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	03/18/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise for 3 of 8 residents reviewed for nutritional status (Resident #9, #25, and #31). The facility failed to implement the RD's 02/21/2026 nutritional recommendations for Resident #9 who experienced a significant weight loss of 6.5% (6 lbs.) from 01/02/2026 to 02/10/2026. The facility failed to ensure the physician's orders included the amount of liquid nutritional supplement to be administered to Resident #25 and Resident #31. The facility failed to ensure the staff responsible for the delivery and administration of liquid nutritional supplements were clearly identified. These failures could place residents with weight loss at risk for malnourishment, further weight loss, skin breakdown, and a decreased quality of life. Findings included: 1.During an observation on 03/16/2026 at 01:00 PM, Resident #9 was observed to receive lunch on a tray served by a CNA-B. After a couple of minutes of watching Resident #9 not attempt to feed herself, CNA-B attempted to spoon feed Resident #9. Resident #9 was observed closing her mouth and turning her face away from the spoons of food offered by the aid. There was no Health shake noted on Resident #9's lunch tray. Record review of a face sheet dated 03/17/2026 indicated Resident #9 was a [AGE] year-old female who initially admitted to the facility on [DATE]. She had diagnoses which included spastic quadriplegic cerebral palsy (severe form of cerebral palsy caused by brain damage and affects all four limbs, the trunk, and face resulting in extreme muscle stiffness, limited mobility, and causes speech, swallowing, and cognitive impairments), profound intellectual disability, and anorexia (a serious mental health eating disorder).Resident #9 had a hospital stay from 02/06/2026-02/10/2026 where she was treated for Influenza A, pneumonia, and a urinary tract infection. Record review of a quarterly MDS dated [DATE] noted Resident #9 was coded for significant weight loss. The MDS included a BIMS assessment which noted Resident #9 was rarely/never understood and required the supervision and assistance of one person with eating. Record review of an undated care plan indicated Resident #9 had a potential for nutritional problem related to her diagnoses of cerebral palsy and anorexia. The care plan identified interventions to address the concern which included providing Resident #9 with assistance with all meals and serving diet and supplements as ordered. Record review of the medical records indicated Resident #9's weights were as follows: 01/2/2026 92 lbs,02/02/2026 89 lbs, 02/10/2026 86 lbs, 03/04/2026 89 lbs. Record review of the March 2026 physician's orders revealed an order dated 11/18/2025 for Resident #9 to be given a Health Shake twice a day. Record review of the Dietary Supplement List indicated Resident #9 was on the list to receive a Health Shake at lunch daily. Record review of the February and March clinical records did not reveal any documentation of Health Shakes being provided to Resident #9 nor of Resident #9's acceptance or refusal of the nutritional supplements. Record review of a Nutrition/Dietary Note dated 02/21/2026 indicated Resident #9 had experienced significant weight loss and recommended discontinuing the health shakes and adding 90ml of Med Pass twice a day. A review of the nutritional information for Health Shakes and Med Pass indicated the following:1 (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Health Shake contained 220 calories and 6 grams protein 90ml Med Pass contained 290 calories and 9 grams protein. Record review of Resident #9's February and March physician orders, MARs, and TARs indicated the 02/21/2026 RD's recommendations to discontinue the Health Shakes and start Med Pass 90ml twice a day had not been implemented. During an interview on 03/18/2026 at 09:40 AM, the RD said it was her first visit to the facility and said she was not familiar with Resident #9. After reviewing the previous RD's 02/21/2026 recommendations, she said the previous RD replaced the Health Shakes with Med Pass because the Med Pass offered more nutrition by way of increased calories and protein. During an interview on 03/18/2026 at 09:45 AM, the DM said the previous RD would document her recommendations in the residents' charts and send her recommendations to the ADON. She said the ADON would print the recommendations and give them to the doctor for approval. She said once the recommendations were approved, the ADON would transcribe the physician's orders into the EHR and send the DM a dietary communication form. During an interview on 03/18/2026 at 10:05 AM, the ADON said she was responsible for following up on the RD's recommendations. She said she did not see the RD's 02/21/2026 recommendations for Resident #9 in the progress notes. She said the previous RD did not send her the recommendations as she was supposed to. The ADON said she transcribed the physician's orders for Resident #9 to receive the 2 health shakes daily into the clinical record but failed to assign them to the MAR. She said the MAR would communicate the instructions to give Resident #9 a health shake and the Medication Aide would document the health shake was given. The ADON said there was no documentation to show Resident #9 had received the health shakes. During an interview on 03/18/2026 at 10:50 AM, the DON said there had been problems with receiving communications from the previous RD who was no longer affiliated with the facility. She said the facility had a new RD and she was going to review the communication process with her. The DON 2. Record review of a face sheet dated 03/18/2026 indicated Resident #25 was an [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses which included dementia, dysphagia (difficulty swallowing, vitamin D deficiency, and debility (a state of severe weakness often characterized by frailty, exhaustion, and reduced functional capacity). Record review of a quarterly MDS dated [DATE] noted Resident #25 had a BIMS score of 4 indicating her cognition was severely compromised. The same MDS noted Resident #25 was coded for significant weight loss. Record review of the medical records indicated Resident #25 weighed 117 lbs. on 02/14/2026 and 108 lbs. on 03/04/2026, indicating a 7.5% (9 lbs.) weight loss. Record review of the progress notes dated 02/18/2026 indicated Resident #25 had a weight loss of 7.5% and a new order was received from the Nurse Practitioner to give Resident #25 90ml of Med Pass 2.0 daily with the morning medications. Record review of Resident #25's February and March 2026 physician's orders revealed an order dated 02/19/2026 for Med Pass 2.0 in the morning for weight decrease. The order did not specify the amount of Med Pass to be given. The order did not identify who was responsible for giving Med Pass 2.0 to Resident #25. Record review of Resident #25's 2026 February and March MARs revealed there were no instructions for Resident #25 to be given Med Pass 2.0. There was no documentation of Resident #25 having received Med Pass 2.0 with her morning medications or at any other time. 3. Record review of a face sheet dated 03/17/2026 indicated Resident #31 was a [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses which included dementia, schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms and a milder form of mania which is a condition with extreme changes in mood or emotions), bipolar disorder (a mental health condition that causes extreme mood swings), and chronic kidney disease. Record review of an admission MDS dated [DATE] noted Resident #31 had a BIMS score of 12 indicating her cognition was moderately compromised. Record review of the medical records indicated Resident #31 weighed 119 lbs. on 01/23/2026 and 110 lbs. on 02/02/2026, indicating a 7.5% (9 lbs.) weight loss. Record review of the progress notes dated 02/18/2026 indicated Resident #31 had a weight loss of 7.5% and a new order was received from the Nurse Practitioner to give Resident #31 90ml of Med Pass 2.0 daily with the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	morning medications. Record review of resident #31's February and March physician's orders revealed an order dated 02/19/2026 for Med Pass 2.0 in the morning for weight decrease. The order did not specify the amount of Med Pass to be given. Record review of Resident #31's 2026 February and March 2026 MARs revealed there were no instructions for Resident #31 to be given Med Pass 2.0 daily. There was no documentation of Resident #31 having received Med Pass 2.0 in February and March, 2026. During an interview on 03/17/2026 at 02:35 PM, the ADON said she was responsible for transcribing dietary recommendations into the physician's orders and selecting the appropriate electronic health records such as the MAR or TAR. She said she failed to specify the amount of Med Pass 2.0 that was to be given to Resident #25 and Resident #31 in the physician's orders. She said the orders should have included the specific amount of Med Pass 2.0 to be given and the order should have been assigned to the appropriate EHR for administration. She said if the order was not on the MAR, then the Medication Aide or Nurse administering medications would not know to give it which result in the residents not receiving supplemental nourishment and potentially having further weight loss. The ADON said dietary staff were responsible for providing the dietary supplements which included the liquid Med Pass supplement on the trays of those residents who ate in the dining room. She said the medication aides were responsible for administering the Med Pass supplement to the residents who did not always take their meals in the dining room. Record review of the facility's policy dated 2005 and revised April 2007 and titled Nutrition (Impaired)/Unplanned Weight Loss-Clinical indicated the following: Assessment: 5.The physician will review possible causes of anorexia or weight loss with the nursing staff and/or dietician before ordering interventions. Treatment: 2. The physician will authorize appropriate general or cause-specific interventions, as indicated. A record review of the facility's policy dated 2001 and revised July 2016 and titled Medication and Treatment Orders indicated the following: Orders for medications and treatments will be consistent with principles of safe and effective writing.

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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 - Some	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** Based on observation, 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 4 of 6 residents (Residents #9, #25, #31,and #55) reviewed for medical records accuracy The facility failed to ensure the administration of nutritional supplements was documented in the clinical records for Resident #55, Resident # 9, Resident #25, and Resident #31. The facility failed to ensure physician orders included complete instructions for the administration of a liquid nutritional supplement (Med Pass) for Resident #9, Resident #25, Resident #31, and Resident #55. The facility failed to ensure the physician's orders for liquid nutritional supplements were transcribed into the MARs. These failures could place residents at risk for incomplete clinical records. Findings included: 1.Record review of a face sheet dated 03/17/2026 indicated Resident #55 was a [AGE] year-old female born 01/13/1934 and admitted on [DATE]. According to a face sheet dated 03/17/2026, she had diagnoses which included cerebral infarction, dementia, and dysphagia (difficulty swallowing). Record review of a MDS dated [DATE], noted Resident #55 had a BIM's score of 4 which indicated she had severely impaired cognition. Record review of progress notes dated 2/18/2026 revealed the dietitian recommended a nutritional supplement (Med Pass 2.0) to be administered in the morning for Resident #55 due to weight decrease, with instructions to provide 90ml with breakfast. T The dietitian's recommendation was not transcribed onto the February and March 2026 MAR or TAR. There was no documented evidence that the nutritional supplement was administered as recommended and ordered. Record review of the physician's orders dated 3/16/2026 revealed the physician's orders did not specify the amount of Med Pass 2.0 to be provided each morning with meals. During an interview on 3/17/2026 at 1:15p.m., LVN C stated she had been employed at the facility for approximately two weeks and acknowledged there was no documentation on the MAR or TAR to indicate the Med Pass supplement was administered or recorded. LVN C stated she was unable to confirm whether the supplement had been given to the resident. During an interview on 3/17/2026 at 1:20p.m., ADON confirmed the dietitian's recommendation was not reflected or documented on the MAR or TAR. ADON acknowledged the physician order did not specify the exact volume of the Med Pass supplement. She stated the supplement was provided on the resident's breakfast tray and that a communication form had been submitted to the dietary manager to ensure the Med-Pass supplement was included on the resident's breakfast tray. The ADON further acknowledged she was unable to confirm whether the resident had consumed the supplement. Duning an interview on 3/17/2026 at 1:25 p.m., the Dietary Manager stated the dietitian recommendations are communicated thorough the ADON and the physician, then forwarded to the dietary via a communication form. For Resident #55, she identified a 2/18/2026 communication form indicated Med Pass 90 ml daily with breakfast. She stated the supplement was measured and placed on the resident's breakfast tray; however, she was unable to confirm whether the resident consumed the supplement. During an interview on 3/17/2026 at 1:29 p.m., the DON further confirmed that the dietitian's recommendation was not reflected or documented on the MAR or TAR. The DON stated the supplement was provided on the resident's breakfast tray and that a communication form had been submitted to the dietary manager to ensure the Med-Pass supplement was included. The DON further stated that a recent weight review conducted a few days prior showed Resident #55 had gained weight, which was confirmed by a reweigh on 3/17/2026. The DON indicated the dietitian was scheduled to make rounds later that day and would reevaluate the resident in response to the recent weight gain. 2. A record review of a face sheet dated 03/17/2026 indicated Resident #9 was a [AGE] year-old female who initially admitted to the facility on [DATE]. She had diagnoses which included spastic quadriplegic cerebral palsy (severe form of cerebral palsy caused by brain damage and affects all four limbs, the trunk, and face resulting in extreme muscle stiffness, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	limited mobility, and causes speech, swallowing, and cognitive impairments), profound intellectual disability, and anorexia (a serious mental health eating disorder). A record review of a quarterly MDS dated [DATE] noted Resident #9 was coded for significant weight loss. The MDS included a BIMS assessment which noted Resident #9 was rarely/never understood. A record review of an undated care plan indicated Resident #9 had a potential for nutritional problem related to her diagnoses of cerebral palsy and anorexia. The care plan identified interventions to address the concern which included providing Resident #9 with assistance with all meals and serving diet and supplements as ordered. A record review of the March 2026 physician's orders revealed an order dated 11/18/2025 for Resident #9 to be given a Health Shake twice a day. A record review of the Dietary Supplement List indicated Resident #9 was on the list to receive a Health Shake at lunch daily. A record review of Resident #9's March 2026 MAR indicated there were no physician orders or instructions to give her a Health Shake. There was no documentation of Resident #9 receiving Health Shakes twice daily. 3. A record review of a face sheet dated 03/18/2026 indicated Resident #25 was an [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses which included dementia, dysphagia (difficulty swallowing), vitamin D deficiency, and debility (a state f severe weakness often characterized by frailty, exhaustion, and reduced functional capacity). A record review of a quarterly MDS dated [DATE] noted Resident #25 had a BIMS score of 4 indicating her cognition was severely compromised. The same MDS noted Resident #25 was coded for significant weight loss. A record review of the medical records indicated Resident #25 weighed 117 lbs. on 02/14/2026 and 108 lbs. on 03/04/2026, indicating a 7.5% (9 lbs.) weight loss. A record review of the progress notes dated 02/18/2026 indicated Resident #25 had a weight loss of 7.5% and a new order was received from the Nurse Practitioner to give Resident #25 90ml of Med Pass 2.0 daily with the morning medications. A record review of the February and March physician's orders revealed an order dated 02/19/2026 for Med Pass 2.0 in the morning for weight decrease. The order did not specify the amount of Med Pass to be given. A record review of Resident #25's 2026 February and March 2026 MARs revealed there were no instructions for Resident #25 to be given Med Pass 2.0. There was no documentation of Resident #25 having received Med Pass 2.0 with her morning medications or at any other time. 4. A record review of a face sheet dated 03/17/2026 indicated Resident #31 was a [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses which included dementia, schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms and a milder form of mania which is a condition with extreme changes in mood or emotions), bipolar disorder (a mental health condition that causes extreme mood swings), and chronic kidney disease. A record review of an admission MDS dated [DATE] noted Resident #31 had a BIMS score of 12 indicating her cognition was moderately compromised. A record review of the medical records indicated Resident #31 weighed 119 lbs. on 01/23/2026 and 110 lbs. on 02/02/2026, indicating a 7.5% (9 lbs.) weight loss. A record review of the progress notes dated 02/18/2026 indicated Resident #31 had a weight loss of 7.5% and a new order was received from the Nurse Practitioner to give Resident #31 90ml of Med Pass 2.0 daily with the morning medications. A record review of the February and March physician's orders revealed an order dated 02/19/2026 for Med Pass 2.0 in the morning for weight decrease. The order did not specify the amount of Med Pass to be given. A record review of Resident #31's 2026 February and March 2026 MARs revealed there were no instructions for Resident #31 to be given Med Pass 2.0 daily. There was no documentation of Resident #31 having received Med Pass 2.0 in February and March, 2026. During an interview on 03/18/2026 at 09:45 AM, the DM said the previous RD would document her recommendations in the residents' charts and send her recommendations to the ADON. She said the ADON would print the recommendations and give them to the doctor for approval. She said once the recommendations were approved, the ADON would put the physician's orders into the EHR and send the DM a dietary communication form. The DM said the kitchen provided the residents who ate breakfast in the dining room with Med Pass. She said her staff did not monitor the residents to see if they consumed the supplement. She said the dietary staff did (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not document they gave the Med Pass supplement. During an interview on 03/17/2026 at 02:35 PM, the ADON said she was responsible for transcribing dietary recommendations into the physician's orders and assigning the orders to the appropriate electronic health records such as the MAR and TAR. She said she failed to specify the amount of Med Pass 2.0 that was to be given to Resident #25 and Resident #31 in the physician's orders. She said the orders should have included the specific amount of Med Pass 2.0 to be given and the order should have been assigned to the MAR for administration. She said if the order was not on the MAR, then the Medication Aide or Nurse administering medications would not know to give it and could result in the residents not receiving supplemental nourishment and potentially having further weight loss. The ADON said dietary staff were responsible for providing the dietary supplements which included the liquid Med Pass supplement on the trays of those residents who ate in the dining room. She said the medication aides were responsible for administering the Med Pass supplement to the residents who did not always take their meals in the dining room. She said the dietary staff would put dietary supplements on the residents' meal trays, but they were not responsible for monitoring whether or not the residents consumed the supplements. She said nursing was responsible for monitoring residents for consumption of nutritional supplements. The ADON said there was no documentation of Residents #9, #25, and #31 having received or consumed the nutritional supplements that were ordered by the nurse practitioner or physician. A record review of the facility's policy dated 2001 and revised July 2016 and titled Medication and Treatment Orders indicated the following: Orders for medications and treatments will be consistent with principles of safe and effective writing. A record review of the facility's policy dated 2001 and revised November 2014 and titled Orders, Receiving and Transcribing indicated the following: 7.Commercial Dietary Supplements - When receiving orders for commercial dietary supplements, specify the type, amount, and frequency.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect and promote the rights of each resident for 6 of 11 residents (Residents #14, #35, and 4 other unidentified Residents) reviewed for dignity and respect. CNA-A and CNA-B were observed eating their personal lunch in the secure unit dining area where Resident #14, Resident #35, and four unidentified Residents were sitting and waiting for their lunch to be served. This failure could place residents who reside in the secured unit of the facility at risk of not being treated with courtesy, consideration, and respect. Findings included: A record review of a face sheet dated 03/18/2026 indicated Resident #14 was a [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses which included Alzheimer's dementia and major depressive disorder. An elopement risk assessment completed on 02/14/2025 indicated Resident #14 was an elopement risk and was assigned placement on the secured unit of the facility. An annual MDS dated [DATE] noted Resident #14 had a BIMS score of 4 indicating her cognition was severely compromised, was independently ambulatory, and was able to feed herself. A record review of a face sheet dated 03/17/2026 indicated Resident #35 was a [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses which included dementia, depression, and anxiety. An elopement risk assessment completed on 02/24/2025 indicated Resident #35 was an elopement risk and was assigned placement on the secured unit of the facility. An annual MDS dated [DATE] noted Resident #35 had a BIMS score of 14 indicating her cognition was intact, was independently ambulatory, and was able to feed herself. During an observation on 03/16/2026 at 01:00 PM, 6 (six) Residents (Residents #14, #35, and four other unidentified residents) were noted sitting in the dining room area of the secure unit. 2 CNAs (CNA-A and CNA-B) were noted eating their lunch in the area that opened to the dining room and visible to the residents. In response to being told lunch was about to be served, Resident #14 said, Good, I'm hungry. Resident #35 waved her hand toward CNA-A and CNA-B and said, Me too, they're not. During an interview with Resident #14 and Resident #35 on 03/16/2026 at 02:10 PM, Resident #14 said she thought it was rude to eat in front of someone who had not eaten. Resident #35 said, If I did that, my mother would have sent me outside and I wouldn't have gotten another bite of food. During an interview on 03/17/2026 at 11:30 AM, CNA-B said she ate lunch in the area that opened to the dining room so she could keep an eye on the residents in the dining room. She said lunch had not been served to the residents prior to eating her lunch in front of them. She said she heard Resident #14 and Resident #35 say they were hungry. CNA-B said the Residents should not have to watch staff eat when the Residents have nothing to eat. CNA-B said she did not consider how it may have looked to the Residents. CNA-B said the courteous and respectful thing would have been for her and CNA-A to have taken turns eating lunch so they could eat somewhere where the residents would not have seen them. During an interview on 03/17/2026 at 11:35 AM, CNA-A said she usually ate her lunch in the area of the dining room so she could see down the hall and watch for residents who were not in the dining area. She said lunch had not been served prior to eating her lunch in front of them. She said she heard Resident #14 and Resident #35 say they were hungry. She said the Residents should be treated with courtesy, consideration, and respect. She said she and CNA-B should not have been eating their lunch in front of the Residents who had not eaten and were hungry. During an interview on 03/17/2026 at 01:45 PM, the DON said she expected staff to be courteous and respectful of all the residents. She said the aides in the secured unit should not have been eating in view of the residents when the residents had not eaten their lunch and had nothing to eat. Record review of the facility's policy dated as revised August 2009 and titled Resident Rights indicated the following: Policy StatementEmployees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate MDS was completed for 1 of 5 residents (Resident #35) reviewed for MDS assessment accuracy. The facility failed to complete an MDS assessment that accurately reflected Resident #35's health status. This failure could place residents at risk of not receiving appropriate care and services to maintain the highest level of well-being. Findings included: A record review of a face sheet dated 03/17/2026 indicated Resident #35 was a [AGE] year-old female who re-admitted to the facility on [DATE] after being discharged from the hospital where she was treated for Influenza A, bilateral pneumonia, and sepsis (a life-threatening medical emergency caused by the body's response to an infection). A record review of an annual MDS with an assessment reference date (ARD) of 02/09/2026 indicated Resident #35 was coded for dehydration during the 7-day look-back period (the 7 days immediately preceding the ARD).Resident #35 had a BIMS score of 14 indicating her cognition was intact. A record review of the hospital emergency department notes dated 02/02/2026 indicated Resident #35 was admitted to the hospital with a primary diagnosis of Influenza A and sepsis secondary to bilateral pneumonia. The list of co-existing and historical diagnoses did not include a diagnosis of dehydration. A record review of the hospital Discharge summary dated [DATE] noted Resident #35's list of active diagnoses were as follows: Hospital Diagnoses: Active: Influenza A (virus causing seasonal flu), Bilateral pneumonia (infection of the lungs), GERD (gastroesophageal reflux disease - condition where acid flows back into the esophagus causing heartburn, chest pain, and potential damage to the tissue lining of the esophagus), Type 2 diabetes mellitus (chronic condition where the body resists insulin or fails to produce insulin causing high blood sugar levels), Hypertension, Respiratory failure (condition when the lungs cannot adequately supply oxygen to the blood or remove carbon dioxide from the blood), Sepsis (life-threatening emergency caused by the body's extreme reaction to an infection). A diagnosis of dehydration was not listed in the hospital's list of active diagnoses. A record review of the PCP's notes dated 02/05/2026 indicated the PCP performed an in-facility follow-up visit on 02/05/2026 and addressed the diagnoses of hypertension, Influenza A, pneumonia, GERD, and Type 2 diabetes. The physician documented the following visit summary: Assessment: 1. Influenza A/bilateral pneumonia/acute respiratory failure with hypoxemia (low level of oxygen in the blood)/sepsis syndrome: Completing antibiotics. Feeling better. 2. Status post fall: No documented injury 3. Debility: Seems to be close to baseline 4. Diabetes: Sugars are doing well 5. Gastroesophageal reflux disease: Asymptomatic.The PCP's progress notes and history and physical did not include a diagnosis of nor treatment for dehydration. A record review of the hospital and the facility records did not reveal any documentation of intake and output, documentation of clinical signs of dehydration, nor documentation of elevated laboratory values indicative of dehydration. During an interview on 03/18/2026 at 11:15 AM, the MDS Coordinator said she was responsible for coding the MDS assessments. She said she coded Resident #35's MDS assessment for dehydration because she noted Resident #35 received fluids while she was in the hospital and had fever. She said she thought that was sufficient evidence for a dehydration diagnosis. The MDS Coordinator said the facility used the MDS RAI 3.0 Manual as the facility's guidelines for coding the MDS. During an interview with the DON on 03/18/2026 at 11:40 AM, she said her expectations were for the MDS assessments to be coded correctly. A record review of the MDS RAI 3.0 Manual dated October 1, 2025 indicated the following: J1550: Problem Conditions (cont.) Dehydrated: Check this item if the resident presents with two or more of the following potential indicators for dehydration: 1. Resident takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups). Note: The recommended intake level has been changed from 2,500 ml to 1,500 ml to reflect current practice standards. 2. Resident has one or more potential clinical signs (indicators) of dehydration, including but not limited to dry mucous membranes, poor (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	03/18/2026

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 - Few	skin turgor (the skin's elasticity representing the ability to change shape and snap back quickly, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, or abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, blood urea nitrogen, or urine specific gravity). 3. Resident's fluid loss exceeds the amount of fluids they take in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).

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	03/18/2026

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an MDS was electronically transmitted to the CMS System within 14 days after completion of the assessment for 5 of 24 residents reviewed for assessments. (Residents # 15, 20, 41,42 and 62) The facility did not transmit an admission MDS assessment within 14 days into the CMS system as required. This failure could place residents at risk of not having records completed and submitted in a timely manner as required. Findings include: A review of Resident #15's face sheet dated 03/18/2026 reflected a [AGE] year-old female. She was admitted to the facility on [DATE]. Resident #15 was discharged on 12/4/2025 which reflected that the MDS record was over 120 days old. A review of Resident #20's face sheet dated 03/18/2026 reflected a [AGE] year-old male. He was admitted to the facility on [DATE]. Resident #20 was discharged on 11/17/2025 which reflected that the MDS record was over 120 days old. Review of the electronic MDS tab for Resident #20 revealed the admission MDS was dated 03/18/2026. The admission MDS status reflected incomplete, assessment was never added to a batch, meaning the assessment had not been electronically transmitted to CMS. A review of Resident #41's face sheet dated 03/18/2026 reflected a [AGE] year-old female. She was admitted to the facility on [DATE]. Resident #41 was discharged on 9/26/2025 which reflected that the MDS record was over 120 days old. Review of the electronic MDS tab for Resident #41 revealed the admission MDS was dated 03/18/2026. The admission MDS status reflected incomplete, assessment was never added to a batch, meaning the assessment had not been electronically transmitted to CMS. A review of Resident #42's face sheet dated 03/18/2026 reflected a [AGE] year-old male. He was admitted to the facility on [DATE]. Resident #42 was discharged on 10/22/2025 which reflected that the MDS record was over 120 days old. Review of the electronic MDS tab for Resident #42 revealed the admission MDS was dated 03/18/2026. The admission MDS status reflected incomplete, assessment was never added to a batch, meaning the assessment had not been electronically transmitted to CMS. A review of Resident #62's face sheet dated 03/18/2026 reflected a [AGE] year-old male. He was admitted to the facility on [DATE]. Resident #42 was discharged on 10/7/2025 which reflected that the MDS record was over 120 days old. Review of the electronic MDS tab for Resident #62 revealed the admission MDS was dated 03/18/2026. The admission MDS status reflected incomplete, assessment was never added to a batch, meaning the assessment had not been electronically transmitted to CMS. An interview with the MDS Nurse on 3/17/2026 at 3:12 PM revealed she was responsible for ensuring the MDS was completed and transmitted. The MDS Nurse revealed the Admissions MDS should have been completed and transmitted by the 14th day. The MDS nurse revealed the admission MDS for Residents #15, 20, 41, 42 and 62 had not been completed and transmitted. She stated the reason the MDS had not been completed and transmitted was that she just did not realize that these 5 residents' MDS had not been transmitted, but it was her responsibility to transmit all MDS to CMS. When asked for a policy she said, the policy they use is CMS's RAI Assessment Transmission refers to the electric transmission by state and federal guidelines. An interview with the DON on 03/17/2026 at 3:30 PM revealed she was not aware Residents # 15, 20, 41, 42 and 62's MDSs had not been completed and transmitted. She said it was the responsibility of the MDS nurse to complete and transmit the MDS, and she was indirectly responsible also to make sure that all MDSs are being transmitted in a timely manner. Record Review of the CMS RAI Version 3.0 Manual, dated October 2023, indicated in Chapter 2, page 2-39 09. Discharge Assessment-Return Not Anticipated (A0310F), Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days). The RAI Manual further revealed the discharge assessment-return not anticipated must be submitted within 14 days after the MDS completion date (Z0500B +14 calendar days) .