

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation and interview, the facility failed to maintain a clean, comfortable, and homelike environment by failing to ensure residents received housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior. Findings: Observation on 07/20/2026 at 9:26 a.m. Hall X revealed strong odors throughout hallway with hall floors having numerous areas of dirt and debris on floor. Interview on 07/20/2026 at 9:27 a.m. with S8CNA on Hall X revealed she was assigned to care for residents on Hall X. S8CNA revealed she performed CNA duties, but was also recently informed CNAs had to perform housekeeping duties because housekeeping department was short staffed. S8CNA stated she would not perform housekeeping duties. Observation on 07/20/2026 at 11:53 a.m. of Hall X revealed there was a strong urine and musky odor present on the hall. Observation of Room A revealed a large amount of black residue on the floor near the doorway that opened to the Hall X. The black residue was noted throughout the resident's room and bathroom. The black residue appeared as mildew with a large amount of dirt and debris throughout the floor. Observation on 07/20/2026 at 11:55 a.m. of Room B revealed a large amount of mildew on the privacy curtain. Observation on 07/20/2026 at 11:56 a.m. of Room C revealed a large amount of dirt and debris including food residue or particles throughout the floor in resident's room. Observation on 07/20/2026 at 11:58 a.m. of Room D revealed a strong feces odor on hallway near the resident's door. Observation revealed a trail of feces from resident's bed into bathroom. Observation of resident's bathroom revealed feces smeared on the floor, wall, and toilet. Interview and observation on 07/20/2026 at 12:09 p.m. of Hall X with S3DON confirmed the above findings. S3DON confirmed the rooms were unsanitary and were in need of cleaning. S3DON revealed she was instructed by S1Director of Operations since the facility was short staffed in housekeeping the CNAs were going to be assigned housekeeping duties. S3DON revealed she inserviced the CNAs and added it to their duties, but she would not enforce the house keeping responsibilities as she did not think it was fair. Interview on 07/20/2026 at 12:20 p.m. with S1Director of Operations revealed the facility did not have a current housekeeping supervisor. S1Director of Operations revealed he was responsible for the housekeeping department and overseeing staff completed their duties. Observation at time of interview for the above findings on Hall X with S1Director of Operations, acknowledged the rooms were unsanitary and in need of cleaning.		

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident (#3) was free of chemical restraints by failing to:1. assess the resident prior to administering a chemical restraint for potential underlying causes of the resident's behavior,2. attempt a less restrictive alternative for the resident's behavior, and3. assess the resident after the chemical restraint was administered.This deficient practice was identified for 1(#3) of 3 sampled residents. The facility's total census was 81.Findings:Review of the facility's July 2022 Antipsychotic Medication Use policy revealed in part.Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed.The policy's Interpretation and Implementation section revealed in part.residents would only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective.Further review revealed in part.in the case of an emergency situation (that is, an acute onset or exacerbation of symptoms or immediate threat to the health or safety of a resident or others), pertinent non-pharmacological interventions must be attempted, unless contraindicated, and documented following the resolution of the acute psychiatric situation.Review of Resident #3's clinical record revealed he was admitted to the facility on [DATE]. The resident's diagnoses included Unspecified Dementia, Unspecified Severity, with Other Behavioral Disturbance, Intermittent Explosive Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms, and Pseudobulbar Affect.Review of Resident #3's Progress Notes revealed the following in part.:Psychosocial Note dated 06/12/2026 at 9:12 a.m. in which the nurse documented Upon entering the room, resident is sitting up in bed - placed BP cuff on resident's arm and as it was taking BP with trying to give medication, resident smacks this nurse's hand away and the medicine flew across the room, all over the floor. Tried to de-escalate with no success. Resident yelling, Get the f*** away from me. Refusing to give BP cuff back, had to quickly grasp the BP cup latch off resident as he began reaching out to hit this nurse. Upon leaving room resident began coming into hallway and cursing at the aide, F*** that B**** - and walking toward her. She tried to de-escalate the situation, but resident continued to walk toward her yelling, f*** that b****. Aide walks off and states he is becoming violent and is trying to starting to come after this nurse. Walking away from resident, he starts yelling down the hall to the aide, You fat b****. Unable to console, aide gets DON and she gets resident to go back into the room.Administration Note dated 06/13/2026 at 3:46 p.m. in which the nurse documented the resident had refused all meds as well as blood glucose monitoring.Psychiatry Note dated 06/15/2026 (Signed Date: 06/21/2026 at 4:09:31 PM) in which S5PNP documented Documentation indicates that on 06/16 the patient experienced significant behavior escalation requiring administration of a B52 (Diphenhydramine 50 mg, Haloperidol 5 mg, Ativan 2 mg) injection for acute agitation and behavioral dysregulation. Staff report that although he returned to baseline following intervention, episodes of irritability, verbal opposition, and noncompliance have continued to occur.Order Note dated 06/16/2026 at 12:04 p.m. which included in part.Diphenhydramine HCl Injection Solution 50mg/ml - Inject 50 mg intramuscularly one time only for aggressive behaviors toward staff for 1 day with Ativan 2mg (a central nervous system depressant) and Haloperidol 5 mg IM (an antipsychotic medication).Order Note dated 06/16/2026 at 12:06 p.m. which included in part.Haloperidol Lactate Injection Solution 5mg/ml - Inject 5 mg intramuscularly one time only for (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aggressive behaviors toward staff for 1 day with Diphenhydramine 50mg and Ativan 2mg IM.Review of Resident #3's June 2026 MAR confirmed S5PNP's note dated 06/15/2026 (signed 06/21/2026) which revealed the resident was administered the following medications on 06/16/2026 between 12:25 p.m. and 12:58 p.m.:Ativan Injection Solution 2mg/ml - Inject 2mg intramuscularly one time only for aggressive behaviors toward staff for 1 day with Diphenhydramine 50mg and Haloperidol 5mg IM,Diphenhydramine HCl Injection solution 50mg/ml - Inject 50 mg intramuscularly one tome only for aggressive behaviors toward staff for 1 day with Ativan 2 mg and Haloperidol 5 mg IM, andHaloperidol Lactate Injection 5mg/ml - Inject 5mg intramuscularly one time only for aggressive behaviors toward staff for 1 day with Diphenhydramine 50mg and Ativan 2mg IM.Review of Resident #3's progress notes revealed no documentation of the specific condition and/or behaviors he was exhibiting, attempts to identify possible underlying causes for the undocumented behaviors, or documentation of attempts to provide less restrictive alternatives, such as non-pharmacological interventions prior to the administration of the B52 injection. Further review revealed there was no assessment of the resident's condition, or resolution of symptoms, following the B52 injection.Further review of Resident #3's June 2026 MAR revealed there was no documentation of any behavior monitoring of the resident throughout the entire month; specifically for 06/16/2026.Interview on 07/22/2026 at 11:46 a.m. with S3DON confirmed there was no documentation in Resident #3's clinical record regarding his condition, or behaviors, prior to the administration of the B52 injection on 06/16/2026. S1DON also confirmed that she would expect to see an assessment of a resident prior to, and after, administration of a chemical restraint. S1DON confirmed the facility did not have a specific Chemical Restraint Policy and Procedure other than the Antipsychotic Medication Use policy which she had provided.Telephone interview on 07/22/2026 at 12:39 p.m. with S5PNP revealed she could not remember the details regarding the staff contacting her on 06/16/2026 for orders regarding the resident's behaviors but it was probably due to his usual behaviors of attempting to hit staff, intermittently refusing his medications or being verbally aggressive. She stated it was not unusual for them to call her requesting prn orders for Resident #3. S5PNP stated she usually attempted to treat residents in-house with medications such as a B52 injection prior to sending them to an in-patient psychiatric facility unless their behaviors were too violent. She stated that she would absolutely expect an assessment of the resident, including their vital signs, after receiving a heavy medication such as a B52 injection.Telephone interview on 07/22/2026 at 12:56 p.m. with S4LPN revealed she had administered the B52 injection to Resident #3 on 06/16/2026 due to his violent behaviors that day. She stated he had hit a CNA and threatened to kill her. S4LPN stated she was not the assigned nurse for the resident that day but she did administer the injection due to his assigned nurse was afraid of him. S4LPN confirmed she did not contact the physician for orders, document the resident's behaviors in the Progress Notes, or document if the medication was effective.		

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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. Based on interview and record review the facility failed to ensure resident assessments were completed accurately for 1 (Resident #1) of 3 residents sampled. Findings:Review of Resident #1's medical record revealed an admission date of 01/28/2026. Resident #1 had diagnoses that included in part. Alzheimer's Disease, Dementia Severe with other Behavioral Disturbance, Neurocognitive Disorder with Lewy Bodies, Type 2 Diabetes Mellitus, and Depression.Review of Resident #1's Discharge Return Anticipated MDS with ARD of 07/10/2026 revealed Resident #1 had a BIMS of 3, which indicated severe cognitive impairment. Resident #1 had no behavioral symptoms exhibited which included no rejections of care. Review of the prior MDS lookback details revealed rejection of care had not been coded on previous MDS assessments dated 02/04/2026, 04/12/2026, and 05/05/2026.Interview on 07/21/2026 at 3:20 p.m. with S3DON revealed she was aware of Resident #1 having refusals of care, and he often did not take his medications. S3DON revealed since admission Resident #1 had refusals of taking his medications. S3DON revealed S2RN was responsible for MDS. Record Review of Resident #1's MDS with S3DON confirmed Resident #1's refusals of care should have been coded on MDS, and was not.Interview on 07/21/2026 at 4:02 p.m. with S2RN revealed she was responsible for completing MDS at the facility. Review of Resident #1's Discharge MDS with ARD of 07/10/2026 with S2RN revealed Resident # 1 had not been coded for refusals of care. S2RN stated if resident had been coded for refusals on any previous MDS it would not need to be coded again. Informed S2RN surveyor had reviewed all previous MDS assessments for coding of refusals, and reviewed the question detail tracking responses for this question on MDS, and it had not been coded since admission. S2RN acknowledged the refusal of care should have been coded on MDS.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on interviews and record reviews, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 (Resident #1) of 3 residents sampled with behavioral health diagnoses by failing to:1. Develop and implement a person-centered plan of care that addressed Resident #1's refusals of care including adherence to prescribed medication regimen;2. Ensure Resident #1's drug regimen remained free from an antipsychotic prescribed for undiagnosed Schizophrenia;3. Ensure Resident #1 had accurate monitoring of behaviors; and4. Notify the Psychiatric NP of Resident #1's refusals/non-adherence to prescribed medication regimen. Findings:Review of the facility's policy titled Behavioral Health Services dated 02/2019 on 07/22/2026 at 11:20 a.m. read in part. The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Review of the facility's policy titled Antipsychotic Medication Use dated 07/2022 on 07/22/2026 at 11:20 a.m. read in part. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use. Diagnoses alone do not warrant the use of antipsychotic medication. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met: The behavioral symptoms present a danger to the resident or others; AND: the symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); or behavioral interventions have been attempted and included in the plan of care, except in an emergency. Antipsychotic medications will not be used if the only symptoms are one or more of the following: Wandering; Poor self-care; Restlessness; Impaired memory; Mild anxiety; Insomnia; Inattention or indifference to surroundings; Sadness or crying alone that is not related to depression or other psychiatric disorders; Fidgeting; Nervousness; or Uncooperativeness. Review of the facility's policy titled Requesting, Refusing and/or Discontinuing Care or Treatment dated 07/2022 on 07/22/2026 at 11:20 a.m. read in part. The healthcare practitioner must be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the request.Review of Resident #1's medical record revealed an admission date of 01/28/2026. Resident #1 had diagnoses that included in part. Alzheimer's Disease, Dementia Severe with other Behavioral Disturbance, Neurocognitive Disorder with Lewy Bodies, Type 2 Diabetes Mellitus, and Depression.Review of Resident #1's Discharge MDS with ARD of 07/10/2026 revealed Resident #1 had a BIMS of 3, which indicated severe cognitive impairment. Resident #1 had no behavioral symptoms exhibited which included no rejections of care. Review of the prior MDS lookback details revealed rejection of care had not been coded on previous assessments dated 02/04/2026, 04/12/2026, and 05/05/2026. Review of the MDS revealed Schizophrenia had not been coded as a diagnoses for Resident #1.Review of Resident #1's 07/2026 physician orders read in part.04/27/2026- Monitor for the following behaviors: itching, picking at skin, restlessness, agitation, hitting, increase in complaints, biting, kicking, spitting, foul language, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusal of care every shift.04/27/2026- Quetiapine Fumarate (antipsychotic) Oral Tablet, give 25 mg by mouth at bedtime related to schizophrenia.04/27/2026- Risperidone (antipsychotic) Oral Tablet, give 1 mg by mouth two (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times a day for severe psychosis related to schizophrenia. Review of Resident #1's medical record revealed no evidence of a diagnoses of Schizophrenia. Review of Psychiatric evaluation completed prior to admission that was dated 01/09/2026 revealed an assessment of: Unspecified dementia, unspecified severity, with other behavioral disturbance. Review of an inpatient psychiatric evaluation dated 04/12/2026 revealed diagnostic impression: Mood disorder unspecified, dementia with behavioral disturbances. The psychiatric evaluations revealed no supporting evidence of a schizophrenia diagnosis. Review of Psychiatric evaluations completed by S5PNP dated 07/10/2026, 06/17/2026, and 06/10/2026 read in part. Review of nursing documentation confirms continued adherence to prescribed psychotropic medications. There was no supporting evidence by S5PNP of a schizophrenia diagnosis. Review of Resident #1's 06/2026 and 07/2026 EMARs revealed documented refusals of medication regimen. Review of 06/2026 EMAR revealed refusals of medication was documented on 17 out of 30 days. Review of the behavior monitoring for 06/2026 EMAR revealed refusals were documented 0 out of 30 days. Review of 07/2026 EMAR revealed refusals of medication was documented for 7 out of the 9 days the resident was in the facility. Review of the behavior monitoring for 07/2026 EMAR revealed refusals were documented 2 out of the 9 days. Review of Resident #1's current comprehensive plan of care with target completion date of 08/09/2026 revealed no evidence of a diagnoses of Schizophrenia, or rejections of care. Interview on 07/21/2026 at 3:20 p.m. with S3DON revealed she was aware of Resident #1 having refusals of care, and he often did not take his medications. S3DON revealed since admission Resident #1 had refusals of taking his medications. S3DON revealed S2RN was responsible for MDS and care planning for residents. Resident #1's MDS and Care Plan was reviewed with S3DON. S3DON confirmed Resident #1's refusals of care should have been care planned and coded on MDS, and was not. Reviewed Resident #1's medical record with S3DON, S3DON confirmed Resident #1 did not have a diagnosis of schizophrenia, so he should not receive medications that was ordered with an indication of schizophrenia. Interview on 07/21/2026 at 4:02 p.m. with S2RN revealed she was responsible for completing care plan and MDS at the facility. Review of Resident #1's current and previous care plans with S2RN confirmed the resident had not been care planned for refusals, and should have been. Review of Resident #1's medical record with S2RN revealed Resident #1 had been ordered Seroquel and Risperdal for diagnoses of schizophrenia. S2RN acknowledged Resident #1's medical record did not reflect a diagnosis of schizophrenia, therefore he should not receive medications indicating this diagnosis. Telephone interview on 07/22/2026 at 9:23 a.m. with S7NP revealed regarding Resident #1, no behaviors had been reported to her by facility staff including refusals of taking medications. S7NP stated if she had been notified, she would have left it up to S5PNP as to what other approaches should be taken with the resident. Interview on 07/22/2026 at 10:05 a.m. with S3DON revealed S3DON reviewed Resident #1's established diagnoses, orders, 06/2026 and 07/2026 EMARS, care plan, MDS, and recent inpatient psychiatric records with surveyor. S3DON confirmed during months of 06/2026 and 07/2026 Resident #1 often refused medications. S3DON confirmed this documentation was accurate and the administration of medications would not be located anywhere else in the resident's medical record. S3DON confirmed behavior monitoring of refusals should have been documented accurately each shift, but was not. Review of Resident #1's Care plan and MDS, S3DON confirmed these records should reflect refusals, so other interventions could be implemented. Review of current medications revealed Seroquel and Risperdal were ordered with indication of use listed as schizophrenia. S3DON reviewed medical record including inpatient psychiatric evaluations, and confirmed Resident #1 did not have a diagnosis of schizophrenia. Interview on 07/22/2026 at 11:05 a.m. with S6LPN Admin Nurse confirmed during review of Resident #1's medical record that Resident (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 did not have diagnosis of schizophrenia, and stated the physician should have been contacted to clarify order, but was not. Telephone interview on 07/22/2026 at 12:30 p.m. with S5PNP revealed she recalled Resident #1 with diagnoses of Dementia. S5PNP revealed she could not recall if Resident #1 had a schizophrenia diagnosis. S5PNP stated after going to inpatient psychiatric stay resident could have come back with different diagnoses, but that would have been reflected in the inpatient psychiatric evaluation. S5PNP revealed she had not been made aware of Resident #1's medication refusals in recent months. S5PNP revealed she reviewed progress notes and relied on staff communications if refusal of medications were occurring. S5PNP revealed she did not review Resident #1's EMARs and relied on progress notes. S5PNP revealed she rounded at the facility 3 times a week, so if something was going on with residents, including refusals, she would expect to be notified by staff to increase visits.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs by failing to adequately monitor a resident's behaviors related to his psychotropic medication use for 1 (#3) of 3 sampled residents. The facility's census was 81. Findings: Review of Resident #3's clinical record revealed he was admitted to the facility on [DATE]. The resident's diagnoses included Unspecified Dementia, Unspecified Severity, with Other Behavioral Disturbance, Intermittent Explosive Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms, and Pseudobulbar Affect. Review of Resident #3's Order Summary Report revealed he was receiving the following medications: Auvelity (an antidepressant) 45-105 mg 1 tablet by mouth one time a day related to Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms, Paroxetine HCl (an antidepressant) 20 mg by mouth one time a day for mood changes related to Intermittent Explosive Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms, and Risperidone (an antipsychotic) 1.5 mg by mouth two times a day for aggressive behaviors related to Unspecified Dementia, Unspecified Severity, with Other Behavioral Disturbance. Review of Resident #3's Care Plan with a target date of 10/07/2026 revealed an identified focus of The resident uses psychotropic medications r/t intermittent explosive disorder, pseudobulbar affect. The interventions included in part. Observe for occurrence of target behaviors symptoms (delusions, hallucinations, pacing, wandering, disrobing, inappropriate response to verbal communication, agitation, aggression towards staff/others, etc.) and document per facility protocol. Review of Resident #3's June and July 2026 MARs revealed there was no documentation of behavior monitoring for Resident #3. Interview on 07/22/2026 at 10:18 a.m. with S3DON confirmed the resident did not have any behavior monitoring documented for June or July 2026. Interview on 07/22/2026 at 11:06 a.m. with S6LPN Admin Nurse revealed Resident #3's behavior monitoring was not resumed after he returned from his hospital stay in May 2026. She confirmed she had added the monitoring to the physician's orders and MARs on this date after the DON had informed her it was missing.		