STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195394	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor Nursing & Rehabilitation Home	307 Foster Street Rayville, LA 71269

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 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. Based on observations and interviews, the facility failed to: 1.) ensure proper hair restraint for kitchen staff and 2.) store food and discard expired items in accordance with professional standards for food service safety. This deficient practice had the potential to effect 57 residents that received meals prepared in the facility's kitchen. Findings:Review of the undated facility's date marking for food safety policy revealed in part, the following:-The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded.-The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared.-The marking system shall consist of a label and the day/date of opening.-The discard day or date may not exceed the manufacturer's use by date, or 48 hours, whichever is earliest.Review of the undated facility's dietary employee personal hygiene policy revealed in part, the following:-All dietary staff must wear hair restraints (e.g. hairnet, hat and/or beard restraint) to prevent hair from contacting foodOn 01/06/2026 at 7:55 a.m. during an initial kitchen tour of the revealed the following:The dry storage area contained the following items that had been opened and not labeled with an open date: a (22 quart) storage container was open and not covered with a hard white substance on the bottom (identified as sugar by the S5Dietary Manager), within this storage container - an opened five pound bag of cake mix with no open date, an open five pound bag of gingerbread mix not labeled with an open date, an opened five pound bag of cornmeal with no open date, two open bags identified by the S5Dietary Manager as brownie mix not labeled with an open date, one package of peach drink mix opened and not labeled with an open date, one (32) ounce package of cheese sauce powder mix opened and not labeled and one (17) ounce package of mouse mix, opened and not labeled.The walk-in refrigerator contained three individual containers of whole milk dated December 23, three individual containers of whole milk dated December 28 and two milk crates containing individual containers of reduced fat milk dated January 4.The walk- in freezer contained: four loaves of bread that were identified by S5Dietary Manger with no identifying information or dates, one bag of what was identified as pieces of sausage by the S5Dietary Manager with no open date, one unlabeled bag of white circular objects approximately 2 inches in diameter identified by S5Dietary Manger as cookies with no identifying information or dates.Observation of S6Cook on 01/05/2026 at 8:01 a.m. revealed S6Cook was not wearing a hairnet or any type of hair covering while working in the kitchen. During an interview at this time, S6Cook confirmed he/she forgot his/her hair covering.Observation and interview with S6Cook on 01/05/2026 at 11:25 a.m. revealed S6Cook was not wearing a beard covering and explained the facility did not have any beard coverings.During an interview on 01/06/2026 at 8:15 a.m., S5Dietary Manager confirmed the above items should have been labeled with open dates according to the facility policy after being opened and the individual milk containers from December 23 and December 28 should have not been in the walk- in cooler.During an interview on 01/05/2026 at 11:27 a.m., S5Dietary Manager confirmed S6Cook should be wearing a beard net and the facility did not have any available. During an interview on 01/07/2026 at 2:37 p.m., S1Administrator confirmed staff should wear hair nets and beard coverings according to the facility policy.During an interview on 01/07/2026 at 2:39 p.m., S1Administrator confirmed items in the kitchen should be labeled and dated with open dates and kitchen staff should be following facility policies.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations and interviews, the facility failed to ensure garbage had been disposed of properly. The facility census was 58 residents and the deficient practice had the potential to affect all residents.Findings:Review of the facility's Disposal of Garbage and Refuse policy undated revealed in part,:-Garbage and refuse containers shall be durable, cleanable, and free from crack or leaks and covered when not in use.-Refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids, doors, or covers. Containers and dumpsters shall be kept covered when not being loaded. Surrounding area shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized.Observation during the initial tour of the kitchen on 01/05/2026 at 7:55 a.m. revealed only 1 trash can in the kitchen, that trash can was covered and did not have a foot pedal. Further observation revealed the dining area attached to the kitchen and separated from the dishwashing area by an open window contained an uncovered trash can.Observation of the outside dumpsters on 01/06/2026 at 8:37 a.m. revealed one dumpster with three large and long rusted horizontal cracks on the bottom front of the dumpster that made items inside the dumpster visible. The same dumpster also had a corner with a large separation of the metal that made a white trash bag and items in the dumpster visible through the separation. During an interview on 01/05/2026 at 7:55 a.m., S5Dietary Manger confirmed the only trash can in the kitchen did not have a foot pedal and the trash can in the kitchen/dining area separated by the dishwashing area open window was uncovered.During an interview with S1Administrator on 01/07/2026 at 2:49 p.m., S1Administrator confirmed all trash should be discarded and contained appropriately.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation and interviews the facility failed to maintain all kitchen equipment in safe operating condition as evidenced by the three torn door seals on three individual refrigerator doors of one refrigerator, one broken toaster, one toaster missing a crumb catcher, two of the three toasters were stored and full of bread crumbs, four full size pans covered in a black hardened substance, four half pans covered in a black hardened substance, two ovens covered with hardened black substance, one oven with four silver pieces of material approximately the size of a golf ball and a microwave with dark splattered substance on top and sides.Findings:Observation of the kitchen during the initial tour on 01/05/2026 at 7:55 a.m. revealed three torn door seals on three individual refrigerator doors of one refrigerator, one broken toaster, one toaster missing a crumb catcher, two of the three toasters were stored and full of bread crumbs, four full size pans covered in a black hardened substance, four half pans covered in a black hardened substance, two ovens covered with hardened black substance, one oven with four silver pieces of material approximately the size of a golf ball and a microwave with dark splattered substance on top and sides. During an interview on 01/05/2026 at 8:35 a.m. S5Dietary Manger confirmed the kitchen equipment should be working and clean. During an interview on 01/07/2026 at 3:00 p.m. S1Administrator confirmed the equipment in the kitchen should be in good repair and clean.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, the facility failed to maintain a safe, clean, comfortable and homelike environment for 2 (#39 and #46) of 2 sampled residents reviewed for environmental concerns.The facility failed to ensure:1. Resident #39's air conditioning/heating unit was kept clean;2. Resident #46's sink faucet remained in good repair. Findings:Resident #39On 01/05/2026 at 9:40 a.m. and 01/06/2026 at 8:40 a.m., a black substance was observed on the vent of Resident #39's air conditioner/heating unit.On 01/06/2026 at 9:20 a.m., an observation conducted with S1Administrator of Resident #39's air conditioning/heating unit confirmed that the vent had a black substance present and the vent needed to be cleaned. Resident #46On 01/05/2026 at 10:15 a.m. and 01/06/2026 at 8:45 a.m., observations made of Resident #46's bathroom sink revealed the faucet to be corroded and cracked creating a gap in the faucet underneath the cold water tap.On 01/06/2026 at 9:22 a.m., an observation conducted with S1Administrator confirmed Resident #46's sink faucet was damaged and cracked from corrosion and needed to be replaced.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to report an injury of unknown origin to the State Agency no later than 24 hours in accordance with State law for 1 (#55) of 1 resident reviewed for abuse.Findings: Review of the incident and accident policy and procedure with review/revised date of 07/01/2025 revealed in part:It is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Policy explanation: The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. Alert risk management and/or administration of occurrence's that could result in claims or further reporting requirements. Meeting regulatory requirements for analysis and reporting of incidents and accidents. Compliance Guidelines: 2. Licensed staff will report incidents/accidents and assist with completion of any investigative information to identify root causes. 4. Incidents that rise to the level of abuse, misappropriation, or neglect will be managed and reported according to the facility abuse prevention policy. 5. The following incidents/accidents require an incident/accident report but are not limited to: alleged abuse, elopement, entrapment, equipment malfunction, falls, observed accidents/incidents, resident to resident altercations, resident injuries due to staff handling, self-inflicted injuries and unobserved injuries. 12. The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. 13. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions. 15. If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the DON and/or Administrator. Review of the policy and procedure for Abuse, Neglect, and Exploitation with a revised date of 07/01/2025 revealed in part: Policy:It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.Policy Explanation and Compliance guidelines:1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.b. Establish policies and procedures to investigate any such allegations; and c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, and dementia management and resident abuse prevention.2. The facility will provide ongoing oversight and supervision of staff in order to ensure that its policies are implemented as written.The components of the facility abuse prohibition plan are discussed herein:II Employee Training C. Training topics will include:3. Recognizing signs of abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown origin. 4. Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown origin. IV. Identification of Abuse, Neglect, and ExploitationA. The facility will have a written procedure to assist staff in identifying the different types of abuse- mental, verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations.B. Possible indicators of abuse include, but are not limited to:3. Physical injury of resident of unknown sourceVII. Reporting/ResponseA. The facility will have written procedure that include:1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within the specified timeframes.a. Immediately, but not later than 2 hours after the allegation is made, if the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	events that cause the allegation involve abuse or result in serious bodily injury, orb. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury,B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident as required by state agencies. Record review revealed Resident #55 had diagnoses of chronic diastolic congestive heart failure, atrial fibrillation, dementia, cognitive communication deficit, rheumatoid arthritis, and history of malignant neoplasm of the right breast.Review of the quarterly MDS dated [DATE] revealed Resident #55 had a BIMS of 8 indicating moderate cognitive impairment. Further review of the MDS revealed Resident #55 was dependent on staff for all ADLs and required substantial/maximum assistance with rolling in bed and was dependent for transfers. On 01/05/2026 at 9:15 a.m., an observation of Resident #55 revealed she was sitting up in bed. Further observation revealed a large bruise to the right shoulder/armpit area. Interview with Resident #55 at that time revealed she was unable to state how the bruise to the right shoulder/armpit area occurred.On 01/06/2026 at 1:27 p.m., an interview with S7CNA during an observation of changing resident #55's brief revealed she stated the bruise to the right shoulder/armpit had been there for several weeks. S7CNA further stated she was not aware of a specific reason for the bruising.Review of Resident #55's current medications in part revealed an order for Eliquis 2.5 mg twice a day by mouth.Review of the nurses' note dated 12/04/2025 by S4Treatment Nurse revealed she was notified by the hospice CNA that a new large bruise was identified under the right armpit. S4Treatment Nurse performed a skin assessment of the area. The bruise was 7 cm by 3 cm with a light purple tint. Resident was asked if she had any pain and resident responded, Well, I didn't even know it was there. But it doesn't hurt. When asked if resident remembers how it was acquired, resident stated, No, but you know how fragile my skin is. S4Treatment nurse noted that the sling lift was used Monday to transfer the resident to the Geri chair. S4Treatment nurse educated primary CNAs of proper placement of lift and lift techniques.On 01/07/2026 at 8:30 a.m., an interview with S8LPN regarding the bruise to Resident #55 right shoulder/armpit area revealed the resident was gotten up a while back with the lift and they believe the lift pad caused the bruise. S8LPN further said it was reported to S2DON and S1Administrator. On 01/07/2026 at 8:40 a.m., an interview with S2DON revealed she was aware of the bruise on Resident #55's right shoulder/armpit but did not remember how it happened and was not sure if an incident report with an investigation was completed when the bruise was identified on 12/04/2025. S2DON further stated the only information they had regarding the bruise to the right shoulder/armpit area were the notes in the computer and then S2DON produced a written statement she had completed. Review of the written statement by S2DON dated 12/04/2025 revealed:I was notified by the wound care nurse that a bruise was noted to resident right shoulder/armpit area. Upon exam, active range of motion/passive range of motion were within normal limits and resident denies pain. When I asked her what happened, the resident states I didn't even know it was there. Resident has a history of easy bruising and skin tears. The lift used to maneuver resident is the sling lift which does not go under the arms to cause the bruising. Sometimes resident is assisted by placing her hand under her arm to assist her sitting up or repositioning. CNAs were verbally spoken to by wound care nurse on using draw sheets and proper body mechanics for positioning patient and that she is a very easy bruiser. During an interview on 01/07/2026 at 10:39 a.m., S2DON confirmed the facility did not report the injury of unknown origin to the State Agency as required regarding the large bruise to Resident #55's right shoulder/armpit area when it was identified on 12/04/2025. During an interview on 01/07/2026 at 1:15 p.m., S1Administrator confirmed they did not report the bruise to the right shoulder/armpit area on Resident #55 when it was discovered to the State Agency as an injury of unknown origin when it was discovered.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to investigate an injury of unknown origin for 1 (#55) of 1 resident reviewed for abuse. Findings:Review of the incident and accident policy and procedure with review/revised date of 07/01/2025 revealed in part:It is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Policy explanation: The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. Alert risk management and/or administration of occurrence's that could result in claims or further reporting requirements. Meeting regulatory requirements for analysis and reporting of incidents and accidents. Compliance Guidelines: 2. Licensed staff will report incidents/accidents and assist with completion of any investigative information to identify root causes. 4. Incidents that rise to the level of abuse, misappropriation, or neglect will be managed and reported according to the facility abuse prevention policy. 5. The following incidents/accidents require an incident/accident report but are not limited to: alleged abuse, elopement, entrapment, equipment malfunction, falls, observed accidents/incidents, resident to resident altercations, resident injuries due to staff handling, self-inflicted injuries and unobserved injuries. 12. The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. 13. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions. 15. If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the DON and/or Administrator. Review of the policy and procedure for Abuse, Neglect, and Exploitation with a revised date of 07/01/2025 revealed in part: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.Policy Explanation and Compliance guidelines:1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.b. Establish policies and procedures to investigate any such allegations; and c. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, and dementia management and resident abuse prevention.2. The facility will provide ongoing oversight and supervision of staff in order to ensure that its policies are implemented as written.The components of the facility abuse prohibition plan are discussed herein: II Employee Training C. Training topics will include: 3. Recognizing signs of abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown origin. 4. Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown origin. IV. Identification of Abuse, Neglect, and ExploitationA. The facility will have a written procedure to assist staff in identifying the different types of abuse-mental, verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations.B. Possible indicators of abuse include, but are not limited to:3. Physical injury of resident of unknown sourceV. Investigation of Alleged Abuse, Neglect and ExploitationA. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.B. Written procedures for investigating include:1. Identifying staff responsible for the investigation.3. Investigating different types of alleged violations.4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	might have knowledge of the allegations.5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment had occurred, the extent, and cause, and6. Providing complete and thorough documentation of the investigation. Record review revealed Resident #55 had diagnoses of chronic diastolic congestive heart failure, atrial fibrillation, dementia, cognitive communication deficit, rheumatoid arthritis, and history of malignant neoplasm of the right breast.Review of the quarterly MDS dated [DATE] revealed Resident #55 had a BIMS of 8 indicating moderate cognitive impairment. Further review of the MDS revealed Resident #55 was dependent on staff for all ADLs and required substantial/maximum assistance with rolling in bed and was dependent for transfers. Review of Resident #55's current medications in part revealed an order for Eliquis 2.5 mg twice a day by mouth.On 01/05/2026 at 9:15 a.m., an observation of Resident #55 revealed she was sitting up in bed. Further observation revealed a large bruise to the right shoulder/armpit area. Interview with Resident #55 at that time revealed she was unable to state how the bruise to the right shoulder/armpit area occurred.On 01/06/2026 at 1:27 p.m., an interview with S7CNA during an observation of changing resident #55's brief revealed she stated the bruise to the right shoulder/armpit had been there for several weeks. S7CNA further stated she was not aware of a specific reason for the bruising.On 01/07/2026 at 8:30 a.m., an interview with S8LPN regarding the bruise to Resident #55 right shoulder/armpit area revealed the resident was gotten up a while back with the lift and they believe the lift pad caused the bruise. S8LPN further said it was reported to S2DON and S1Administrator. On 01/07/2026 at 8:40 a.m., an interview with S2DON revealed she was aware of the bruise on Resident #55's right shoulder/armpit but did not remember how it happened and was not sure if an incident report with an investigation was completed when the bruise was identified on 12/04/2025. S2DON further stated the only information they had regarding the bruise to the right shoulder/armpit area were the notes in the computer and then S2DON produced a written statement she had completed.Review of the nurses' note dated 12/04/2025 by S4Treatment Nurse revealed she was notified by the hospice CNA that a new large bruise was identified under the right armpit. S4Treatment Nurse performed a skin assessment of the area. The bruise was 7 cm by 3 cm with a light purple tint. Resident was asked if she had any pain and resident responded, Well, I didn't even know it was there. But it doesn't hurt. When asked if resident remembers how it was acquired, resident stated, No, but you know how fragile my skin is. S4Treatment nurse noted that the sling lift was used Monday to transfer the resident to the Geri chair. S4Treatment nurse educated primary CNAs of proper placement of lift and lift techniques. Review of the written statement by S2DON dated 12/04/2025 revealed:I was notified by the wound care nurse that a bruise was noted to resident right shoulder/armpit area. Upon exam, active range of motion/passive range of motion were within normal limits and resident denies pain. When I asked her what happened, the resident states I didn't even know it was there. Resident has a history of easy bruising and skin tears. The lift used to maneuver resident is the sling lift which does not go under the arms to cause the bruising. Sometimes resident is assisted by placing her hand under her arm to assist her sitting up or repositioning. CNAs were verbally spoken to by wound care nurse on using draw sheets and proper body mechanics for positioning patient and that she is a very easy bruiser. During an interview on 01/07/2026 at 10:39 a.m., S2DON confirmed the facility did not complete a full investigation regarding the large bruise to Resident #55's right shoulder/armpit area which was an injury of unknown origin when it was identified on 12/04/2025. During an interview on 01/07/2026 at 1:15 p.m., S1Administrator confirmed they did not investigate the cause of the bruise to the right shoulder/armpit area which was an injury of unknown origin on Resident #55 when it was discovered on 12/04/2025.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure an infection prevention and control program was maintained to help prevent the development and transmission of communicable diseases and infections for 4 (#5, #7, #17, #20) of 4 residents reviewed for infection control. The facility failed to ensure:1. EBP precautions were followed during catheter care (#5);2. Infections control procedures followed during wound care (#7);3. A syringe was stored properly after staff provided PEG care (#20); and4. An EBP sign was placed on a resident's door (#17)Findings: Review of the facility's Infection Prevention and Control Program policy revised on 05/01/2025 revealed in part: Policy Explanation and Compliance Guidelines: 4. Standard Precautions: e. Environmental cleaning and disinfection shall be performed according to facility policy. All staff have responsibilities related to the cleanliness of the facility, and are to report problems outside of their scope to the appropriate department. 10. Equipment Protocol: a. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment. Review of the Flushing a Feeding Tube policy dated 05/01/2025 revealed the plunger should have been removed from the barrel of the syringe and staff were to wash the equipment in warm water and place into the labeled bag. Review of the policy and procedure titled Transmission Based Precautions with a reviewed/revised date of 06/01/2025 revealed in part: Policy: It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens modes of transmission. Initiation of Transmission-Based Precautions (Isolation Precautions). e. Signage that includes instructions for use of specific PPE will be placed in a conspicuous location outside the resident's room, wing, or facility wide. Additionally, either the CDC category of transmission-based precautions or instructions to see the nurse before entering will be included in the signage. f. The facility will have PPE readily available near the entrance of the resident's room and will don appropriate PPE before or upon entry into the environment of a resident on transmission-based precautions. Resident #17 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195394	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor Nursing & Rehabilitation Home	307 Foster Street Rayville, LA 71269

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed Resident #17 had an admission date of 12/30/2025 with diagnoses which included venous insufficiency and type 2 diabetes. Review of the January 2026 physician orders revealed Resident #17 had 3 pressure ulcers and 3 venous ulcers. On 01/06/2026 at 9:05a.m., an interview with S4Treatment Nurse confirmed Resident #17 had 3 pressure ulcers and 3 venous ulcers. On 01/06/2026 at 8:30 a.m., an observation Resident #17's door revealed there was no signage indicating transmission based precautions were to be implemented. On 01/02/2026 at 10:45 a.m., an interview with S2DON confirmed the proper signage should have been placed on Resident #17's door. Resident #20 Review of the medical record revealed Resident #20 was admitted on [DATE] with diagnoses which included dysphagia. On 01/06/2026 at 9:50 a.m., a bolus feeding by S3LPN was observed. After completion of the bolus feeding, S3LPN left the piston syringes assembled and did not rinse them with warm water. There was water in the tip of one syringe and tube feeding liquid remained in the tip of the second syringe. On 01/06/2026 at 10:45 a.m., an interview with S2DON confirmed the syringes should have been disassembled, rinsed, and allowed to dry. Resident #7 Review of Resident #7's medical record revealed an admission date of 01/23/2019 with diagnoses that included Stage 3 pressure ulcer to left dorsum 1st digit, chronic peripheral venous insufficiency, diabetes mellitus, and generalized muscle wasting and atrophy. Review of Resident #7's medical record revealed a physician order dated 11/21/2025: cleanse stage 3 PU to left medial distal 1st digit with wound cleanser, pat dry, apply Hydrogel AG, cover with bordered foam, and secure with tape as needed for soilage or dislodgement until healed. Review of Resident #7's medical record revealed a care plan for Resident #7's Stage 3 pressure ulcer to left medial distal 1st digit. Further review revealed an intervention to provide wound care treatment as ordered. On 01/06/2026 at 8:10 a.m., an observation of Resident #7's wound care revealed S4Treatment Nurse failed to perform the following: -sanitize the resident's over bed table prior to placing the wound care supplies on the table. -place a protective barrier between the small red biohazard bag and the resident's over bed table. -sanitize the small pen light after the pen light made contact with Resident #7's wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-sanitize the resident's over bed table after removal of the small red biohazard bag. On 01/06/2026 at 8:30 a.m., an interview with S4Treatment Nurse reported she had completed wound care. S4Treatment confirmed she had failed to properly sanitize her pen light, the resident's over bed table prior to and after wound care, and to place a protective barrier under the small red biohazard bag that was placed on the resident's over bed table. On 01/07/2026 at 3:20 a.m., S2DON was informed of the above infection control concerns identified during wound care for Resident #7. S2DON acknowledged S4Treatment Nurse failed to follow proper infection control procedures. Resident #5 Review of the record for resident #5 revealed diagnoses in part of: resistant to multiple antibiotics, urinary tract infection, and urinary retention with foley catheter placement. Review of the current physician orders in part revealed to cleanse the foley catheter with soap and water every shift, Enhanced Barrier Precautions every shift. Review of the care plan revealed: The resident is on enhanced barrier precautions (EBP) related to foley catheter. Approaches - direct care staff to utilize gowns and gloves for all personal care. On 01/07/2026 at 9:59 a.m., observation of the outside of resident #5's door revealed signage indicating enhanced barrier precautions. Further observation revealed there was PPE located on the wall next to the resident's door. Observation of catheter care performed by S7CNA revealed she did not utilize a gown to provide catheter care. On 01/07/2026 at 10:15 a.m., an interview with S7CNA confirmed there was signage on Resident #5's door indicating the resident was on enhanced barrier precautions and further confirmed that she should have worn a gown while providing catheter care.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure residents have the right to be free from chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. The facility failed to ensure a PRN order for a psychotropic medication was limited to 14 days for 1 (#2) of 5 residents reviewed for unnecessary medications.Findings:Review of the medical record for Resident #2 revealed a re-admission date of 08/31/2020 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction, hypertension, diabetes, late syphilis, and unspecified dementia (unspecified severity) with other behavioral.Review of the most recent physician's orders dated 10/03/2024 revealed an order for Oxazepam oral capsule 15 milligrams PRN every 24 hours as needed for insomnia to be given at night with no discontinue date. Review of the Pharmaceutical Consultant Report dated 10/13/2025 revealed the following recommendation for Oxazepam 15 milligrams every night PRN: a PRN psychotropic is limited to 14 days and required the prescriber to evaluate the resident prior to extending the order. If extending the order, document the rationale for the extended time period in the medical record and indicate a specific duration. Further review of the report revealed the physician did not indicate a specific duration for the PRN order. During an interview on 01/07/2026 at 2:09 p.m., S2DON confirmed the physician did not indicate a specific duration for the PRN order of a psychotropic medication.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to update the plan of care for 1 (#55) of 1 resident reviewed for an injury of unknown origin.Findings: On 01/05/2026 at 9:15 a.m., an observation of resident #55 revealed she was sitting up in bed. Further observation revealed a large bruise to the right shoulder/armpit area. Interview with resident #55 at that time revealed she was unable to state how the bruise to the right shoulder/armpit area occurred.On 01/06/2026 at 1:27 p.m., an interview with S7CNA during an observation of changing resident #55's brief revealed she stated the bruise to the right shoulder/armpit had been there for several weeks.On 01/07/2026 record review revealed resident #55 had diagnoses of chronic diastolic congestive heart failure, atrial fibrillation, Dementia, Cognitive Communication Deficit, Rheumatoid Arthritis, and history of malignant neoplasm of the right breast.Review of the quarterly MDS dated [DATE] revealed resident #55 had a BIMS of 8 indicating moderate cognitive impairment.Further review of the MDS revealed resident #55 was dependent on staff for all ADLs and required substantial/maximum assistance with rolling in bed.Review of resident #55's current medications revealed an order for Eliquis 2.5mg twice a day by mouth.Review of the nurses' note dated 12/04/2025 by S4Treatment Nurse revealed she was notified by the hospice CNA that a new large bruise was identified under the right armpit. S4Treatment Nurse performed a skin assessment of the area. The bruise was 7cm by 3cm with a light purple tint.Review of the plan of care revealed the resident was on anticoagulant therapy.Approaches to the plan of care revealed- daily skin inspections and report abnormalities to the nurse. Further review of the approaches revealed to monitor/document/report as needed adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB, loss of appetite, sudden changes in mental status, significant or sudden changes in v/s.On 01/07/2026 at 1:19 p.m., a review of the current plan of care revealed it was not updated when the bruise to the right shoulder/armpit was identified. On 01/07/2025 at 1:30 p.m., an interview with S2DON agreed the plan of care was not updated when the bruise appeared to resident #55's right shoulder/armpit area.