

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Colonial Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 426 North Washington Street Marksville, LA 71351	
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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30658</p> <p>Based on record review and interview, the facility failed to ensure 8 (S2Licensed Practical Nurse (LPN), S3LPN, S4Certified Nursing Assistant (CNA), S5CNA, S6CNA, S7CNA, S8CNA, S9CNA,) out of 8 (S2Licensed Practical Nurse (LPN), S3LPN, S4Certified Nursing Assistant (CNA), S5CNA, S6CNA, S7CNA, S8CNA, S9CNA,) nursing/direct care staff records reviewed, were re-trained on their policy & procedure for abuse, after an incident of staff to resident verbal abuse occurred for 1 (#1) of 3 (#1, #2, and #3) sampled residents. This deficient practice had the potential to affect all 59 residents residing in the facility.</p> <p>Findings:</p> <p>A review of the facility's Policy & Procedure on Abuse revealed in part the following:</p> <p>Residents have the right to be free from abuse</p> <p>Training: Employees shall be trained in orientation, annually and as needed on the following topics which include:</p> <p>Prevention of Abuse, Neglect, and Exploitation</p> <p>Identifying what constitutes abuse</p> <p>Recognizing signs of abuse</p> <p>Review of Resident #1's medical record revealed he was admitted [DATE], with Diagnoses to include Schizoaffective Disorder, Essential Hypertension, Transient Cerebral Ischemic Attack, Cerebral Vascular Accident, and Depression. Review of Resident #1's Significant Change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 04/08/2024, revealed a BIMS (Brief Interview for Mental Status) score of 15 which indicated the resident was cognitively intact.</p> <p>Review of the facility's Investigation report revealed:</p> <p>Occurred: 04/28/2024 at 1:30 p.m.</p> <p>Discovered: 04/28/2024 at 1:30 p.m.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 195445
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>S13RN (Registered Nurse) reported that around 1:30 p.m. she was down the hall by the activities room and heard Resident#1 and S12Ward Clerk exchanging words regarding cigarettes, as she got closer she could hear foul language being exchanged as Resident #1 and S12Ward Clerk were arguing about the cigarette schedule. S13RN intervened and instructed S12Ward Clerk to clock out and go home until further notice from S1Administrator. On 05/02/2024, after interviewing all the residents who smoked, I have concluded my investigation. The incident in question was an isolated incident and unfortunately, S12Ward Clerk acted impulsively and failed to conduct herself in a professional manner.</p> <p>Review of Resident #1's Nurses Note revealed, on 04/28/2024-the RN was down the hall near activity office when S12Ward Clerk and Resident #1 began arguing over the smoking schedule. S12Ward Clerk was in the nurse's station at the ward clerk area and Resident #1 was right outside the door of the station. Both were cursing and screaming at each other regarding the smoking schedule. S12Ward Clerk stood up screaming, F . you, I will hit you, you m .ther fu .er while lunging toward Resident #1. The resident then began to scream at S12Ward Clerk, what time you get off work? Meet me outside. S4CNA was present in the station and was standing between the two, after minutes of screaming and cursing at each other S4CNA got the two separated, and staff was able to calm Resident #1 down and take him out to smoke.</p> <p>Review of the facility's In-service training revealed on 04/29/2024 staff received training on abuse policy and smoking policy; however there was no documented evidence that S2LPN, S3LPN, S4CNA, S5CNA, S6CNA, S7CNA, S8CNA, and S9CNA received the in-service training.</p> <p>Interview on 05/13/2024 at 1:25 p.m. with S4CNA revealed she was at the nurse's station on 04/28/2024 when Resident #1 walked in the facility from outdoors after smoking. S4CNA stated Resident #1 asked S12Ward Clerk for a cigarette and S12 [NAME] Clerk refused. S4CNA stated Resident #1 told her she didn't know anything and called S12Ward Clerk a b .ch. S4CNA stated S12Ward Clerk then told Resident #1 if he called her that again she would slap him. S4CNA stated she then got between Resident #1 and S12Ward Clerk to prevent further escalation. S4CNA confirmed she did not receive re-training on abuse and neglect following this incident.</p> <p>Interview on 05/14/2024 at 9:45 a.m., S1Administrator stated the facility did not have any documented evidence the above mentioned staff were provided abuse and neglect training after the staff to resident incident of verbal abuse that occurred on 04/28/2024.</p>		