STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195478	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Columns Rehabilitation and Healthcare Center	3025 Fourth Street Jonesville, LA 71343

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 3 (#2, #3, and #4) of 4 (#1, #2, #3, and #4) sampled residents. The facility failed to 1. Ensure Resident #2 was not physically abused by Resident #3; 2. Ensure Resident #3 was not physically abused by Resident #4; and 3. Ensure Resident #4 was not physically abused by Resident #3. Findings: Review of the facility's policy titled Abuse, Neglect, Misappropriation of Resident Property, Suspicious Injuries of Unknown Source, Exploitation, with an effective date of 07/26/2023, revealed in part .The facility's policy strictly prohibits abuse and neglect. This policy is against abuse, neglect, exploitation and misappropriation of resident property including abuse by any other person, including, but not limited to other residents. Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Willful means the individual must have acted deliberately (not-inadvertently or accidentally), not that the individual must have intended to inflict or harm. A cognitively impaired resident that hits another resident, may be considered abusive. Resident #2 Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses that included in part . Acute Pulmonary Edema, Dementia Mild with other behavioral symptoms, Anxiety Disorder, Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease and Bronchitis. (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 Resident #2's Quarterly MDS with an ARD of 02/14/2025, revealed a BIMS score of 15, indicating intact cognition. The MDS revealed Resident #2 was independent with eating, oral hygiene, toileting, dressing, personal hygiene, transfers and ambulation. Resident #3 Review of Resident #3's medical record revealed he was admitted to the facility on [DATE], with diagnoses that included in part .Unsteadiness on Feet, Dementia, Moderate without behavioral disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety, Hallucinations Unspecified and Cognitive Communication Deficit. Review of Resident #3's Admission's MDS with an ARD of 02/09/2025, revealed a BIMS score of 99 (resident was unable to complete the interview). The MDS revealed Resident #3 required supervision or touching assistance with eating. Resident #3 required substantial/maximal assistance with toileting, bathing and dressing; partial/moderate assistance with transfers; and used a manual wheelchair for mobility. Review of Resident #3's medical record revealed Resident #3 was sent to theER on [DATE], and was to be transferred to a behavioral hospital due to escalating behavior at the facility. Review of Resident #3's Care Plan with a Target date of 05/12/2025, read in part . 1. I have a behavior problem, (problem onset date of 02/06/2025). I am resistant to ADL care from CNAs at times. I become easily agitated and will be combative and verbally aggressive with staff at times. I will spit out my meds and refuse care. Interventions included in part .Bring me to the nurse's station for closer supervision when I become intrusive. 2. Disrobing in public (problem onset date of 02/06/2025). I get very confused and will believe things that are not true. I do not like being corrected. 03/04/2025 - Intrusive, physically/verbally aggressive. Interventions included in part .I will be removed from the situation and taken to alternate location as needed. I will have interventions as necessary to protect the rights and safety of others. Resident #4 Review of Resident #4's medical record revealed he was admitted to the facility on [DATE], with diagnoses that included in part .Aphasia, Cognitive Communication Deficit, Unspecified Dementia severe without behavioral disturbance, Psychotic Disturbance Mood Disturbance and Bipolar Disorder. Review of Resident #4's Quarterly MDS with an ARD of 02/12/2025, revealed a BIMS score of 5, indicating severe cognitive impairment. The MDS revealed Resident #4 required substantial/maximal assistance with transfer, toileting, bathing and dressing. Resident #4 used a manual wheelchair for mobility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility Incident Report dated 03/04/2025 at 5:15 p.m., read in part .Resident #2 yelled up the hall Help, we have a problem down here. Staff went down hall and observed Resident #2 standing in her room, and Resident #3 was in hallway in front of her (Resident #2's) room. Resident #2 stated Resident #3 came in her room, and she asked him to get out. In return, Resident #3 kicked her in her right shin before she could get assistance. Immediate Action Taken: Inspected Resident #2's skin. No redness, bruising, or opened area noted at this time. Resident #2 denies injury or pain at this time. DON notified of situation. Resident #3 immediately removed by another staff member from hallway. Injuries observed at time of incident - No injuries observed. Review of the facility Incident Report dated 03/04/2025, revealed a note dated 03/07/2025 (no time), that read in part .Upon investigation, it was noted that Resident #3 was showing signs of increased agitation in the dining room and was not easily re-directed. Staff then escorted him to his room to be in a lower stimulating environment. Moments later, Resident #2 was calling for assistance. Investigation revealed that Resident #3 had entered Resident #2's room trying to get her snacks. Resident #2 stated that she started yelling at him to get out of her room, when he kicked her in her right lower leg. Resident #2 stated that Resident #3 was backing out of her room when Resident #4 intervened on her behalf. Resident #2 stated Resident #4 hit Resident #3 in the back, and started pulling his (Resident #3's) wheelchair out of her doorway. Meanwhile, Resident #2 called for staff assistance. Resident #4 stated that as soon as he had Resident #3 in the hallway, Resident #3 managed to turn around facing Resident #4, then kicked him (Resident #4) on the right lower leg. Staff immediately deescalated the situation by removing Resident #3 from the area, and by placing him on 1:1 supervision. Interview on 04/09/2025 at 9:46 a.m. with S1 DON, revealed video surveillance captured the following in part . 03/04/2025 at 5:00 p.m. - staff brought Resident #3 into the dining room for meal service. Resident #3 was placed at the back table. Resident #3 immediately unlocked his wheelchair and moved from table to table, attempting to take other residents' belongings. Several residents were calling to someone to move him elsewhere. Staff attempted re-direction. During this time Resident #3 was observed touching what seemed to be everything. He was also seen trying to eat from dirty dishes that were placed in the window. Resident #3 was re-directed again. 03/04/2025 at 5:15 p.m. - S1 CNA removed Resident #3 from the dining room and escorted him to his room. S1 CNA then walked up the hall to tell Resident #3's nurse. 03/04/2025 at 5:16 p.m. - Resident #3 came out of his room and opened Resident #2's room door and entered her room. Resident #3 was seen slowly backing out of Resident #2's room. 03/04/2025 at 5:17 p.m. - Resident #4 came out of his room and hit Resident #3 in his back, and started to pull Resident #3's wheelchair out of Resident #2's doorway. Resident #2 was seen standing in the hallway looking towards the nurse's station calling for assistance. While Resident #4 had a hold of Resident #3's wheelchair, Resident #3 managed to turn his wheelchair around and then kicked Resident #4 on the leg. S1 DON confirmed at that time that Resident #2 and Resident #4 were victims of resident to resident physical abuse by Resident #3, and Resident #3 was a victim of physical abuse by Resident #4 on 03/04/2025. (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 04/08/2025 at 1:30 p.m. with Resident #2 revealed about a month ago (03/04/2025), Resident #3 who resided across the hallway from her attempted to enter her room. Resident #2 stated she told Resident #3 no, but he continued to try and enter her room. Resident #2 stated Resident #3 kicked her on the right shin. Resident #2 stated Resident #4 (roommate to Resident #3), came to get Resident #3 out of her room. Resident #2 stated Resident #4 hit Resident #3 on the back, and Resident #3 kicked Resident #4 on the leg. Interview on 04/08/2025 at 12:18 p.m. with Resident #4, revealed he remembered the evening when Resident #3 tried to enter resident #2's room; however, he was unable to remember the date. Resident #4 stated he heard Resident #2 call for help, so he went across the hall to see what was going on. Resident #4 stated Resident #3 was trying to push past Resident #2 to enter he room. Resident #4 stated he went to grab resident #3's wheelchair to get him away from Resident #2, and he hit Resident #3 across his back. Resident #4 revealed Resident #3 then turned in his wheelchair and kicked him on the leg. Telephone interview on 04/09/2025 at 10:23 a.m. with S2 CNA, revealed on 03/04/2025 at 5:00 p.m. Resident #3 was in the dining room in a wheelchair. S2 CNA stated Resident #3 left his table and went to where the dirty dishes were in the kitchen window, and was trying to get food off the dirty plates. S2 CNA stated she re-directed Resident #3 back to his table and he became verbally aggressive calling her the N word. S2 CNA stated Resident #3 left his table again and was messing with other residents in the dining room. S2 CNA stated Resident #3 rolled up to a blind resident and was trying to get something out of his back pack. Another resident intervened, and Resident #3 became verbally aggressive towards that resident. S2 CNA stated she took Resident #3 out of the dining room back to his room, and stopped by the nurse's station and told S3 LPN about Resident #3's behaviors. Telephone interview on 04/09/2025 at 11:41 a.m. with S3 LPN revealed on 03/04/2025 Resident #3 had been upset that day after his Care Plan meeting, because it had been determined Resident #3's still required a pureed diet. S3 LPN stated S2 CNA had reported to her she had to remove Resident #3 from the dining room during the evening meal, because he was being disruptive in the dining room, and messing with other residents. S3 LPN stated Resident #3 had no behaviors at the other meal services that day. S3 LPN stated she told S2 CNA that's fine, I'll check on him in a few minutes. S3 LPN revealed before she could check on Resident #3, he exited his room and tried to enter Resident #2's room and kicked her on the leg. When Resident #4 tried to intervene, he (Resident #4) hit Resident #3 in the back, and in turn Resident #3 kicked Resident #4 on the leg.