STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER Colfax Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 366 Webb Smith Drive Colfax, LA 71417	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44844 Based on interview and record review, the facility failed to ensure a resident's right to be free from resident to resident physical abuse, for 1 (#4) of 5 (#1, #2, #3, #4, and #5) sampled residents. The facility failed to: 1. Ensure S3 CNA and S4 CNA reported Resident #5's aggressive behaviors, and increased agitation to the nurse; and 2. Ensure Resident #4 was not physically abused by Resident #5. Findings: Review of the facility's undated policy titled Seven Step Abuse Prevention Policy, revealed in part .It is the policy of the facility to have a seven (7) step Plan to assist in preventing abuse, neglect, misappropriation of resident's property, and to keep residents as safe as possible. The policy consists of seven (7) areas: Screening, Training, Prevention, Identification, Investigation, Protection, and Reporting/Response. Physical abuse defined: the willful infliction of injury, unreasonable confinement (involuntary seclusion), intimidation, or punishment of a person with resulting physical harm or pain or mental anguish. Examples include hitting, slapping, pinching, kicking, or controlling behavior through corporal punishment. Review of a facility Incident Report documented by S1 Administrator, and dated 09/25/2024, revealed in part . At 5:59 p.m. on 09/25/24, Resident #5 entered his room, and Resident #4 (roommate) was in the room. Resident #5 became agitated because he believed Resident #4 smelled like urine and he didn't want to smell him. Resident #5 began to strip linen off of Resident #4's bed, although staff had recently changed Resident #4, and put fresh linen on his bed. Resident #4 did not want the linen changed and voiced to Resident #5 to leave his bed alone. Both residents vacated their room into the hallway where they could be heard by staff. As staff rushed to intervene, Resident #5 hit Resident #4. Resident #4 sustained a small superficial cut on the inside of his lip. No other injuries noted. Resident #4 (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record revealed Resident #4 was admitted to the facility on [DATE], with diagnoses that include: Paraplegia unspecified; Unspecified Intracranial Injury, Schizophrenia Unspecified; Schizoaffective Disorder, Bipolar Type; Personal History of Traumatic Brain Injury; Depression Unspecified; and Bipolar Disorder unspecified. Review of Resident #4's Quarterly MDS with an ARD of 12/12/2024, revealed a BIMS score of 12 (indicating moderate cognitive impairment). The MDS revealed Resident #4 required setup or clean-up assistance with eating and oral hygiene, supervision or touching assistance with mobility, and is always incontinent of bladder and bowel. Review of Resident #4's Care Plan with a Target Date of 12/25/2024 read in part . 1. The resident is resistant to care related to diagnosis of Schizophrenia, Bipolar, and a history of refusing hygiene care, with interventions which included: Allow the resident to make decisions about treatment regime, to provide sense of control; Give clear explanation of all care activities prior to an as they occur during each contact. 2. The resident has Schizophrenia, Schizoaffective Disorder and Bipolar Disorder, with interventions which included: Monitor behavior episodes and attempts to determine underlying cause, consider location, time of day, persons involved, and situations. Document behavior and potential causes. Resident #5 Review of Resident #5's clinical record revealed he was admitted to the facility on [DATE], with diagnoses that included: Epilepsy Unspecified; Unspecified Dementia, Unspecified severity without behavioral disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety; Schizoaffective Disorder; Profound Intellectual Disabilities; Alcohol Abuse uncomplicated; and Paraphilia Unspecified Review of Resident #5's Quarterly MDS with an ARD of 09/18/2024, revealed a BIMS score of 8 (indicating moderate cognitive impairment). The MDS revealed Resident #5 required supervision or touching assistance with oral hygiene, personal hygiene and dressing. Resident #5 was independent with bed mobility and ambulation. Review of Resident #5's Care Plan with a Review Date of 12/13/2024, read in part . 1. The resident has impaired Cognitive Function/ Dementia, or Impaired Thought Processes related to Dementia, Schizophrenia, and Impaired Decision Making with interventions which included: cue, reorient, and supervise as needed. Interview on 10/02/2024 at 10:12 a.m. with S2 DON, revealed on 09/25/2024, Resident #5 became upset because his room smelled like urine. S2 DON revealed Resident #5 ripped Resident #4's bed linen off and threw it on the floor, then proceeded to hit Resident #4 in the face with his fist. S2 DON revealed Resident #4 sustained a cut to his lip. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/02/2024 at 10:39 a.m. with Resident #5 revealed staff had changed Resident #4's sheets while he (Resident #5) was asleep. Resident #5 revealed when he awakened, the room smelled like urine and feces. Resident #5 revealed two workers asked him what he was doing, and he stated he changed Resident #4's bed linen because he couldn't stand the odor. Resident #5 revealed Resident #4 came back in the room and told him not to fool with his stuff, and started cursing him (Resident #5) out. Resident #5 revealed Resident #4 was cursing and mad so he (Resident #5) punched Resident #4 in the nose with his fist in the hallway. Resident #5 stated workers came and he got upset at workers for telling him to leave Resident #4's belongings alone. Interview on 10/02/2024 at 11:11 a.m. with Resident #4, revealed he entered his room one evening about a week ago (couldn't remember the date), and Resident #5 had ripped the sheets off of his bed and thrown them on the floor. Resident #4 stated he became upset and started cursing. Resident #4 revealed Resident #5 hit him three times with his fist in the face. Resident #4 revealed his lip had a cut which was painful. Telephone interview on 10/02/2024 at 11:36 a.m. with S3 CNA, revealed on 09/25/2024 at approximately 6:00 p.m., she saw Resident #5 stripping Resident #4's linen off of his bed. S3 CNA revealed she heard S4 CNA ask Resident #5 why he stripped Resident #4's bed. S3 CNA revealed Resident #5 stated because it was pissy. S3 CNA revealed Resident #4 asked Resident #5 to stop touching his stuff. S3 CNA stated I left it alone and went back to changing another resident. S3 CNA revealed she heard yelling, and walked in the hallway, and saw Resident #5 hit Resident #4 in the face. S3 CNA revealed she immediately got between Resident #4 and Resident #5, and told them to stop. S3 CNA revealed Resident #5 pushed her, and hit Resident #4 again. Telephone interview on 10/02/2024 at 11:43 a.m. with S4 CNA, revealed she was at the end of the hall and saw Resident #5 stripping linen off of Resident #4's bed. S4 CNA revealed she stopped and asked Resident #5 why he stripped Resident #4's bed linen off of his bed. S4 CNA revealed she could tell Resident #5 was already aggravated. S4 CNA revealed Resident #5 started yelling and cursing saying I'm tired of smelling piss. S4 CNA revealed she told Resident #5 it was clean linen, and Resident #5 threw it in the hallway. S4 CNA revealed she left Resident #5, and went to assist S3 CNA clean another resident. S4 CNA revealed she heard yelling, and saw Resident #5 hit Resident #4 in the face with his fist. S4 CNA revealed when a resident was aggressive or having behaviors they should report it to the nurse. S4 CNA confirmed she should have reported Resident #5's behavior of increased agitation to the nurse and did not. Interview on 10/02/2024 at 1:32 p.m. with S1 Administrator and S2 DON confirmed that S4 CNA should have notified a nurse about Resident #5's increased agitation on 09/25/2024. S1 Administrator confirmed Resident #4 was a victim of resident to resident physical abuse by Resident #5 on 09/25/2024.