

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675453	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Collinwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 S Rigsbee Rd Plano, TX 75074	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 4 residents (Resident #7) reviewed for ADL care provided to dependent residents. Based on interviews, and record review the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 4 residents (Resident #7) reviewed for ADL care provided to dependent residents. The facility failed to ensure Resident #7 received any of her scheduled showers based on records reviewed for July 2025. This failure could place residents at risk of not receiving necessary services to maintain good personal hygiene, skin integrity, or decreased self- esteem. Findings Included: Record review of Resident #7's face sheet, dated 08/06/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident had a diagnosis which included rash and other non-specific skin eruption. Record review of Resident #7's Comprehensive MDS Assessment, dated 07/29/25, reflected the resident was unable to complete the interview for a BIMS score. The Comprehensive MDS Assessment reflected the resident required extensive assistance with ADL care. Record review of Resident #7's Comprehensive Care Plan dated 06/10/25, reflected the resident refused showers and had skin tears in multiple areas. Interventions included encouraging showers and keeping the resident's skin clean and dry. Record review of Resident #7's Comprehensive Care Plan, dated 07/16/25, reflected the resident was incontinent of urine and bowel. One of the approaches was for hygiene as needed after every incontinent episode to maintain dignity. Record review of Resident #7's Bath/Shower Sheets for the month of July 2025, reflected the resident had one shower sheet on file dated 07/24/25, which indicated the resident had refused a shower. Record review of Resident #7's progress notes for the month of July 2025, reflected no notes indicating the resident refusing showers nor were there any notes indicating any attempts to contact the resident's responsible party regarding the resident's refusal to take a shower. In an interview on 08/05/2025 at 10:29 AM, Resident #7 was asked if she was receiving her showers and she stated she wanted a shower. The resident was asked if she refused showers or received bed baths but did not respond. In an interview on 08/06/25 at 10:45 AM the ADON stated the CNAs were to complete a shower sheet for all residents, whether they received a shower or refused a shower. She stated if a resident refused a shower, the CNA was to notify the hall nurse and advise them of the refusal so the nurse could attempt to persuade the resident to shower, and if they were unsuccessful, the nurse was to contact the responsible party to see if they could convince the resident to take a shower. She was advised that Resident #7 had only 1 shower sheet on file for the month of July 2025, which indicated the resident had refused a shower. She stated the resident was scheduled to receive her showers during the 2 PM to 10 PM shift on Tuesday, Thursday, and Saturday. She stated the resident had a history of refusing showers and it was care planned. She stated a shower sheet indicating a refusal to shower should have been completed each time she was scheduled for a shower. She stated not providing the resident her scheduled showers could result in skin break down. In an interview on 08/06/25 at 1:32 PM with Resident #7, the ADON, and the Receptionist, Resident was asked if she wanted a shower in Spanish by the Receptionist and she said yes and she was taken to get a shower. In an interview on 08/06/25 at 2:20 PM CNA A, stated she had been at the facility for 9 months. She stated most of the times she provided Resident #7 bed baths. She stated they were supposed to complete a shower sheet for all residents, even if they refused a shower. She stated she did provide the residents bed baths but did not complete the shower sheets for the resident. She stated she did not always work the 500- hall and only worked with the resident a few times. She stated they were to document the refusal and notify the hall nurse. She stated she did notify the hall nurse but failed to document it. She stated if the resident did not receive their scheduled showers, she could get sick. In an interview on 08/06/25 at 2:29 PM, LVN D stated he had been at the facility more than 4 years. He stated he was the nurse for the 500-hall. She stated Resident #7 sometimes refused showers, so they tried to give her bed baths. He stated CNAs were required to complete shower sheets for the resident, whether she received a shower or refused. He stated if the resident refused a shower, the CNA was to notify him, and he would attempt to persuade the resident and notify family to assist. He was made aware that Resident #7 only had one shower sheet in the binder, and he stated she should have had a shower sheet for all scheduled days. He stated the resident was scheduled for showers on Tuesday</p>		