of Resident #8's nursing notes dated 6/26/24 at 2:24 p.m. day three of three monitoring due to inappropriate sexual behaviors will continue to monitor. Record review of Resident #8's physician's physical examination dated 7/3/24 indicated poor insight, poor judgement, and poor recall. Record review of Resident #7's nursing notes dated 9/23/24 indicated CNA E said Resident #7 was being aggressive with other residents and herself. The nurse went to check on the resident and he was very agitated. PRN Lorazepam was given to calm resident down. He was sitting in the common room using foul language. Record review of a Provider Investigation report dated 11/20/24 indicated on 10/3/24 at 1:30 p.m., Resident # 7 pushed Resident #1 causing her to fall. Resident #1 had no injuries and both residents had dementia. No other Provider Investigation Report was found for Resident #7. Review of Resident #7's nursing notes dated 10/3/24 at 12:35 p.m. said Resident #7 was very upset and was witnessed pushing Resident #1 down. He yelled. She was in my way. Record review of Resident #1's nursing notes dated 10/3/24 at 12:45 p.m. indicated Resident #1 had witnessed fall in the hallway when she was pushed down by Resident #7. Resident #1 was found sitting on the floor. When asked where she hursts she stated all over. The resident received an order for a pelvic x ray. Record review of Resident #1's nursing notes dated 10/4/24 indicated x-rays of pelvis results received indicated no acute fracture or dislocation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #7's nursing notes dated 10/4/24 at 3:58 a.m. indicated he was placed on Q 15 checks for 72 hours. Review of Resident #7's Q 15-minute monitoring indicated on 10/4/24 he was in another residents room at 12:00 p.m. to 12:30 p.m. and had behaviors of restlessness, wandering, pacing and agitation. On 10/4/24 at 7:45 p.m. he was swinging a cane. He was sent to the hospital. Record review of Resident #7's nursing notes dated 10/4/24 at 10:29 p.m. indicted the nurse was called to the locked unit by CNA, the resident was standing in the hallway with a cane in his hand and swinging at another resident and staff. The CNA told the nurse that the resident choked the other resident involved. The nurse tried to reason with Resident #7 and asked him to release the cane. He became more agitated. The nurse separated the residents by putting the female resident in her room. The nurse then went for help and called 911. The resident was sent to the ER. Record review of Resident #7's Hospital After Visit Summary dated 10/4/24 indicated medications have changed, start taking Haldol 2 mg tablet by mouth every 8 hours as need for agitation. The reason for visit was a psychiatric evaluation. The diagnoses were dementia without behavioral disturbance, psychotic disturbances, mood disturbances, or anxiety. Review of a Resident #7's nursing notes dated 10/5/24 at 12:12 p.m. indicated Resident #7 arrived back at the facility. Record review of Resident #7's Order Audit Report indicated on 10/5/24 an order for Haloperidol oral 3mg give one tablet by mouth every 8 hours as needed for agitation. The order was discontinued on 10/28/24. Record review of Resident #8's nursing note dated 10/5/24 at 7:29 a.m. indicated day one of aggression received from Resident #7. Record review of Resident #8's nursing note dated 10/7/24 at 3:37 p.m. indicated day three of three of aggression received from Resident #7. There were no delayed injuries noted. The resident had no complaints of pain or discomfort at this time. Record review of Resident #7's progress note dated 10/16/24 indicated he had grabbed another resident by the wrist and would not let her go. Staff were able to get him to let her go but he was very agitated. Record Review of Resident #7's Progress Note/History and Physical dated 10/18/24 indicted Resident #7 was sent to the ER earlier this month for agitation and attempting to harm others on the memory care unit. Nursing staff reported he had been redirectable, and they were monitoring him closely. During an observation and interview on 12/17/24 at 10:21 p.m. Resident #7 was sitting in a chair. When staff asked him what he preferred to be called he yelled loudly and said he was fine. During an interview on 12/17/24 at 10:22 a.m., CNA K said she had only been on the unit for 2 days and Resident #7 was had anger issues and was easily agitated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675563	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Nursing & Rehabilitation Center	508 Pierce St Lindale, TX 75771

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 12/17/24 at 10:19 a.m., Resident #8 was sitting at the table in the common area. She talked about her family and how they had dumped her at the facility. The more she talked the more upset she became. She said the facility was okay, but she should not be there. Resident #8 said the staff and residents were fine for the most part. During an interview on 12/18/24 at 11:12 a.m. LVN G said when she was working the floor, she was responsible for the residents on the locked unit. She said on 10/21/24 Resident #7 was in Resident #8's face trying to make her sit down. She said Resident #7 grabbed Resident #8 by the wrist and did not want to let her go. LVN G said most of Resident #7's arguments were with Resident #8. She said Resident #7 thought Resident #8 was his wife and they bickered back and forth. LVN G said Resident #7 tried to tell Resident #8 what to do and insisted that she do it right then. During a telephone interview 12/18/24 at 11:17 a.m., LVN H said she remembered an incident of aggression with Resident #7. She said the incident occurred on 10/4/24 when Resident #7 was swing a cane. LVN H said there was one resident standing in the hallway, Resident # 8, and it was her cane that Resident #7 had. She said she could not remember if another resident was in the hallway She said that was right after it was reported to her that he had choked Resident #8 in the hallway. During an interview on 12/18/24 at 12:58 p.m. LVN J said he was the nurse on the unit on day shift. He said it was an ongoing thing between Resident #7 and Resident #8. He said Resident #7 thought Resident #8 was his wife. He said sometimes Resident #8 was with it and realized Resident #7 was not her husband. LVN J said other times Resident #8 would think Resident #7 was her husband. He said they acted like a married couple that did not get along. LVN J said they fussed at each other, sit together, or walk together. LVN J said, at times, Resident #8 would tell Resident #7 to do something, and he would listen. He said Resident #8's dementia goes and comes. During an interview on 12/18/24 at 2:15 p.m., CNA E said she had seen Resident # 7 get angry and hit at women. She said he mostly had controversy with Resident #8. She said she saw him choke Resident #8. She said she had gone into his room and Resident #8 was sitting on the side of the Resident #7's bed holding his hand. She had asked Resident #8 to leave and Resident #7 wanted her to sleep with him. CNA E said Resident #8 told him she was not going to sleep with him, and Resident # 7 got upset and told Resident #8 she needed to give him his fifteen hundred dollars back. She said Resident #8 told him she did not have his money and left the room. She said Resident #8 was on her way to her room and Resident #7 came behind her yelling. She said Resident #7 was to the back side of Resident #8 and put his hands around her neck as if to choke her. The CNA said she was right there within reaching distance and told him to stop and he removed his hands from Resident #8's neck. She said he did not squeeze or have a chance to choke Resident #8, but he did put his hands around her neck. She said she had written a statement and told the former DON the same thing. During a telephone interview on 12/19/24 at 11:03 a.m., the former DON said Resident #8 could not make her own decisions. She stated she was on the unit for a reason, but she can make some decisions. She said she was aware of the incident when Resident #7 supposedly choked Resident #8. She said she did an investigation into that incident and Resident #7 never put hands around the neck. She said she was told he only touched her on the back of her neck; there were no red marks. She said her assessments did not show that he had harmed her physically, he had only touched her. She said when Resident # 7 came into the facility and was very confused. The former DON said she did not believe he was aggressive toward any of the staff. He was independent and missed his wife. The former DON said no harm occurred. (continued on next page)

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	675563	A. Building B. Wing	12/27/2024

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Record review of Resident #3's face sheet indicated he was an [AGE] year-old male admitted to the facility on [DATE]. Some of his diagnoses were Alzheimer's Disease (a progressive disease that destroys memory and important mental functions), dementia (general memory loss), and psychotic disorder (mental illness that cause abnormal thinking and perceptions- a loss of reality.) Record review of Resident #3's admission MDS dated [DATE] indicated a BIMS score of 3 indicating severe cognitive impairment. The MDS indicated Behavioral indicators of psychosis such as delusions, misconceptions or beliefs that are firmly held, but contrary to reality. Resident # 3 also had behaviors that occurred one to three days a week of physical symptoms directed towards others such as hitting, pushing, or grabbing. He also has other behavioral symptoms not dir [TRUNCATED]

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on observation, record review, and interview the facility failed implement their abuse policy to ensure residents had the right to be free from abuse and neglect, allegations were investigated, 7 of 11 residents reviewed for abuse and neglect. (Resident #1, #2, # 3, #4, #5, #7, and #8) 1. The facility failed to ensure Resident #2 was free from abuse after Resident #2 indicated MA B physically assaulted her on 11/9/24. The facility failed to address the abuse, report/investigate the allegations of abuse or suspend the alleged perpetrator. 2. The facility failed to provide assistance and supervision for Resident #1 between the hours of 12:20 am and 5:30 am on 6/2/24. Resident #1 rolled out of bed and was not checked on during this time. 3. The facility failed to ensure residents were free from abuse from Resident #7. a. Resident #7 was in Resident #8's room and was found touching Resident #8's genital area. Resident #8 had no pants on. This incident was not investigated, and no measures were put in place to protect Resident #8. b. Resident #7 pushed Resident #1 down on 10/3/24. c. Resident #7 choked Resident #8 on 10/4/24. d. Resident #7 had additional incidents of aggressive behaviors per nursing notes dated 10/16/24 with no detailed information. 4. The facility failed to ensure residents were free from abuse from Resident #3. a. Resident #3 grabbed a female resident by the wrist and would not let go on 10/28/24. b. Resident #3 hit Resident #4 in the mouth on 10/31/24. c. Resident #3 hit Resident # 5 in the head several times on 11/16/24 and was transferred to a behavioral unit. This incident was not investigated or reported to HHSC. An Immediate Jeopardy (IJ) situation was identified 12/19/24 at 4:50 p.m. While the IJ was removed on 12/22/24 at 2:32 p.m., the facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as a pattern due to the facility's need to evaluate the effectiveness of the corrective systems. The facility failures could have caused residents serious physical injury, and emotional abuse due to neglect and continued abuse. Findings Included: (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facilities, signs and symptoms of abuse and neglect policy revise January 20, 2021. Indicate it was the policy of the facility to prohibit resident abuse or neglect in any form and to report in accordance with the law any incident in which there was cause to believe a resident's physical or mental health or welfare had been adversely after by abuse or neglect cause by another person. Abuse was defined as willful infliction of injury, unreasonable, confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Neglect is defined as failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. The following examples of actual abuse are neglect with signs and symptoms, [NAME] or bruises, sexual exploitation, signs of neglect, caregiver indifference to resident personal care needs, and leaving someone unattended who needs supervision. Sexual abuse was defined as the non-consensual sexual contact of any type with a resident. The policy indicated all residents will be immediately protected from harm. All allegation involving staff will necessitate suspension. If another resident is the alleged perpetrator, they shall immediately be assessed for treatment options. The safety and protection of other residents is the facility's concern. Reporting- indicate all allegations of abuse will be reported to the appropriate state agency and to all other agencies as required by regulation. 1. Record review of Resident #2's face sheet indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Some of her diagnoses were unsteadiness on feet, dementia (general memory loss) mild with anxiety (feelings of fear, dread, and uneasiness that may occur as a reaction to stress), nicotine dependence, post-traumatic stress disorder (difficulty recovering after experiencing or witnessing a terrifying event) and borderline personality disorder (mental disorder characterized by unstable moods, behavior, and relationships). Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated her BIMS score was a 13 indicating she was cognitively intact. The MDS indicated Resident # 2 required set up assistance only with all ADLs. Record review of Resident #2's care plan indicated a Focused area with an initiation date of 5/15/24 that she was a smoker. She was noncompliant with the safe smoking policy. She hid cigarettes and smoking material in her room and was educated repeatedly on these issues. She became confrontational with other residents, staff and visitors during smoke times for no apparent reason. Resident #2 had a Focused area of behavior problems related to smoking and smoking times. One of the interventions was care givers were to provide an opportunity for positive interaction, and attention. Record review of an incident report dated 11/9/24 at 10:10 p.m. indicated this nurse was called by nurse in the front station to report that Resident #2 had been physically aggressive towards MA B. As per front nurse, MA B was just asking Resident #2 to back up a little bit since she was already inside the nurse's station and was in the way of one of the cabinets she needed to open. When MA B pushed her wheelchair back, that was when the resident grabbed the MA's left arm and caused a scratch. Resident #2 called for police assistance without anyone's knowledge. Both parties were interviewed by the police. The nurse talked to the resident, and she claimed MA B grabbed her arm and assaulted her. Resident #2's mental status was oriented to person, place, time, and situation. There was a section for statements and the comment that indicated there were no statements found. There were no injuries noted post incident. Other information was the residents' smoke schedule changed recently and that did not make her happy. (continued on next page)

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	675563	A. Building B. Wing	12/27/2024

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's nursing note dated 11/9/24 at 10:23 p.m. indicated the nurse was called by nurse in the front station to report Resident #2 had been physically aggressive towards the MA B. As per front nurse, MA B was asking resident to back up a little bit since she was already inside the nurse's station and was in the way of one of the cabinets that she needed to open. When MA B pushed her wheelchair back, that was when the resident grabbed the MA's left arm and caused a scratch. This nurse talked to Resident #2 and calmed her down. And she verbalized that the MA had assaulted her. This nurse talked to both sides and agreed amicably and just escalated out of proportion. When the police arrived, the resident was in her room resting. Both parties were interviewed by the police. The Resident was sent to the hospital for an evaluation. Signed by LVN C Record review of Resident #2's nursing notes dated 11/9/24 at 11: 45 p.m. indicated the resident came back from the hospital with no new orders. She was sent out to a psychiatric evaluation due to an earlier incident. The resident is resting in bed with no behaviors. Record review of Resident #2's After Visit Summary dated 11/9/24 indicated the reason for visit was a psychiatric evaluation with a diagnosis of physical assault, left upper arm pain, and speech impairment. There were instructions to schedule an appointment for neurology and a family practitioner. Record review of Resident #2's nursing noted dated 11/12/24 indicated she was transferred to another facility. Record Review of Resident #2's hospital records obtained from the facility on 12/18/24 at 12:31 p.m. indicated Resident #2 was sent to the hospital on 11/9/24 for a psychiatric evaluation. The resident reportedly got into a physical altercation with of the caregiver at the facility. The patient stated she got into an argument with a staff member that she did not get along with. She stated the worker grabbed her left forearm and refused to let go despite the patient asking her to, so she pulled away violently. Resident #2 reported bruising to her left arm and some pain with movement of the left wrist, left elbow, and left shoulder. She remembered the incident fully. She stated she did this to get away from her. She stated they keep telling her that she had dementia, and she did not believe them. She was able to answer the month, year, date of birth, location, and identified the situation without significant difficulty. Comments were mild bruising noted to the left distal bicep, left distal forearm, mild pain with range of motion of the wrist and elbow and shoulder. The Clinical Impression on 11/10/24 at 12:35 a.m. was physical assault and left arm pain. (continued on next page)

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	675563	A. Building B. Wing	12/27/2024

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a Provider Investigation Report indicated HHSC was notified on 12/19/24 at 3:30 p.m. after surveyor intervention. The report contained statements from LVN C (with no date) said LVN M told her she had seen Resident #2 had jumped up and grabbed MA Bs hand causing a skin tear. (There was no statement from LVN M). LVN C said both parties claimed they were grabbed by the arm. She said Resident #2 insisted she was assaulted. LVN C said she checked both of their arms and neither had any visible marks. She said she was preparing to send the resident out to the ER for an evaluation as ordered by her supervisor. Resident #2 had called the police and they showed up. The resident went to the ER for a couple of hours. There were no new orders given to the nurse in report. There was no mention of any injury. When Resident #2 came back from the hospital Resident #2 said she was just tired. A statement dated 12/19/24 from MA B said on the second time she found Resident #2 behind the nursing station on 11/9/24 and told her she was going to move her. MA B said in her statement when she moved Resident #2 back, she jumped up and swung at her barley grazed her. (She did not say she grabbed her.) She said she went and talked to a LVN M who was in the room with a resident. She then said she went and found LVN C and told her Resident #2 was mad about her cigarettes. She said she avoided Resident #2 all night. She said another staff member reported to her that Resident #2 was telling other residents she was going to call the police and tell them she hit her. She said later an officer came and took her statement. Record review of MA B's personnel file indicated she worked double weekends as an MA. Review of her time sheet indicted she last worked Sunday, 12/15/24; her regular scheduled day. During a telephone interview with the hospital ER doctor on 12/18/24 at 11:54 a.m., he said he needed to review the ER notes from 11/9/24. He said the facility had sent Resident #2 to the hospital on 11/9/24. The report he received from the facility was Resident #2 had dementia. He said there was nothing wrong with Resident #2's cognitive recall. She did not have a diagnosis of dementia. He said Resident #2 told him the staff member that abused her did not like her and Resident #2 had words with that staff on several occasions. He said Resident #2 said the staff member grabbed her arm and would not let go despite her asking her to let go. He said they did an assessment of Resident #2 and determined bruising on her left distal forearm and left distal bicep were consistent with her story and she was indeed assaulted. He said again after reviewing Resident #2's chart there was no indication she had dementia from their testing. He said they usually sent the ER report with the resident back to the facility, but he could not be sure. During an interview on 12/18/24 at 12:29 p.m., the Marketing Director said the hospital usually sent the ER records back with the residents when they came from the hospital. She said Resident #2's ER or After Visit Summary records were already uploaded to the facility digital file. However, it took a few days for the physician report to generate. The Hospital records for Resident #2's was uploaded today into the facility's digital system. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 12/18/24 at 4:00 p.m., LVN C said when she arrived at the nursing station on 11/9/24 Resident #2 was in there in a Wheelchair at the nursing station. She said there may have been another resident that witnessed the incident. She said the facility had cameras. LVN C said when she arrived, she listened to both MA B and Resident #2. She said the MA B said Resident #2 got too close in the nursing station and she asked Resident #2 to move, and the resident would not. She said the aide told her she had pushed Resident #2's wheelchair back. The LVN said the MA B told her Resident #2 had clawed her on the arm. LVN C said Resident #2 said she was assaulted. LVN C said they were arguing back and forth exchanging words and accusations. She said she got them separated and Resident #2 went to her room and apparently called the police. The nurse said she did not call the police. She said the police came and talked to both the MA B and Resident #2. LVN C said she had called the former ADON and was told to send the resident to the hospital for an evaluation. She said she had only looked at Resident #2's hand/ wrist area where she said the aide had grabbed her and she did not see any bruising. She did not do a full body assessment. LVN C said she did not write a statement, and as far as she knew the incident was resolved. She said when the police came, they mentioned the word assault but she had called her supervisor and done what she was told. She said she knew what abuse was and did not believe any abuse had occurred. She said when the resident came from the hospital there were no new orders on her paperwork, and she did not see anything else. During a telephone interview on 12/18/24 at 4:30 p.m. MA B said there were two incidents that occurred with Resident #2 on 11/9/24. She said the first incident Resident #2 was behind the nurse's station in one of the employee bags, and she asked her to back up. MA B said she pulled Resident #2's wheelchair back and the resident was upset. She said Resident #2 grabbed her on the forearm on that occasion. MA B said the second time she came back to the nurse's station again, and Resident #2 was back at the nursing station trying to open the cigarette box. She said she told Resident #2 she was going to have to move her back. MA B said Resident #2 went on about her cigarettes. She said she told her she was going to pull back the wheelchair, and Resident #2 jumped out of the chair and was trying to hit her. She said this happened right at shift change, but she could not say anyone witnessed the incidents. She said she had heard staff saying Resident #2 said she had assaulted her. MA B said that night about an hour and half later, the police came, and she told them what happened. She said she had a scratch on her hand, and they took a picture her hand. She said Resident #2 had swung at her, but she barely scratched her. MA B said Resident #2 was mad at her because, previously, they had words about the cigarettes. She said Resident #2 would want to go and smoke and demand to be smoked. MA B said they sent Resident #2 to the hospital to be evaluated. The MA said she did not touch Resident #2 she only touched her wheelchair. The MA said Resident #2 accused her of assault; she was telling the aides on the floor, and police. MA B said she did feel like she was accused of abuse. MA B said no one asked her questions other than the LVN C at that time and no one asked questions after. She said no one asked her to write a statement. During an interview on 12/19/24 at 2:35 p.m., the Director of Operations said they were not aware Resident #2 had a diagnosis of physical assault. They did not have the hospital records uploaded into the computer until today. He said at the time of the incident the former Administrator had turned in her notice a few days before effective immediately and the DON had left without notice on 11/8/24. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 12/20/24 at 4:16 p.m., the Administrator said that LVN C and MA B had written their statements on yesterday, 12/19/24. She stated she called the allegation of abuse into the state on 12/19/24 regarding Resident #2 that occurred on 11/9/24. She said MA B had come to the facility long enough for the in service and to write her statement and left on 12/19/24. The Administrator said she was not employed at the facility at the time of the incident. Record review of the facility census report dated 12/17/24 indicated the census on the unit was 13. It also indicated Resident #1, Resident #3, Resident #4, Resident #7, and Resident #8 all resided on the locked unit. 2. Record review of Resident #1 face sheet indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Some of her diagnoses were vascular Dementia (brain damage caused by multiple strokes which caused memory loss), assistance with personal care, unsteadiness on feet, muscle weakness, and lack of coordination. Record review of Resident #1's quarterly MDS dated [DATE] indicated a BIMS score of 2 which indicate severe cognitive impairment. The resident had behaviors of disorganized thinking or incoherent rambling, or irrelevant conversations, which could be unclear or illogical. The MDS indicated she required touching assistance with eating, and putting on and taking off footwear, and dressing. She was independent with transfers, sit to stand, and walking. Record review of Resident #1's care plan with an initiation date 9/6/23 indicated a Focus area of at risk for wandering or elopement. She resided on the secure unit. Resident #1 had a Focused area of communication deficit related to dementia. One of the interventions was to provide a safe environment, with call light within reach, and the bed in the lowest position. Resident #1 had a Focus area of episodes of aggression and resistant with care. The resident preferred her door shut. She kept her door closed and did not like anyone in her space/room. She was very anti-social and preferred to stay to herself in her room. Resident #1 had a Focused care area of ADL self-care performance deficit related to dementia and altered thought process. Record review of Resident #1's computerized physician orders indicted an order to admit to the secured unit for exit seeking behaviors with a revision date of 11/23/24. Record review of a Provider Investigation Report indicated on 7/2/24 indicated CNA A was working the 10p to 6 a shift. She failed to check on Resident #1 between 12:20 a.m. and 5:30 a.m. Resident #1 rolled out of bed and was on the floor close to 4.5 hours. CNA A took her break around 3:00 a.m. and notified the charge that she had checked all residents, however that was not true. The family had 2 cameras in Resident #1's room and were aware of what happened. The report indicated CNA A failed to check on Resident # 1. The report stated if CNA A had rounded frequently, Resident #1 would not have been left on the floor for an extended period without attention. Based upon the film recording of the incident CNA A failed to care for Resident #1. The allegation of neglect was confirmed, and CNA A was terminated. During an observation on 12/17/24 at 10:17 a.m., Resident #1 sitting at the table and did not respond when spoken to but was noted to be ambulatory. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675563	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Nursing & Rehabilitation Center	508 Pierce St Lindale, TX 75771

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview 12/18/24 at 11:17 a.m., LVN H said on 7/2/24, CNA A said she was going on break around 3:00 a.m. LVN H said CNA A said she had just completed rounds on everyone on the unit, and everything was good. LVN H said when CNA A was doing her last round about 5:30 a.m. she found Resident #1 on the floor. She said she was informed by the family the resident had been on the floor for hours. She then asked CNA A if she had checked on Resident #1 at 3:00 a.m. and she said she was not sure. During a telephone interview on 12/18/24 at 2:27 p.m., CNA A said she did not remember if she had checked on Resident #1 on the night of 7/2/24. She said it had been a while and she was not sure. 3. Record review of Resident #7's face sheet indicted he was an [AGE] year-old male admitted to the facility on [DATE]. Some of his diagnoses were dementia (general memory loss), cognitive communication deficit, lack of coordination, and generalized muscle weakness. Record review of Resident #7's quarterly MDS dated [DATE] indicated his BIMS score was 1 indicated severe cognitive impairment. The only behavior he had listed on the MDS was rejection of care which occurred one to three days a week. He required setup and cleaned up help with most ADLs and he was independent with transfers and walking. Review of Resident #7's care plan indicated a Focused area of diagnosis of dementia with agitation and delirium secondary to alcohol abuse with an initiation date of 9/6/23 and a revision date of 12/17/24. Some of the approaches were to acknowledge moods in one-to-one interventions as needed, monitor for changes in mood and behaviors. A Focused area of Resident #7 had the potential to be physically and verbally aggressive related to dementia and poor impulse control. On 5/1/24, he was verbally and physical aggressive to staff. The care plan indicated on 7/28/24, he was physically aggressive a resident tapped on the arm. On 10/3/24, he had physical aggression toward a resident. On 10/4/24, he had physical aggression towards a resident. Some of the interventions were to administer medications, analyze times of day, circumstances, triggers, and de-escalate the behavior and document, send to acute hospital as needed, when he became agitated, intervene before the agitation escalates. (There was no mention of sexually in appropriate behaviors. There was no mention of aggression after 10/4/24.) Record review of Resident #7's physician orders indicated on Order dated 12/7/24 for Lorazepam 0.5 mg to give 1 tablet by mouth every 12 hours as needed for anxiety related to a diagnosis of dementia. An order dated 12/9/24 revealed an order for Depakote 500 mg delayed release. Give 1 tablet by mouth two times a day related to unspecified dementia. Record review of Resident #7's computerized physician's orders indicated an order for medication management may provide psychiatric services dated 9/8/23. Record review of Resident #8's face sheet indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Some of her diagnoses were Alzheimer's Disease (a progressive disease that destroys memory and important mental functions), and adjustment disorder (a mental disorder that involves and intense emotional or behavioral response to a stressful event or life change.) Record review of Resident #8's quarterly MDS dated [DATE] indicated a BIMS score of 9 which indicated moderate cognitive impairment. Resident #8's functional status was she was independent with toileting hygiene and dressing. She was independent with bed mobility, transfers, walking/ambulation. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #8' s care plan indicated a focused area of ADL care performance deficit related to dementia, with an initiation date of 5/10/24. Some of the interventions were the resident required one person assist with bathing, hygiene, dressing and transfers. (No mention of behaviors or an inappropriate relationship) Record review of an incident report dated 6/23/24 at 10:26 a.m. indicated Resident #8 was found lying in her bed without any pants/underwear while being touched in her private area (vaginal) by Resident #7. The residents were unable to give a description. Residents were asked to stop and were separated. There were no injuries at the time of the incident. The residents thought they were married to each other. Record review of a nursing note dated 6/24/24 at 2:35 a.m. indicated the resident was found by nurse doing rounds lying in her bed with no pants/underwear while being touched in her private parts by Resident #7. The residents were told to stop and separated. Notified all parties. Record review of Resident #8's nursing notes dated 6/24/24 at 8:15 a.m. day one of three monitoring due to inappropriate sexual behaviors will continue to monitor. Record review of Resident #8's nursing notes dated 6/25/24 at 8:51 a.m. day two of three monitoring due to inappropriate sexual behaviors will continue to monitor. Record review of Resident #8's nursing notes dated 6/26/24 at 2:24 p.m. day three of three monitoring due to inappropriate sexual behaviors will continue to monitor. Record review of Resident #8's physician's physical examination dated 7/3/24 indicated poor insight, poor judgement, and poor recall. Record review of Resident #7's nursing notes dated 9/23/24 indicated CNA E said Resident #7 was being aggressive with other residents and herself. The nurse went to check on the resident and he was very agitated. PRN Lorazepam was given to calm resident down. He was sitting in the common room using foul language. Record review of a Provider Investigation report dated 11/20/24 indicated on 10/3/24 at 1:30 p.m., Resident # 7 pushed Resident #1 causing her to fall. Resident #1 had no injuries and both residents had dementia. No other Provider Investigation Report was found for Resident #7. Review of Resident #7's nursing notes dated 10/3/24 at 12:35 p.m. said Resident #7 was very upset and was witnessed pushing Resident #1 down. He yelled. She was in my way. Record review of Resident #1's nursing notes dated 10/3/24 at 12:45 p.m. indicated Resident #1 had witnessed fall in the hallway when she was pushed down by Resident #7. Resident #1 was found sitting on the floor. When asked where she hursts she stated all over. The resident received an order for a pelvic x ray. Record review of Resident #1's nursing notes dated 10/4/24 indicated x-rays of pelvis results received indicated no acute fracture or dislocation. (continued on next page)

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	675563	A. Building B. Wing	12/27/2024

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #7's nursing notes dated 10/4/24 at 3:58 a.m. indicated he was placed on Q 15 checks for 72 hours. Review of Resident #7's Q 15-minute monitoring indicated on 10/4/24 he was in another residents room at 12:00 p.m. to 12:30 p.m. and had behaviors of restlessness, wandering, pacing and agitation. On 10/4/24 at 7:45 p.m. he was swinging a cane. He was sent to the hospital. Record review of Resident #7's nursing notes dated 10/4/24 at 10:29 p.m. indicted the nurse was called to the locked unit by CNA, the resident was standing in the hallway with a cane in his hand and swinging at another resident and staff. The CNA told the nurse that the resident choked the other resident involved. The nurse tried to reason with Resident #7 and asked him to release the cane. He became more agitated. The nurse separated the residents by putting the female resident in her room. The nurse then went for help and called 911. The resident was sent to the ER. Record review of Resident #7's Hospital After Visit Summary dated 10/4/24 indicated medications have changed, start taking Haldol 2 mg tablet by mouth every 8 hours as need for agitation. The reason for visit was a psychiatric evaluation. The diagnoses were dementia without behavioral disturbance, psychotic disturbances, mood disturbances, or anxiety. Review of a Resident #7's nursing notes dated 10/5/24 at 12:12 p.m. indicated Resident #7 arrived back at the facility. Record review of Resident #7's Order Audit Report indicated on 10/5/24 an order for Haloperidol oral 3mg give one tablet by mouth every 8 hours as needed for agitation. The order was discontinued on 10/28/24. Record review of Resident #8's nursing note dated 10/5/24 at 7:29 a.m. indicated day one of aggression received from Resident #7. Record review of Resident #8's nursing note dated 10/7/24 at 3:37 p.m. indicated day three of three of aggression received from Resident #7. There were no delayed injuries noted. The resident had no complaints of pain or discomfort at this time. Record review of Resident #7's progress note dated 10/16/24 indicated he had grabbed another resident by the wrist and would not let her go. Staff were able to get him to let her go but he was very agitated. Record Review of Resident #7's Progress Note/History and Physical dated 10/18/24 indicted Resident #7 was sent to the ER earlier this month for agitation and attempting to harm others on the memory care unit. Nursing staff reported he had been redirectable, and they were monitoring him closely. During an observation and interview on 12/17/24 at 10:21 p.m. Resident #7 was sitting in a chair. When staff asked him what he preferred to be called he yelled loudly and said he was fine. During an interview on 12/17/24 at 10:22 a.m., CNA K said she had only been on the unit for 2 days and Resident #7 was had anger issues and was easily agitated. (continued on next page)

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	675563	A. Building B. Wing	12/27/2024

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 12/17/24 at 10:19 a.m., Resident #8 was sitting at the table in the common area. She talked about her family and how they had dumped her at the facility. The more she talked the more upset she became. She said the facility was okay, but she should not be there. Resident #8 said the staff and residents were fine for the most part. During an interview on 12/18/24 at 11:12 a.m. LVN G said when she was working the floor, she was responsible for the residents on the locked unit. She said on 10/21/24 Resident #7 was in Resident #8's face trying to make her sit down. She said Resident #7 grabbed Resident #8 by the wrist and did not want to let her go. LVN G said most of Resident #7's arguments were with Resident #8. She said Resident #7 thought Resident #8 was his wife and they bickered back and forth. LVN G said Resident #7 tried to tell Resident #8 what to do and insisted that she do it right then. During a telephone interview 12/18/24 at 11:17 a.m., LVN H said she remembered an incident of aggression with Resident #7. She said the incident occurred on 10/4/24 when Resident #7 was swing a cane. LVN H said there was one resident standing in the hallway, Resident # 8, and it was her cane that Resident #7 had. She said she could not remember if another resident was in the hallway She said that was right after it was reported to her that he had choked Resident #8 in the hallway. During an interview on 12/18/24 at 12:58 p.m. LVN J said he was the nurse on the unit on day shift. He said it was an ongoing thing between Resident #7 and Resident #8. He said Resident #7 thought Resident #8 was his wife. He said sometimes Resident #8 was with it and realized Resident #7 was not her husband. LVN J said other times Resident #8 would think Resident #7 was her husband. He said they acted like a married couple that did not get along. LVN J said they fussed at each other, sit together, or walk together. LVN J said, at times, Resident #8 would tell Resident #7 to do something, and he would listen. He said Resident #8's dementia goes and comes. During an interview on 12/18/24 at 2:15 p.m., CNA E said she had seen Resident # 7 get angry and hit at women. She said he mostly had controversy with Resident #8. She said she saw him choke Resident #8. She said she had gone into his room and Resident #8 was sitting on the side of the Resident #7's bed holding his hand. She had asked Resident #8 to leave and Resident #7 wanted her to sleep with him. CNA E said Resident #8 told him she was not going to sleep with him, and Resident # 7 got upset and told Resident #8 she needed to give him his fifteen hundred dollars back. She said Resident #8 told him she did not have his money and left the room. She said Resident #8 was on her way to her room and Resident #7 came behind her yelling. She said Resident #7 was to the back side of Resident #8 and put his hands around her neck as if to choke her. The CNA said she was right there within reaching distance and told him to stop and he removed his hands from Resident #8's neck. She said he did not squeeze or have a chance to choke Resident #8, but he did put his hands around her neck. She said she had written a statement and told the former DON the same thing. [TRUNCATED]

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	675563	A. Building B. Wing	12/27/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on interview and record review, the facility failed to ensure a resident received adequate supervision and assistive devices to prevent accidents for 1 of 11 residents reviewed for accidents. (Resident #6) The facility failed to ensure CNA D prevented Resident #6 from failing during a mechanical lift transfer by transferring the resident alone. This facility failure could place residents at risk of injuries including lacerations and bruising to the forehead. Findings included: Record review of Resident #6's face sheet dated 12/16/24 indicated he was a [AGE] year-old male admitted to the facility on [DATE]. Some of his diagnoses were paralysis on the left side due to a stroke, need for assistance with personal care, generalized muscle weakness, and lack of coordination. Record review of Resident #6's quarterly MDS assessment dated [DATE] indicated his cognition was severely impaired. His functional limitation in range of motion was impaired on one side for the upper extremity (shoulder, elbow, wrist, and hand) and Lower extremity (hip, knee, ankle, and foot.) The MDS indicted Resident #6 was dependent on staff for all ADLs including sit to stand and transfers. Record review of Resident #6's care plan with an initiation date of 10/26/22 indicated Resident #6 had an ADL self-care performance deficit related to stroke and contractures. An intervention was Resident #6 required a mechanical lift for transfers with two staff. Record review of Resident #6's nursing notes dated 11/14/24 at 4:53 p.m. indicated an aide notified the nurse that Resident #6 had fallen from the Hoyer lift. An assessment of the incident showed Resident #6 was lying next to the bed with the Hoyer sling still attached to the Hoyer. The right side of his face had facial swelling and a gash in the center. The resident was unable to follow commands and his right eye was more sluggish than the left. Called the NP and received orders to send Resident #6 to the ER for further evaluation. Signed by LVN F. Record review of a nursing note dated 11/15/24 at 12:34 a.m. indicated Resident #6 was back at the facility following a witnessed fall incident. He had no fractures. He received a new order for ointment applied topically three times daily for 7 days to his right brow laceration. No other injures noted. Record review of Resident #6's Skin Observation sheet dated 11/15/24 indicted a new skin issue of a laceration with bruising to the right eye area. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of an in-service training dated 11/14/24 indicted when transferring with a Hoyer lift, two persons must be present to assist. An attachment to the in-service titled Transfers and Mechanical Lift Guidelines with no date indicated to make sure all equipment or assistance is available prior to the start of a lift transfer, and there must be two staff members for lifting nonweight bearing residents. Record review of nursing note dated 11/16/24 at 9:59 a.m. indicated Day 3 of 3 days post fall from Hoyer lift and ER visit, day 2 of day 7 of ointment to the right brow. No distress noted at this time and no delayed injuries note, Resident #6 continued with trace edema to the right eye. Record review indicated an Employee Termination Form dated 11/19/24 indicating CNA D was terminated due to failure to meet performance expectations. The reason was she failed to use two people with a Hoyer lift transfer resulting in an incident. Record review of a Provider Investigation Report dated 11/20/24 indicated on 11/14/25 at 5:00 p.m. a staff member transferred a resident with a mechanical lift without assistance and the resident fell to the floor. The employee was suspended immediately, and staff were in-serviced on the protocol for safe transfers using mechanical lift. The facility findings were confirmed. During an interview on 12/17/24 at 12:06 p.m. the ADON said on 11/14/24 she had been ADON for 5 days and they did not have a DON at that time or currently. She said she was told CNA D had allowed Resident #6 to fall during a Hoyer lift transfer. The ADON said CNA D did not ask for assistance and the Hoyer lift pad strap came off the Hoyer lift during the transfer. The ADON said all Hoyer lift transfers required two people. They removed the Hoyer lift from the hall due to the strap holders being small. She said they no longer used that lift. During an interview on 12/17/24 at 12:44 p.m. the Maintenance Supervisor said the incident on 11/14/24 occurred after hours and he was not at the facility at the time. He said what they told him was the lift pad straps came of the Hoyer lift. He said it was a new lift and they had only had it for a few weeks. The Maintenance Supervisor said after he looked at it the hook holders on the lift, he made the determination they were too small. He said they had removed that Hoyer from the hall and gotten a new lift to replace it. He said prior to the incident on 11/14/24, no staff had reported any problems to him about the Hoyer lift. He said he could not remember if he had inspected the lift prior to it being placed on the hall. He said there was no schedule for checking the Hoyer lifts. He stated the company that inspected the facility scales, checked the Hoyer lifts twice a year when they did the scales. During an interview on 12/17/24 at 12:52 a.m. LVN F said she was called to the room by CNA D on 11/14/24. She said when she went into the room, Resident #6 was on the floor on his right side, with his head toward the end of the bed. She said he had some facial swelling with a gash to his right eye. She said she had initiated neuros and he was more sluggish than usual, and he was sent to the ER. LVN F said Resident #6 was nonverbal and could not say what happened or how he felt. She said the Hoyer lift straps were still attached. She said CNA D was in the room without assistance. LVN said the aide did not ask her for assistance prior to transferring the resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/17/24 at 1:23 p.m., the Therapy Director said he was not at the facility on 11/14/24 when Resident #6 fell from the Hoyer. He said he had worked at the facility for [AGE] years and conducted regular training on transfers and lift transfers. He said during all the training on Hoyer's, staff were told to always have two people to transfer with Hoyer lift. Therapy Director said CNA D was a seasoned aide that knew what she was doing. He said that he and the Maintenance Supervisor looked at the Hoyer lift the next day and observed the hocks on the Hoyer were smaller than normal. He said they felt the Hoyer was not appropriate for use so, they got rid of the Hoyer and got another one. He said the Hoyer had been at the facility for a week at the most. During a telephone interview on 12/17/24 at 1:46 p.m., CNA D said she had performed a Hoyer lift transfer of Resident #6 on 11/14/24. She said the hooks on the Hoyer lift were not very big. She said she had gone in alone to transfer Resident #6 from the bed to the chair. She said the transfer had gone well until the resident was up in the air from the bed and between the bed and the chair. She said one of the lift pad straps had come off and he went down headfirst. She said it was the first strap on the right side by his head, and then she said it was the strap closer to his right foot. She said she did not panic when it happened. She bent over to his face to see if he was alright. She said he did not speak, but he was grunting. She said she had gone to get the LVN F. CNA D said prior to the transfer she did not ask for help. She said she knew it was supposed to be two people to transfer Resident #6. CNA D said she knew better, but she was not the only one that had transferred Resident #6 unassisted. She said she had done so in the past but had just got caught at that time. CNA D said she was glad the resident was not badly hurt, and she was sorry. During an interview on 12/18/24 at 9:00 a.m., the Administrator said people that checked the weight machine, checked the Hoyer's when they came twice a year. She said she did was not employed by the facility until 11/25/24 and was not aware of the details of the incident involving Resident #6' s fall on 11/14/24. During an interview on 12/19/24 at 1:15 p.m., the Director of Operations said that the facility had purchased a new Hoyer lift after the incident on 11/14/24 with Resident #6 and he provided a receipt. Record review of an invoice statement dated 11/21/24 indicated a power patient lift was purchased by the facility.