

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 05/29/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #156</p> <p>Review of Resident #156's medical record revealed an admit date of 04/30/2025, with diagnoses that included, in part .Cerebral Infarction due to Thrombosis of Right Posterior Cerebral Artery, Cocaine Abuse with Cocaine-Induced Mood Disorder/Sleep Disorder, and Anxiety Disorder.</p> <p>Review of Resident #156's admission MDS with an ARD of 05/02/2025, revealed a BIMS score of 04, which indicated severe cognitive impairment. The MDS revealed Resident #156 was independent for transfers and used a walker for mobility.</p> <p>Review of Resident #156's Care plan with a target completion date of 08/11/2025, read in part .Elopement risk related to reported history of Altered Mental Status, Cocaine use with wandering attempts to leave hospital noted. 05/15/2025-Elopement attempt noted: willfully attempted to leave facility without notifying staff, wanted to be discharged back home. Interventions included in part; Elopement precautions: Census checks every 1 hour, each shift related to history of Delirium and wandering (initiated on 05/02/2025). Supervision increased to 1:1 for safety. Vistaril injection IM (intramuscular)1 time as ordered per S14 NP for anxiety. (initiated on 05/15/2025).</p> <p>Review of Resident #156's facility progress notes dated 05/16/2025 at 1:00 p.m., written by S2 DON read in part: Resident #156 left facility (exited X-hall bathroom window) after eating breakfast this morning. He was located & transported back to the facility in stable condition. Upon questioning, resident was noted alert & oriented x 4 with appropriate verbal responses. Resident #156 stated that he left facility to try to find a ride back to his home in New [NAME].</p> <p>Review of a SIMS report completed by the facility revealed on 05/16/2025 at approximately 8:15 a.m. Resident #156 eloped from the facility. The facility was made aware of the elopement on 05/16/2025 at 8:30 a.m. The facility entered the allegation into SIMS reporting system on 05/16/2025 at 6:18 p.m.</p> <p>Interview with S1 Administrator on 05/29/2025 at 8:56 a.m., revealed on 05/16/2025 at approximately 8:15 a. m. Resident #156 eloped from the facility. S1 Administrator revealed she was made aware of the elopement on 05/16/2025 at approximately 8:30 a.m. S1 Administrator confirmed she did not report Resident #156's elopement out of the facility within the 2 hour required timeframe, but should have.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review and interview the facility failed to ensure an allegation of physical abuse and allegation of neglect was reported immediately, but not later than 2 hours after the allegation was made to the State Survey Agency for 2 (#6 and #156) of 30 Sampled Residents. Findings:</p> <p>Review of the facility's undated policy on 05/28/2025 at 08:30 a.m. titled Abuse Prevention and Investigation read in part . The facility defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. This includes deprivation of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Physical abuse includes hitting, slapping, pinching, and kicking. Neglect means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Reporting: All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property will be reported immediately, but not later than 2 hours after the allegation is made if the alleged violation involves abuse or results in serious bodily injury OR within 24 hours if the alleged violation does not involve abuse and does not result in serious bodily injury to the administrator of the facility and to other officials including the state survey agency and adult protective services in accordance with state law through established procedures.</p> <p>Resident #6</p> <p>Review of the medical record for Resident # 6 revealed he was admitted to the facility on [DATE]. Resident #6 had diagnoses that included in part . Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, Chronic Obstructive Pulmonary Disease, Anxiety Disorder, Major Depressive Disorder, Memory Deficit following CVA, and Dysphagia.</p> <p>Review of Resident #6's Quarterly MDS with an ARD of 03/25/2025 revealed a BIMS score of 13, which indicated cognition was intact.</p> <p>Review of a SIMS report completed by the facility revealed on 03/21/2025 at approximately 5:50 a.m. Resident #6 alleged S5 CNA had slapped him on his face. The facility was made aware of the allegation on 03/21/2025 at 8:30 a.m. The facility entered the allegation into SIMS reporting system on 03/21/2025 at 1:29 p.m.</p> <p>Interview on 05/29/2025 1:25 p.m. with S1 Administrator revealed she was responsible for SIMS reporting for the facility. S1 Administrator revealed the alleged staff to resident physical abuse occurred on 03/21/2025 at approximately 5:50 a.m., and she was made aware of the allegation on 03/21/2025 at 8:30 a.m. S1 Administrator revealed she entered the incident into SIMS on 03/21/2025 at 1:29 p.m. S1 Administrator confirmed that the incident of alleged staff to resident abuse was not entered into the SIMS within the required timeframe, but should have been.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure adequate supervision was in place for a cognitively impaired resident who was identified as being at high risk for elopement, exhibited exit seeking behaviors, and voiced a desire to leave the facility did not exit the building for 1 (#156) of 11 (#2, #3, #23, #24, #25, #38, #44, #47, #48, #156 and #157) residents at risk for elopement.</p> <p>Findings:</p> <p>This deficient practice resulted in an immediate jeopardy situation for Resident #156 on 05/16/2025 at 8:15 a. m., when Resident #156, who had a BIMS of 4, was cognitively impaired, and exhibited exit seeking behaviors went out of a bathroom window. Resident #156 then walked to a nearby neighborhood approximately 0.5 miles away. At approximately 10:30 a.m., the local police department notified the facility that Resident #156 was in custody after being arrested for theft of a motor vehicle. On 05/16/2025 at 1:00 p. m., Resident #156 returned to the facility.</p> <p>The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation.</p> <p>Findings:</p> <p>Review of the facility policy on 05/27/2025 with a review date of 05/16/2025, and titled Elopements and Wandering Residents, read in part .This facility ensures that residents who exhibit exit wandering behavior and/or at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Elopement occurs when a resident leaves the premises or a safe area without authorization (an order for discharge or leave of absence) and/or any necessary supervision to do so.</p> <ol style="list-style-type: none"> 1. The facility is equipped with door locks/alarms to help avoid elopements. 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation, and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering <ol style="list-style-type: none"> a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. d. Adequate supervision will be provided to help prevent accidents or elopements. <p>Review of Resident #156's medical record revealed an admit date of 04/30/2025, with diagnoses that included, in part .Cerebral Infarction due to Thrombosis of Right Posterior Cerebral Artery, Cocaine Abuse with Cocaine-Induced Mood Disorder/Sleep Disorder, and Anxiety Disorder.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #156's admission MDS with an ARD of 05/02/2025, revealed a BIMS score of 04, which indicated severe cognitive impairment. Resident #156 was independent for transfers and used a walker for mobility.</p> <p>Review of Resident #156's 05/2025 Physician's Orders revealed in part .</p> <p>05/01/2025 -Elopement precautions: Census checks every 1 hour each shift related to history of Delirium and wandering.</p> <p>05/16/2025- Elopement precautions: 1 on 1 staff supervision each shift.</p> <p>Review of Resident #156's Care plan with a target completion date of 08/11/2025, read in part .Elopement risk related to reported history of Altered Mental Status, Status post history of CVA (Cerebral Vascular Accident), Cocaine use with wandering attempts to leave hospital noted. 05/15/2025-Elopement attempt noted: Willfully attempted to leave facility without notifying staff, wanted to be discharged back home. Interventions included in part .Elopement precautions: Census checks every 1 hour each shift related to history of delirium and wandering. (initiated on 05/02/2025). Supervision increased to 1:1 for safety. (initiated on 05/15/2025).</p> <p>Review of Resident #156's Risk of Elopement Evaluation dated 05/01/2025, revealed Resident #156 had verbally expressed the desire to go home, packed belongings to go home, or stayed near an exit door. Resident #156 scored 1.0 on the evaluation which indicated he was at risk for elopement.</p> <p>Review of Resident #156's facility progress notes dated 05/15/2025 at 4:28 p.m., written by S2 DON read as follows: Resident #156 came outside of facility with facility staff & other residents to eat crawfish. Resident #156 noted very calm & cooperative during activity. Later resident noted agitated, uncooperative, & telling staff that he was leaving because he stayed here long enough, and it was time for him to go. Resident #156 noted pushing staff away & attempting to leave facility. S2 DON and S1 Administrator intervened. Resident #156 remained agitated (refused to go inside of building, pushed staff away, & continued to walk off attempting to leave facility). Resident #156 was questioned about where he was going & he stated that he was going back to his home in New [NAME]. Resident #156 requested to call the police to assist him with getting back home. S2 DON informed him that staff could assist him with calling his family to help him. After much encouragement, resident finally agreed to come back inside facility to call his sister. Resident #156 became more agitated after speaking with sister & stated that his sister was always against him. Emotional support provided with very little effectiveness noted. Increased anxiety & agitation with complaints of SOB (shortness of breath) noted. Resident #156's supervision increased to 1:1 at this time for safety.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #156's facility progress notes dated 05/16/2025 at 1:00 p.m., written by S2 DON read as follows: Resident #156 left facility (exited hallway bathroom window) after eating breakfast this morning. Resident #156 was located and transported back to the facility in stable condition. Upon questioning, resident was noted alert & oriented x 4 with appropriate verbal responses. Resident #156 stated that he left facility to try to find a ride back to his home in New [NAME]. A follow up assessment was done with no complaints of discomfort & no s/s (signs and symptoms) of injury noted. S/S of frustration/agitation was noted from resident with expressions of dissatisfaction towards having to return to the facility. Resident #156 repeatedly stated, I'm a mechanic & I need to get back to my business. Resident #156 was reassured that staff was aware of his desire for discharge and was trying to ensure a safe discharge plan for him. Designated staff assigned 1:1 supervision for safety. Resident's primary MD and S14 NP were informed of resident leaving facility & of his current status.</p> <p>Review of a police department report revealed in part ., on 05/16/2025 at approximately 9:29 a.m., this officer was dispatched in reference to a vehicle being in the ditch. The vehicle in question was the same vehicle that was observed in the ditch. Police officers went back to the person who stole the vehicle. While speaking, Resident #156 stated he was trying to get to New [NAME], La. Resident #156 was transported to be booked on the following charges theft of a motor vehicle, criminal damage to property, and illegal possession of stolen things. While in police custody it was learned that Resident #156 was missing person from a local nursing home.</p> <p>Interview with S14 NP on 05/28/2025 at 9:17 a.m. revealed she came to visit Resident #156 on 05/16/2025 at 6:30 a.m. after being notified on 05/15/2025 of Resident #156 trying to leave the facility. S14 NP stated she ordered an injection of Hydroxyzine (Antihistamine) and placed him on 1:1 supervision on 05/15/2025. S14 NP stated that during her visit with Resident #156 on 05/16/2025 he continued to voice to her that he wanted to go home. S14 NP stated she discussed with him that it wasn't a good idea to leave the facility against medical advice and Resident #156 agreed to remain in the facility. S14 NP stated Resident #156 was cooperative and calm during her visit on 05/16/2025. S14 NP stated Resident #156 didn't exhibit any active exit seeking behaviors at the time of her visit but was adamant about going home. S14 NP stated once Resident #156 agreed to remain in the facility, she notified staff of his mood, and lifted his 1:1 supervision.</p> <p>Interview with S15 CNA on 05/28/2025 at 12:06 p.m. revealed she worked on 05/16/2025 during the 6:00 a. m.-2:00 p.m., shift when Resident #156 eloped. S15 CNA revealed she had last seen Resident #156 during breakfast that morning. S15 CNA stated during her observation of Resident #156 during breakfast, Resident #156 was calm with no abnormal behaviors. S15 CNA stated on 05/16/2025 at approximately 8:45 a.m., S2 DON approached her outside on the front porch to inquire if Resident #156 was outside. S15 CNA stated she notified S2 DON that Resident #156 did not go outside on the front porch after breakfast. S15 CNA was made aware by S2 DON that Resident #156 could not be located. S15 CNA stated she, S2 DON, and another CNA began looking throughout the entire facility, checking all resident rooms, laundry room, kitchen, and all exits.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview with S1 Administrator on 05/29/2025 at 8:56 a.m., revealed on 05/16/2025 at 8:15 a.m. she realized Resident #156 was missing. S1 Administrator stated she went down to check on Resident #156 and noticed he wasn't in bed or in the dining room. S1 Administrator stated she alerted staff to begin searching for Resident #156 throughout the facility. S1 Administrator stated she went back to her office to review surveillance footage which showed Resident #156 entered the X-Hall bathroom, but never exited the bathroom. S1 Administrator stated she immediately increased census checks to every 30 minutes for all residents at high risk of elopement. S1 Administrator stated she initiated an in-service for all staff on 05/16/2025 that was completed on 05/20/2025 for Elopement and Wandering Residents as well as Facility Protocol for 1:1 Staff Supervision.</p> <p>Interview with S11 LPN on 05/29/2025 at 11:58 a.m., revealed she observed Resident #156 eating breakfast in the dining room on 05/16/2025 around 8:00 a.m. S11 LPN stated Resident #156 walked past her going towards his room in a good mood. S11 LPN stated Resident #156 had no complaints or any exit-seeking behaviors that morning. S11 LPN stated about 10 minutes later S1 Administrator approached her and asked where Resident #156 was. S11 LPN stated she and S1 Administrator immediately began to look in every room and could not locate him. S11 LPN stated Resident #156 was on 1:1 supervision during the night shift (05/15/2025) but it had been lifted on 05/16/2025 by S14 NP.</p> <p>The facility has implemented the following actions to correct the deficient practice:</p> <ol style="list-style-type: none"> 1. All staff in-serviced on 05/16/2025 on elopement, wandering residents, and facility protocol for 1:1 supervision. The elopement policy was reviewed with all staff on Elopement and Wandering Residents. 2. Resident #156 was immediately assessed with no complaints of discomfort and no signs and symptoms of injuries noted upon return to the facility on [DATE] at 1:00 p.m. Designated staff were assigned to Resident #156 for 1:1 supervision for safety. S14 NP notified of Resident #156's return status, and a new order for Klonopin 0.5 mg was given to Resident #156 for anxiety. 3. Daily Elopement Risk Monitoring tool was started on 05/16/2025 for resident's identified as high risk for elopement in the facility. Monitoring tool reads as follows: S2 DON or designee will monitor residents at risk for elopement daily for 8 weeks then randomly to identify any issues with safety and/or plan of care for safety. 4. Residents identified as high elopement risk were ordered with increased visual checks every 30 minutes every shift which started on 05/16/2025, to be continued indefinitely. 5. A window audit was conducted on 05/16/2025 by S3 Maintenance Director on all resident bedroom windows, bathroom windows in facility, living area, and dining area. <p>Facility completion date 05/23/2025.</p>		