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

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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	01/08/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27140 Based on interview and record review the facility failed to ensure accurate assessments were completed for 3 of 15 residents (Residents #16, #52, and #53) reviewed for accuracy of assessments. The facility failed to ensure Residents #16, #52, and #53's MDS assessment was accurately coded for Preadmission Screening and Resident Review (PASRR). These failures could place residents at risk for not receiving the appropriate care and services to maintain the highest level of well-being. Findings included: 1.A review of Resident #16's face sheet for January 2025 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included bipolar disorder and depressive disorder. A review of Resident #16's PASRR Level 1 screening done 10/24/2024 indicated he now had a primary diagnosis of dementia and would not qualify for specialized services. A review of Resident #16's PASRR Evaluation done10/22/2020 indicated he was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services. A review of Resident #16's annual MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had depression and bipolar disorder. 2. A review of Resident #52's face sheet for January 2025 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included psychotic disorder with delusions, pseudobulbar affect (neurological condition that causes sudden and uncontrollable outbursts of crying or laughter), and dementia. A review of Resident #52's PASRR Level 1 screening done 09/26/2024 indicated he was positive for MI. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #52's PASRR Evaluation done 10/04/2024 indicated he was positive for MI. The resident was positive for mental illness but did not meet the PASRR definition for mental illness for specialized services. A review of Resident #52's admission MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had depression and psychotic disorder. 3. A review of Resident #53's face sheet for January 2025 indicated he was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included psychotic disorder with delusions, major depressive disorder, and vascular dementia. A review of Resident #53's PASRR Level 1 screening done 10/24/2024 indicated he had a primary diagnosis of dementia and the local authority determined a PASRR Evaluation would not be done. He would not qualify for specialized services due to his dementia. A review of Resident #53's admission MDS dated [DATE] Section A1500. Preadmission Screening and Resident Review (PASRR) indicated No if resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section I Active Diagnoses under Psychiatric/Mood Disorder indicated the resident had depression and psychotic disorder. During an interview on 01/08/2025 at 9:15 AM, the MDS Coordinator said the facility used the RAI Version 3. 0 Manual as the policy for completing MDS assessments. She said if she had any questions regarding the MDS assessment she went directly to the RAI manual. She said she also had a corporate resource person. She said Section A 1500 indicated if the resident was positive for mental illness, intellectual disability or developmental disability. She said she did not realize the Section I Active Diagnoses was related to Section A PASRR screening documentation. She said she had been taught if the local authority had found residents that did not qualify for PASRR services because they did not meet the PASRR definition for mental illness for specialized services and she was told to answer no because they were negative. She said she did not know Section A had to be coded as positive for mental illness, intellectual disability or developmental disability even though they did not qualify for PASRR services. 42190 47723

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204 Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications for the facility's only resident with an enteral device (Resident #34). The facility failed to ensure LVN D followed the facility's policy for administration of medications through an enteral tube (gastrostomy tube, G-Tube). This failure could place the resident at risk for clogging and/or damage of the gastrostomy tube and possible leakage of medications, formula, and/or water into the abdominal cavity. Findings include: A record review of a face sheet dated 01/08/2025 indicated Resident #34 was a [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses which included pharyngeal dysphagia (difficulty swallowing due to damage to the throat), erosive esophagitis (inflammation, irritation, or swelling of the lining of the esophagus), irritable bowel syndrome (intestinal disorder causing pain in the belly, gas, diarrhea, and constipation), and gastrostomy tube placement (a feeding tube that is surgically inserted through the abdomen and stomach wall to provide nutrition directly into the stomach - also called enteral tube or G-Tube). A record review of an Admission MDS assessment dated [DATE] noted Resident #34 had a BIMS of 15 which indicated her cognition was intact. The MDS assessment indicated Resident #34 had a feeding tube. A record review of Resident #34's care plan dated 01/08/2024 indicated she was receiving a pureed diet with thin liquids orally with supplementation of liquid feedings via a feeding tube (G-Tube) as needed. The care plan did not include any instructions for administering medications through the G-Tube. A record review of the physician's orders dated 01/07/2025 for Resident #34 included the following: -1 multivitamin with minerals tablet via G-tube one time a day, -1 vitamin C 500mg tablet via G-tube one time a day, -1 zinc 50 mg tablet via G-tube one time a day, - Protonix Oral Packet 40mg (pantoprazole Sodium granules) - give 1 packet via G-tube one time a day - May crush meds/open capsules -Flush enteral tube with 30 mL of water before and after medication administration (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review revealed the physician's orders did not include any other instructions specific for the administration of crushed medications via the G-Tube. During an observation and interview on 01/07/2025 at 08:12 AM, LVN D prepared Resident 34's morning medications consisting of 1 (one) multivitamin with minerals tablet, 1 (one) Vitamin C 500mg tablet, 1 (one) Zinc 50mg tablet and 1 (one) Protonix 40 mg tablet by crushing all the medications together. He placed the crushed medication mixture in a plastic cup and added an unmeasured amount of water. LVN drew the mixture up into a 60 mL syringe. The medications and water mixture measured approximately 25 mL in the syringe. He donned gloves and entered Resident #34's room. After checking the tube for placement and residual, LVN D attached the syringe to Resident #34's G-Tube and used the syringe plunger to push the medication mixture into the tube. After pushing approximately one-half of the mixture into the tube, he said he could not get the rest of the mixture to go in. He withdrew the syringe and said he could see a piece of medication lodged in the tip of the syringe. LVN D was able to dislodge the medication from the tip and back into the syringe barrel. He emptied the contents of the syringe with the uncrushed piece of medication in it back into the medicine cup and used the syringe tip to crush the uncrushed piece. LVN D drew the liquid mixture back up into the syringe, re-connected the syringe to the G-Tube and continued to push the syringe plunger, forcing the mixture into the tube. He disconnected the syringe from the G-Tube, capped the G-Tube, and said he was done. He did not flush the G-Tube with water before nor after administering the medication mixture. During an interview on 01/07/2025 at 10:45 AM, LVN D said the medications were supposed to be crushed and administered separately with water flushes prior to administering any medications, between each medication, and after administering all the medications to reduce the risk of clogging the tube. He said he crushed them all together because he thought Resident #34 might not tolerate the extra water flushes. He said he did not have an order to crush the medications together. He said he forgot to flush the G-Tube with water before and after administering the medications. LVN D said crushing and administering medications together could result in possible tube occlusion. LVN D said he was not supposed to use the syringe plunger to push the medications into the tube. He said he was supposed to remove the plunger from the syringe, pour water for flushes and medications into the syringe barrel, and allow them to drain into the tube via gravity flow. LVN D said forcing medications into and through a G-Tube could result in damage to the tube resulting in possible leakage of medications, formula, and/or water into the abdominal cavity. LVN D said that forcing medications into and through a tube could result in damage to the tube resulting in leakage of medications, formula, and/or water into the abdominal cavity. He said the rationale flushing the tube with water before, between, and after medications was to reduce the risk of clogging the tube resulting in the tube becoming un-usable and possibly requiring surgical replacement. During an interview with the MDS Nurse Coordinator and ADON on 01/07/2025 at 02:12 PM, the MDS Coordinator said medications given via the G-Tube route should be crushed and administered separately. She said the G-Tube should have been flushed with water before, between, and after each medication to reduce the risk of adverse reactions and non-therapeutic responses and possible damage to the tube. The ADON said she expected the nurses to follow the physician's orders and the facility's policy on administering medications through a G-Tube. A record review of the facility's policy dated November 2018 and titled Administering Medications through an Enteral Tube indicated the following: Purpose (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. General Guidelines 3. Administer each medication separately and flush between medications. Procedure 8. When correct tube placement and acceptable residual volume have been verified, flush tubing with 15-30 mL warm purified water (or prescribed amount). 9. a. Remove plunger from syringe. 9. b. Dilute crushed (powdered) medication with at least 30 mL purified water (or prescribed amount). 10. Administer each medication separately. 12. Administer medication by gravity flow. 12. a. Pour diluted medication into the barrel of the syringe 13. If administering more than one medication, flush with 15mL warm purified water (or prescribed amount) between medications 14. When the last of the medication begins to drain from the tubing, flush the tubing with 15 mL of warm purified water (or prescribed amount).

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 41695 Based on interview and record review, the facility failed to use the service of an RN for 8 consecutive hours 7 days a week. The facility did not have RN coverage on the following dates: 12/2/24 - 12/9/24, 12/13/24-12/18/24, 12/20/24-12/22/24, 12/25/24, and 12/28/24 - 1/6/2025. This failure has the potential to affect the residents in the facility and place them at risk of not having staff with advance care skills available to assist in their care needs. Finding included: Record review of the RN Coverage for months of December 2024 and January 2025 indicated there were no RN hours on the following dates: * 12/2/24 - 12/9/24 * 12/13/24-12/18/24 * 12/20/24-12/22/24 * 12/25/24 * 12/28/24 - 1/6/2025 During an interview on 1/6/2025 at 8:45 am, Administrator F, said the facility does not have a full time RN for coverage, she stated a possible negative outcome for not having an RN working for 8 hours/day would be that if something bad happened, the staff would not know what to do and would not have anyone to go to. During an interview on 1/7/2025 at 10:25 AM, the BOM stated the facility did not have a full time RN working in the facility. She stated the consequences of not having an RN in the facility would be not having another set of eyes for the residents. She stated she did not know why there was no full time RN working. A record review of the facility's Departmental Supervision policy dated April 2006, revealed, Policy Statement: The Nursing Services department shall be under the direct supervision of a Registered or Licensed Practical/ Vocational Nurse at all times. Policy Interpretation and Implementation: I. A Registered or Licensed Practical/Vocational Nurse (RN/LPN/LVN) is on duty twenty-four hours per day, seven (7) days per week, to supervise the nursing services activities in accordance with physician orders and facility policy. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. A Registered Nurse (RN) is employed as the Director of Nursing Services (DNS). The DNS is on duty during the day shift Monday through Friday. During the absence of the DNS, a Nurse Supervisor/Charge Nurse is responsible for the supervision of all nursing department activities including the supervision of direct care staff. 47723

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F 0731 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Request a waiver if it can't meet the nurse staffing requirements. 41695 Based on interview and record review, the facility failed to designate a registered nurse (RN) to serve as the DON on a full-time basis since 11/3/2024 The facility did not have a DON from 11/3/2024 to currant date. This failure could place residents at risk of lack of nursing oversight and a higher level of care. Findings include: Record review of DON Coverage from Raw Punch Report dated 1/7/2025 indicated last day of DON coverage was 11/3/2024 with punch out time of 2:38pm with a total of 6.70 hours. During Entrance Conference interview on 1/6/2025 at 8:45 AM with the administrator F, she said they currently do not have a DON. ADM F said her first day of employment was 11/25/2024, and there was not a DON. Record Review of offer of employment for ADM F dated 11/16/2024, offer for employment for the administrator position at [facility] with effective start date of 11/25/2024. During an interview on 1/8/2025 at 2:09 p.m. the ADON, said she began employment on 11/11/2024 and there was not a DON at that time. Record review of letter dated 1/6/2025 at 6:50p.m. from ADM F stated: I am letting you know I am no longer at [facility]. Please take my name off that facility as they were wanting me to say I was DON so they would have RN coverage hours. Adm F, RN, DNP LNFA, [email] During an interview on 1/7/2025@ at 9:00 a.m. with Adm G, he said he was now the Administrator of the facility, and they still do not have a DON. He states have been unable to employee a DON and this was his second day of employment. A record review of the facility's Director of Nursing Services policy dated August 2006, revealed, Policy Statement: The Nursing Services department is under the direct supervision of a Registered. Policy Interpretation and Implementation: I. The Nursing Service department is managed by the Director of Nursing Services. The Director is a Registered Nurse (RN), licensed by this state, and has experience in nursing administration, rehabilitation, and geriatric nursing. 2. The Director is employed full time (40-hours per week) and is responsible for, but is not necessarily limited to: a) Developing and periodically updating nursing service objectives and statement of philosophy (continued on next page)

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F 0731 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b) Developing standards of nursing practice c) Developing and maintaining nursing policies and procedure manuals d) Developing and maintaining written job descriptions for each level of nursing personnel etc.

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47204

Based on observation, interview and record review, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 2 of 4 residents (Resident #34 and Resident #50) reviewed for pharmacy services.

The facility failed to ensure Resident #34's physician orders included accurate and complete instructions for the administration of medications via the enteral route.

The facility failed to ensure Resident #50's Cyanocobalamin (Vitamin B12) Oral Tablet 2500 mcg daily was available for administration resulting in MA B performing mathematical calculations and making substitutions with the doses of the same medication on hand in the facility.

These failures could place residents at risk for non-therapeutic responses to medications and receiving the wrong dose of a medication with a possible decline in health status.

Findings include:

1.A record review of a face sheet dated 01/08/2025 indicated Resident #34 was a [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses which included pharyngeal dysphagia (difficulty swallowing due to damage to the throat) and gastrostomy tube placement (a feeding tube that is surgically inserted through the abdomen and stomach wall).

A record review of the Admission MDS assessment dated [DATE] noted Resident #34 had a BIMS of 15 indicating her cognition to be intact. The MDS assessment indicated Resident #34 had a feeding tube (enteral or G-Tube).

A record review of the physician's orders dated 01/07/2025 for Resident #34 included the following:

-1 multivitamin with minerals tablet via G-tube one time a day,

-1 vitamin C 500mg tablet via G-tube one time a day,

-1 zinc 50 mg tablet via G-tube one time a day,

- Protonix Oral Packet 40mg (pantoprazole Sodium granules) - give 1 packet via G-tube one time a day

- May crush meds/open capsules

-Flush enteral tube with 30 ml of water before and after medication administration

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 01/07/2025 at 08:12 AM, LVN D prepared Resident 34's morning medications consisting of 1 (one) multivitamin with minerals tablet, 1 (one) Vitamin C 500mg tablet, 1 (one) Zinc 50mg tablet and 1 (one) Protonix 40 mg tablet by crushing all the medications together. He placed the crushed medication mixture in a plastic cup and added an unmeasured amount of water. LVN drew the mixture up into a 60 mL syringe. The medications and water mixture measured approximately 25 ml in the syringe. He donned gloves and entered Resident #34's room. After checking the tube for placement and residual, LVN D attached the syringe to Resident #34's G-Tube and used the syringe plunger to push the medication mixture into the tube. He then disconnected the syringe from the G-Tube, capped the G-Tube, and said he was done. LVN D did not flush the G-Tube with water before nor after administration of the medications. During an interview on 01/07/2025 at 10:45 AM, LVN D said the medications were supposed to be crushed and administered separately with water flushes between each medication. He said he crushed them all together because he thought Resident #34 might not tolerate the extra water flushes. He said he did not have a specific order to crush the medications together nor how much water to use to dilute each medication nor how much water to flush the tube with between each medication. He said he knew but forgot that Protonix was not supposed to be crushed. He said he did not know Protonix was to be given with applesauce (orally) or apple juice (orally or via tube). LVN D said crushing and administering medications together could result in chemical incompatibilities leading to an altered therapeutic response and possible tube occlusion. During an interview with the MDS Nurse Coordinator and ADON on 01/07/2025 at 02:12 PM, the MDS Coordinator said medications to be given via the G-Tube route should be crushed and administered separately. She said the G-Tube should have been flushed with water before, between, and after each medication to reduce the risk of adverse reactions and non-therapeutic responses and possible damage to the tube. The ADON said the physician's orders should include the procedure to be used to administer medications via an enteral tube including the amount of water to be used to flush the tube and to dilute the crushed tablets with. She said that if a medication required specific instructions such as not to crush or give with apple juice, then it should be included in the physician's orders so staff would have the information available when administering medications. A record review of the facility's policy dated November 2018 and titled Administering Medications through an Enteral Tube indicated the following: Purpose The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. Preparation 1.Verify that there is a physician's medication order for this procedure. General Guidelines 3. Administer each medication separately and flush between medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Do not crush or split medications for administration through an enteral tube unless first checking with the pharmacy or facility approved Do Not Crush Medication List. 4.a. Tablets that must be crushed prior to administration through an enteral tube require a specific order related to crushing. 2.A record review of a face sheet dated 01/08/2025 indicated Resident #50 was a [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses which included Alzheimer's Disease, Cerebral Infarction (stroke caused by blockage of blood flow to the brain), and vitamin deficiency. A record review of a MDS dated [DATE] noted resident #50 to have a BIMS of 6 indicating his cognition was severely impaired. He was continent, ambulatory, and able to voice basic needs. A record review of a care plan dated 01/08/2025 indicated Resident #50 had a concern for short- and long-term memory loss and required minimal supervision for most activities of daily living. A record review of Resident #50's physician orders dated 01/07/2025 indicated he was to receive Cyanocobalamin (Vitamin B12Oral Tablet 2500 mcg daily. During an observation on 01/07/2025 at 08:43 AM, MA B obtained 2 (two) tablets of Vitamin B12 1000 mcg and 1 (one) tablet of Vitamin B12 500 mcg from her medication cart and put them in a medication cup containing some other medications. She handed the cup of medications to Resident #50 who swallowed the medications. A record review of Resident #50's MAR dated 01/07/2025 indicated MA B had administered 1 Vitamin B12 2500mcg tablet. There was no record of Resident #50 being administered 2 Vitamin B12 1000mcg tablets and 1 Vitamin B12 500mcg tablet. During an interview with MA B on 01/07/2025 at 10:45 AM, MA B said the physician's order was for 1 (one) tablet of Vitamin B12 2500mcg. MA B said she did not have any Vitamin B12 vitamins in the 2500mcg strength so she used 2 (two) of the Vitamin B12 1000mcg tablets plus 1 (one) of the Vitamin B12 500mcg tablets to equal the 2500mcg ordered dose. MA B said she told several people she did not have the Vitamin B12 in the strength listed in the physician's orders, but she had never gotten any. MA B said she made the calculations and determined she would need 2 (two) of the Vitamin B 1000mcg tablets plus 1 (one) of the Vitamin B12 500mcg tablets to equal the physician ordered dose. MA B said medication aides were not supposed to perform drug dose calculations. She said the physician's orders were supposed to indicate exactly what the medication aide was supposed to give to prevent medication giving the wrong dose of a medication. During an interview on 01/07/2025 at 11:45 AM, the ADON said the physician's order for Vitamin B12 2500mcg should have been updated to reflect what the facility had on hand. She said there should be 2 (two) physician orders, one order to give 2 Vitamin B12 1000mcg tablets and a second order to give 1 Vitamin B12 500mcg tablet. She said medication aides were not allowed to calculate medication doses nor make changes in how a dose of medication was to be administered. The ADON said that since the medication aides were signing that they were giving 1 Vitamin B12 2500mcg tablet, there was no way of knowing what strength tablets they were giving nor if they were giving the correct dose. The ADON said administering medications according to the physician's instructions reduced the risk for administering the wrong dose of a medication. (continued on next page)

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's policy dated April 2019 and titled Administering Medications indicated the following: Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204 Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not 5 percent or greater. The facility had a medication error rate of 7% based on 2 errors out of 26 opportunities which involved 1 of 4 residents (Resident #34) observed for medication administration. LVN D failed to ensure a delayed-release medication (releases the medication in the intestine to prevent break-down of the medication by stomach acids) was not crushed. LVN D crushed and mixed Resident #34's morning medications (and administered them via the gastrostomy tube route in a single administration. These failures could place residents who receive medications via the gastrostomy tube route at risk for non-therapeutic responses and/or potential adverse effects of the mediations with a possible decline in health status. Findings include: A record review of a face sheet dated 01/08/2025 indicated Resident #34 was a [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses which included pharyngeal dysphagia (difficulty swallowing due to damage to the throat), erosive esophagitis (inflammation, irritation, or swelling of the lining of the esophagus), irritable bowel syndrome (intestinal disorder causing pain in the belly, gas, diarrhea, and constipation), and gastrostomy tube placement (a feeding tube that is surgically inserted through the abdomen and stomach wall). A record review of the Admission MDS assessment dated [DATE] indicated Resident #34 had a BIMS of 15 which indicated her cognition was intact. The MDS assessment indicated Resident #34 had a feeding tube (enteral or G-Tube). A record review of Resident #34's physician's orders dated 01/07/2025 indicated an order dated 12/16/2024 for Protonix Oral Packet 40mg (Pantoprazole Sodium granules) - give 1 packet via G-tube one time a day. During an observation on 01/07/2025 at 08:12 AM, LVN D prepared Resident #34's morning medications. He obtained 1 (one) multivitamin with minerals tablet, 1 (one) Vitamin C 500mg tablet, and 1 (one) Zinc 50mg tablet from the medication cart and placed all 3 medications in a plastic cup. He said Resident #34 was supposed to get Protonix but said he did not have any in the cart. He said he would have to obtain the Protonix from the automated medication dispensing cabinet in the medication room. LVN D obtained 1 (one) Protonix 40mg tablet from the cabinet, returned to the cart, added the Protonix tablet to the other medications in the cup, and crushed all the medications together. He placed the crushed medication mixture in a plastic cup, added water, and drew the mixture up into a 60 mL syringe. He donned gloves and entered Resident #34's room. After checking the tube for placement and residual, LVN D attached the syringe to Resident #34's G-Tube and administered the medications through the G-Tube. He disconnected the syringe from the G-Tube, capped the G-Tube, and said he was done. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/07/2025 at 10:45 AM, LVN D said the medications were supposed to be crushed and administered separately. LVN D said Resident #34 was supposed to have been given 1 packet of Protonix 40mg granules. He said he did not have any in his cart and that was why he substituted the Protonix 40mg tablet. LVN D said he knew he was not supposed to crush Protonix tablets but forgot. He said he did not know that Protonix was a delayed release medication and that crushing it would increase the risk of the medication being released prematurely resulting in Resident #34 not receiving the intended therapeutic effect of the medication. During an interview with the ADON on 01/07/2025 at 11:15 AM, she said expected the nurses to follow the facility's policy on administering medications through a G-Tube. She said LVN D should not have substituted the Protonix 40 mg tablet for the ordered packet of Protonix granules, should not have crushed the Protonix tablet, and should not have crushed all the medications together and administered them in a single action. A record review of the facility's policy, Administering Medications, and dated April 2019 indicated the following: Policy Statement Medications are to be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 4. Medications are administered in accordance with prescriber orders, . 8. If a .medication has been identified as having adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns. A record review of the facility's policy, Administering Medications through an Enteral Tube, dated November 2018 indicated the following: 3. Administer each medication separately and flush between medications. 4. Do not crush or split medications for administration through an enteral tube unless first checking with the pharmacy or facility approved Do Not Crush Medication List. b. Do not crush enteric coated, sustained release, buccal, or sublingual, or enzyme-specific medications. A review of information on Drugs.com at https://www.drugs.com: FDA Prescribing Information: Pantoprazole: Package Insert/prescribing Information, Last updated November 13, 2024: Dosage and Administration indicated the following: Do not split, chew, or crush Pantoprazole sodium delayed-release tablets.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27140 Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in the facility's only kitchen observed for kitchen sanitation. A 16 oz. bag of tortilla chips was opened and not re-sealed. DA A checked the sanitizing of the dish machine using quaternary ammonia test strips instead of chlorine test strips. The dish machine log [DATE] had been pre-filled with results for the noon check ([DATE]) when the noon meal had not occurred. The results indicated temperatures but no sanitizing conditions for any date. The dish machine log for [DATE] and [DATE] had blanks where washing temperatures and sanitizing results had not been documented. In the walk in cooler ,d+[DATE] oz. nectar thick iced teas, ,d+[DATE] oz. nectar thick orange juice, and , d+[DATE] oz. honey thick water with lemon had been opened and not labeled with the open date. These failures could place residents who ate food from the kitchen at risk of foodborne illness. Findings included: During observations, interviews and record reviews on [DATE] of the kitchen the following was noted: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*at 9:40 AM DA A was washing dishes and was asked to check the sanitizing solution on the dish machine. He took a container of test strips from a wall-mounted storage box above the dish machine and tested the water in the dish machine after the sanitizing cycle. The test strip did not chemically react. The container of test strips was labeled QAC (quaternary ammonia compounds-a sanitizer). The sanitizing solution connected to the dish machine was marked as CL (chlorine). DA A said he had been using the test strips that were in the storage box because those were the strips the dish machine vendor had left. He said he did not know the QAC strips were the incorrect ones. He said he had had the purple chlorine strips before and someone had put the QAC strips in the storage box but he did not know exactly when that happened. DA A said he was to log the wash, rinse and sanitizing results in the logbook that was in the dish room. The DM said, at that time, the dish machine vendor always came when he was not at the facility. He said he did not know the QAC strips were in the storage box. He said the vendor came about a week ago sometime before the first of the year to change out the chemicals. DA A said he had not made any chemical notations in the logbook, only the water temperatures for [DATE]. He had already filled in the noon meal temperatures by 9:00 AM. The DM was asked if he checked the sanitizing logbook on a regular basis and he did not respond to the question. He did not know the logbook had no notations for sanitizing of the dishes in the dish machine for [DATE] through 6, 2025 only the wash and rinse temperatures. The DM said the QAC strips were used to test the sanitizing solution used in the red sanitizing buckets and the 3 compartment sink. The DM left the dish room and returned with a container of test strips labeled chlorine to be used on the dish machine. The DM said the sanitizing solution should test between 50 and 200 ppm. He said the kitchen staff were to check the sanitizer when they washed the dishes for each meal and log it in the Dish Machine Temperature Logbook. The dish machine was tested and the result was 200 ppm which indicated the machine was sanitizing although at a higher concentration noted on the logbook. The DM used liquid paper to erase the temperatures entered for [DATE] noon meal. A copy was made before it was changed. The DM said he did not know the sanitizing results were not entered for all 3 meals for [DATE], [DATE], [DATE], [DATE], [DATE] or for breakfast on [DATE]. *at 10:07 AM in the dry pantry one 16 oz. bag of tortilla chips was opened and the tops\ was rolled down and not secured or placed in a re-sealable bag. After surveyor intervention the DM took the opened bag and placed it in a resealable bag and returned it to the shelf. *at 10:10 AM in the walk in cooler there was one 46 oz. nectar thick orange juice and one 46 oz. honey thick water with lemon, and the packaging indicated May be kept for up to 7 days after opening under refrigeration and two 46 oz. nectar thick iced teas (by another manufacturer) and the packaging indicated Discard if not used within 10 days of opening. The DM said the dates written on the side of the cartons were the truck date when the product came to the facility. He said he did not know the thickened liquid products had an expiration date after opening. He did not do anything with the opened products and they remained in the cooler for service. Record review of the facility's Dish Machine Temperature Logbook at 9:50 AM, dated [DATE], indicated 3 sets of columns which indicated the date, temp/chem and initials of person doing the test. The 3 sets of columns were for the 3 meal times for the day. Day [DATE]) indicated the morning meal and noon meal contained values for the date, temp/chem, and initials for the noon meal that had not occurred. The noon and evening meal values were not recorded on [DATE]. The evening meal values were not recorded for [DATE] and [DATE]. Chem values were not sanitizer values but rinse water temperatures (the values ranged from 50, 59, 69, 70, and 80. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility's Dish Machine Temperature Logbook at 9:50 AM, dated [DATE], indicated 3 sets of columns which indicated the date, wash, rinse, chem and initials of the DM. The 3 sets of columns were for the 3 meal times for the day. Day [DATE]) indicated the morning meal and noon meal contained values for the date, temp/chem, and initials for the noon meal that had not occurred. The noon and evening meal values were not recorded on [DATE]. The breakfast values were not recorded for [DATE], [DATE] and [DATE]. The lunch values were not recorded for [DATE], [DATE], and [DATE]. The evening meal values were not recorded for [DATE], [DATE], [DATE], and [DATE]. Chemical values were inaccurately noted as 58, 59, 62, 63, 68, 69, 76, 77, 78, 80, 89, 98, 101, and 102 when the values can only be 0, 50, 100 or 200 per the chemical testing strip for chlorine. The record was not initialed by the DM on any day. Review of undated directions on the front of the Dish Machine Temperature Logbook binder indicated Make sure you are recording temperatures before the start of each meal to ensure all dishes are being properly sanitized. Low Temperature Dish Machine Wash: ,d+[DATE] degrees; Rinse: 140 degrees; Sanitizer: 50 ppm-100 ppm. Record review of the facility's Sanitation policy, dated [DATE], indicated the following: .Low-Temperature Dishwasher (Chemical Sanitization) a. Wash temperature (120 degrees F); b. Final rinse with 50 parts per million (ppm) hypochlorite (chlorine) for at least 10 seconds. Record review of the facility's Dishwashing Machine Use policy, dated [DATE], indicated the following: 4. Dishwashing machine sanitizer concentrations and contact times will be as follows: Chlorine ,d+[DATE] ppm 10 seconds contact time, Quaternary Ammonium ,d+[DATE] ppm per manufacturer's instructions for contact time. 5. A supervisor will check the dishwashing machine for proper concentrations of sanitizer solution after filling the dishwashing machine and once a week thereafter. Concentrations will be recorded in a facility approved log. Record review the facility's Refrigerators and Freezers policy, dated [DATE], indicated the following: .8. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204 Based on interview and record review, the facility failed to ensure medical records, in accordance with accepted professional standards and practices, were complete and accurately documented for 1 of 5 Residents (Resident #41) reviewed for medical records accuracy. The facility failed to insure Resident #41's OOHDNR code status was accurately reflected in the facility's code status book, on the Resident's face sheet and in the physician orders and care plan. This failure could place residents at risk for receiving resuscitation actions against their declared instructions. Findings include: A record review of Resident #41's face sheet dated [DATE] indicated she was an [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses which included Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), depression (a persistent feeling of sadness and loss of interest in activities), coronary atherosclerosis (condition where plaque builds up in the coronary arteries which can reduce or block blood flow to the heart), communication deficit, and a history of cancer of the colon. The face sheet also indicated Resident #41 had a Full Code status. A record review of Resident #41's Significant Change MDS dated [DATE] noted Resident #41 had a BIMS of 2 which indicated her cognition was severely impaired. She was non-ambulatory, incontinent of bowel and bladder, and dependent on staff for most activities of daily living. A record review of Resident #41's physician orders dated [DATE] noted an order for Full Code dated [DATE]. A record review of Resident #41's care plan dated [DATE] indicated her elected code status was Full Code and the goal was for Resident #41's wishes to be honored and her code status upheld in the event she was found to be without vital signs. A record review of a notebook titled Code Book located at the nurses' station included a green sheet of paper with Resident #41's name on it and the letters DNR on it which indicated Resident #41 was a DNR. A record review of the miscellaneous medical records section indicated Resident #41 had a signed and notarized OOHDNR (Out Of Hospital Do Not Resuscitate) document signed on [DATE] in her chart. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN E on [DATE] at 01:45 PM, LVN E looked in a notebook at the nurse's station and said Resident #41 was a Full Code. An unidentified RN at the nurses' station was sitting at the computer and said Resident #41's face sheet indicated Resident #41 was a Full Code. LVN E said that if Resident #41 was found to be without a pulse, she would initiate cardiopulmonary resuscitation actions. When asked about the OOHDNR document, LVN E said she was a PRN nurse and did not know what was expected. During an interview with the Admission Coordinator on [DATE] at 02:00 PM, she said the facility did not have a DON nor Social Worker and said she helped with the Code Book. She said Resident 41's code status was Full Code. She said Resident #41's family member had gone back and forth regarding code status, but the status was currently a Full Code. When asked about the OOHDNR document, the Admission Coordinator said she would call the family member and verify the status. During an interview on [DATE] at 02:10 PM with Admin 1, she said Resident #41 received hospice services. She said Resident #41's family member changed the Resident's code status and gave the OOHDNR document to hospice. She said hospice did not verbally communicate that change to anyone at the facility. She said hospice should have spoken to the Administrator, DON, Social Worker, or Admission Coordinator about changing Resident #41's code status to DNR code status so a physician's order could have been obtained and Resident #41's medical records updated. During an interview with the Admission Coordinator on [DATE] at 02:40 PM, she said Resident #41's code status was DNR. She said the Resident #41's family member told her he had signed the OOHDNR document with his mother's hospice nurse. She said the hospice nurse faxed the document to the facility but did not verbally communicate the change in code status to anyone at the facility. The Admission Coordinator said evidently the OOHDNR document came by fax and was placed in the tray for items that needed to be scanned into the system. She said it looked like the OOHDNR document was scanned into the system without anybody being made aware of the change in code status. She said if Resident #41 had died , staff would have attempted to resuscitate her. A record review of the facility's policy titled Advance Directives indicated the following: Advance directives will be respected in accordance with state law and facility policy. 5. In accordance with current OBRA definitions and guidelines governing advance directives, our facility has defined advance directives as preferences regarding treatment options and include, but are not limited to: b. Do Not Resuscitate - Indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other lifesaving methods are to be used. 8. Changes or revocation of a directive must be submitted in writing to the Administrator.The Care Plan team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment (MDS) and care plan. 9. The Director of Nursing Services or designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	13. Inquiries concerning advance directives should be referred to the Administrator, Admissions Director, Director of Nursing Services, and/or to the Social Services Director.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47204 Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Residents #34) reviewed for infection control. LVN D failed to don appropriate PPE prior to administering medications through a gastrostomy tube (also called a G-Tube, enteral tube, or feeding tube). This failure could place residents at risk of exposure and/or possible transmission of communicable diseases and infections. Findings include: A record review of a face sheet dated 01/08/2025 indicated Resident #34 was a [AGE] year-old female who was admitted to the facility on [DATE]. She had diagnoses which included pharyngeal dysphagia (difficulty swallowing due to damage to the throat), necrotizing fasciitis of the neck (serious bacterial infection of the body's soft tissue, also called flesh-eating disease), erosive esophagitis (inflammation, irritation, or swelling of the lining of the esophagus), irritable bowel syndrome (intestinal disorder causing pain in the belly, gas, diarrhea, and constipation), alcoholic cirrhosis of the liver with ascites (a condition where fluid builds up in the abdomen due to liver scarring caused by chronic alcohol consumption), and gastrostomy tube placement (a feeding tube that is surgically inserted through the abdomen and stomach wall to provide nutrition directly into the stomach - also called enteral tube or G-Tube)). A record review of Resident #34's Admission MDS assessment dated [DATE] noted Resident #34 had a BIMS of 15 which indicated her cognition was intact. The MDS assessment indicated Resident #34 had a feeding tube. A record review of the physician's orders dated 01/07/2025 indicated Resident #34 had a gastrostomy tube for administration of medications and supplemental nutrition. During an observation on 01/07/2025 at 08:12 AM, LVN D prepared Resident 34's morning medications for administration through her feeding tube. He donned gloves and entered Resident #34's room. Resident #34 had a sign on the doorway entrance into her room which indicated Enhanced Barrier Precautions were required. The sign also said that all providers and staff must wear gloves and a gown for high-contact activities which included feeding tube care or use. There was a 3-drawer plastic container outside the doorway which contained PPE which included gloves and gowns. LVN D did not put on a gown. LVN D told Resident #34 that he had her medications. LVN D got down on one knee, bringing the lower leg of his uniform into direct contact with the floor. LVN checked tube placement and administered the medications through the feeding tube. LVN D said he was done and left the room. He removed his gloves, disposed of them, and performed hand hygiene. (continued on next page)

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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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADON on 01/07/2025 at 10:20 AM, she said Enhanced Barrier Precautions meant the staff were supposed to don gloves and a gown when providing direct patient care to residents with wounds and indwelling medical devices such as urinary catheters, feeding tubes, and tracheostomies. She said the purpose was to prevent and reduce the risk of spreading infections and diseases. During an interview with the MDS Coordinator on 01/08/2025 at 02:30 PM, she said she was the Infection Preventionist as of 01/07/2025. She said nurses were required to wear gloves and a gown when administering medications through a G-tube to reduce the spread of infections and diseases. During an interview on 01/08/2025 at 04:55 PM, LVN D said he did not don a gown because did not think it was necessary since Resident #34 no longer had an infection nor a pressure ulcer. He said he should have donned a gown prior to providing care to Resident #34 because she had a feeding tube which required EBP. A record review of the facility's policy titled Enhanced Barrier Precautions and dated 04/01/2024 indicated the following: It is the policy of this facility to follow CDC guidelines by utilizing Enhanced Barrier Precautions in the care of patients susceptible to multiple drug resistant organisms (MDRO), and to reduce the spread and prevalence of MDRO related infections. Enhanced barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. The use of gown and gloves for high-contact resident care activities is indicated, when Contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. The following situations would warrant Enhanced Barrier Precautions .feeding tubes .