STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195445	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Nursing and Rehabilitation Center	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)
F 0600 Level of Harm - 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** Based on interview and record review, the facility failed to ensure a resident's right to be free from staff to resident physical abuse, for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents investigated for abuse. Resident #1, a cognitive resident, experienced psychosocial harm as a result of the physical abuse by staff. This deficient practice resulted in psychosocial harm to Resident #1 on 10/11/2025 at 1:15 p.m., when Resident #1 reported to S2 CNA that S3 CNA entered his room without invitation and intentionally poured water on him in an attempt to stop him from masturbating. Resident #1, who had a BIMS score of 15 (cognitively intact), was tearful and fearful following the physical abuse from S3 CNA. 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. Findings:Review of the undated facility policy titled Abuse Prevention and Investigation revealed in part. Residents have the right to be free from verbal, sexual, physical, and mental abuse, neglect, corporal punishment, involuntary seclusion, and misappropriation of property, exploitation, and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents will not be subjected to abuse by anyone.1. The facility defines resident abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses that included in part. Schizoaffective Disorder, Bipolar Disorder, Diabetes, Hemiplegia and Hemiparesis following Cerebral Vascular Disease affecting Left Non-Dominant Side, Vascular Dementia, Epilepsy, and Unspecified Other Behavioral Disturbance. Review of Resident #1's Quarterly MDS with an ARD of 08/20/2025, revealed Resident #1 had a BIMS score of 15, which indicated cognition was intact. The MDS revealed Resident #1 was dependent on staff for activities of daily living (ADLs). Review of a progress note dated 10/15/2025 revealed that the Nurse Practitioner was consulted regarding the need to restart Resident #1's antipsychotic medication due to increased sexual behaviors. Review of Resident #1's Care Plan, with a review date of 01/08/2025, revealed in part. On 10/13/2025, an incident that occurred between staff and resident on 10/11/2025 was reported. Documentation stated that on 10/11/2025, staff poured cold water on Resident #1's perineal area during care after the resident was observed masturbating. Interventions implemented on 10/13/2025 included: Monitoring for signs and symptoms of psychosocial decline; Monitoring Resident #1's sexual behaviors every shift and providing privacy as appropriate; referring the resident to the Psychiatric Nurse Practitioner for follow-up evaluation; and administering antipsychotic medication as ordered. Resident #1 did not have a care plan addressing self-pleasuring behaviors prior to the incident on 10/11/2025. Interview on 11/20/2025 at 9:30 a.m. with Resident #1 revealed that on 10/11/2025, S3 CNA entered his room without invitation and intentionally poured water on him in an attempt to stop him from masturbating. Resident #1 stated the incident made him feel distressed and that he cried throughout the night. Resident #1 further reported that he continues to feel fearful that a similar incident may occur again. An interview on 11/20/2025 at 1:35 p.m., with S2 CNA revealed that on 10/11/2025 at approximately 1:30 p.m., she was eating lunch in the dining (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 - Actual harm Residents Affected - Few	room when S3 CNA verbally informed her that she had poured water on Resident #1 in an attempt to stop him from masturbating. S2 CNA reported that upon hearing this information, she immediately went to Resident #1's room to check on him. S2 CNA stated that Resident #1 was crying when she entered the room. S2 CNA observed that Resident #1's bed sheets and brief were wet. S2 CNA reported Resident #1 said How could anyone be so mean, water, and requested to speak with the administrator. S2 CNA reported Resident #1 masturbates in his room frequently. S2 CNA stated staff are aware of his sexual behaviors and have been instructed to close the door or pull the privacy curtain if Resident #1 engages in self pleasure. A telephone interview on 11/20/2025 at 2:58 p.m., with S3 CNA revealed on 10/11/2025 at approximately 1:00-1:15 p.m. S3 CNA was walking down the hallway when she observed Resident #1 engaging in self pleasuring behavior. S3 CNA stated she attempted to stop Resident #1 from masturbating, at which time the resident attempted to grab her arm. S3 CNA further stated she then picked up a cup of water and poured it onto Resident #1's genital area. S3 CNA confirmed she entered Resident #1's room without invitation or clinical need. Resident #1 had not requested assistance with ADLs and did not have his call light activated prior to her entering the room. S3 CNA acknowledged she has been educated to close the door or pull the privacy curtain when Resident #1 is engaging in self pleasuring behaviors. S3 CNA confirmed she did not do so during this incident. An interview on 11/24/2025 at 8:12 a.m. with S1 Administrator confirmed that physical abuse involving S3 CNA and Resident #1 was substantiated during the facility's investigation. S1 Administrator reported that all staff had received training on appropriate responses when Resident #1 engages in self-pleasuring behaviors. S1 Administrator confirmed Resident #1 was found crying in his room after the incident occurred. S1 Administrator also confirmed S3 CNA was suspended on 10/13/2025 and subsequently terminated on 10/16/2025. The facility has implemented the following corrective actions to correct the deficient practice: 1. Staff Education: All staff were in-serviced on 10/13/2025 on the Abuse & Neglect Policy, resident rights to privacy, requirements for reporting abuse or suspected abuse immediately, and physical restraint free facility. 2. Resident Interviews: All residents who received care from S3 CNA were interviewed by the administrator. No complaints or concerns were identified. Residents who were non-interviewable received a full body audit. 3. Medication Management: Resident #1 was re-started on the antipsychotic medication Saphris 5mg BID on 10/15/2025 for management of increased sexual behaviors. 4. Psychiatric Evaluation: Resident #1 was evaluated by the Psychiatric Nurse Practitioner on 10/17/2025. No new orders or recommendations were made. 5. Psychosocial Monitoring: Monitoring by the LPN/floor nurse every shift was implemented to assess for signs and symptoms of psychosocial trauma, including sadness, crying, mood swings, depressed mood, decreased socialization, withdrawal, and refusal of care. 6. Ongoing Abuse Reporting Oversight: A resident abuse and reporting monitoring tool was established. The Administrator will interview eight residents per week for eight weeks, then monthly thereafter, to ensure compliance with abuse reporting expectations. Facility correction date is 10/17/2025.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review and interview the facility failed to ensure an allegation of abuse was reported immediately to the administrator of the facility for 1 (Resident #1) of 3 sampled residents reviewed for abuse. The facility failed to ensure staff reported an allegation of staff-to-resident abuse to facility Administrator. Findings:Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses that included in part. Schizoaffective Disorder, Bipolar Disorder, Diabetes, Hemiplegia and Hemiparesis following Cerebral Vascular Disease affecting Left Non-Dominant Side, Vascular Dementia, Epilepsy, and Unspecified Other Behavioral Disturbance. Review of Resident #1's Quarterly MDS with an ARD of 08/20/2025, revealed Resident #1 had a BIMS score of 15, which indicated cognition was intact. The MDS revealed Resident #1 was dependent on staff for activities of daily living (ADLs). Review of Resident #1's Care Plan, with a review date of 01/08/2025, revealed in part.On 10/13/2025, an incident that occurred between staff and resident on 10/11/2025 was reported to administration. Documentation stated that on 10/11/2025, staff poured cold water on Resident #1's perineal area during care after the resident was observed masturbating. An interview on 11/20/2025 at 1:35 p.m., with S2CNA revealed that on 10/11/2025 at approximately 1:30 p.m., she was eating lunch in the dining room when S3CNA verbally informed her that she had poured water on Resident #1 in an attempt to stop him from masturbating. S2CNA revealed she did not report this incident to her immediate supervisor until 10/13/2025. S2CNA confirmed she should have reported this incident immediately to her supervisor, but did not. An interview with S1 Administrator on 11/24/2025 at 8:12 a.m. confirmed S2CNA should have immediately reported the allegation of abuse between Resident #1 and S3CNA on 10/11/2025 to her supervisor, and she did not. S1Administrator stated all staff are responsible for immediately reporting abuse/suspected abuse.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure a resident's person centered plan of care was reviewed and revised to include approaches/ interventions to address the resident's self pleasuring behavior for 1 (Resident #1) of 3 sampled resident's care plans reviewed. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses that included in part. Schizoaffective Disorder, Bipolar Disorder, Diabetes, Hemiplegia and Hemiparesis following Cerebral Vascular Disease affecting Left Non-Dominant Side, Vascular Dementia, Epilepsy, and Unspecified Other Behavioral Disturbance.An interview on 11/20/2025 at 1:35 p.m., with S2CNA revealed Resident #1 masturbates in his room frequently. S2CNA stated staff were aware of his sexual behaviors and have been instructed to close the door or pull the privacy curtain if Resident #1 engages in self-pleasure.A telephone interview on 11/20/2025 at 2:58 p.m., with S3CNA revealed on 10/11/2025 at approximately 1:00-1:15 p.m. S3CNA was walking down the hallway when she observed Resident #1 engaging in self-pleasuring behavior. S3CNA stated she attempted to stop Resident #1 from masturbating, at which time the resident attempted to grab her arm.Review of Resident #1's Care Plan, with a review date of 01/08/2025, revealed in part. On 10/13/2025, an incident that occurred between staff and resident on 10/11/2025 was reported. Documentation stated that on 10/11/2025, staff poured cold water on Resident #1's perineal area during care after the resident was observed masturbating. Resident #1 did not have a care plan addressing self-pleasuring behaviors prior to the incident on 10/11/2025.