STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195430	A. Building B. Wing	12/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colfax Nursing and Rehab, LLC	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28889 Based on observation, interview and record review, the facility failed to ensure that a resident who was identified as being at high risk for elopement, exhibited wandering and exit-seeking behaviors, and wore a secure care wander guard bracelet, was adequately supervised for 1 (#2) of 18 sampled residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, and #18). This failed practice resulted in an immediate jeopardy situation for Resident #2 on 10/24/2021 at approximately 5:10 a.m. when Resident #2 exited the facility without staff's knowledge through an unlocked patio door on wing 2, and through an opening in the patio gate. Resident #2 was found by facility staff 1.5 miles away at a local gas station, and brought back to the facility at 6:22 a.m. On 11/07/2021 at 9:42 p.m., Resident #2 exited the facility again without staff's knowledge through an unlocked patio door on wing 3, and climbed over the patio fence. A person in the community saw the Resident #2 in the parking lot at a local grocery store and brought her to the local Sheriff's Department on 11/08/2021 at 12:57 a.m. S1 Administrator was informed of the Immediate Jeopardy situations on 12/09/2021 at 5:27 p.m. The Immediate Jeopardy situations were removed on 12/10/2021 at 6:06 p.m. after it was determined through observation, interview, and record review that the facility submitted and implemented a plan of removal that included the following: Action plan for 10/24/2021 Elopement with revision date of 12/10/2021 1. Resident #2 was placed on one to one by staff and every hour by nurse on unit until no longer needed; 2. Breached gate temporarily repaired; 3. Ordered a gate form (local fence company); 4. DON would monitor one on one supervision of staff and nurse twice a week for 2 weeks then weekly and as necessary; (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. All staff were in-service on elopement procedures, Code W procedures, monitoring wandering residents, daily monitoring of gates and facility grounds, 1:1 supervision, and secure care alarm bracelet for resident at risk for elopement. Action plan for 11/08/2021 Elopement with revision date of 12/10/2021 1. Resident #2 on strict one to one even while sleeping; 2. All staff in serviced on strict one to one even while sleeping 3. All chairs removed from patios; 4. Temporary door alarms added to patio doors all staff where in serviced on elopement procedures for the temporary door alarms. The temporary door alarms would continue until doors are securely locked with keypad; 5. Maintenance temporarily repaired fence where resident broke spikes off and used a chair to climb over the fence; 6. Administrator contacted a local medical company for estimate to install remote keypads secure alarms to all patio doors. Received estimate and forwarded to Director. The deficient practice continues at a potential for more than minimum harm for 18 of 95 residents who have been identified by the facility as being at risk for elopement. Findings: Review of the facility's Policy and Procedure titled Wandering and Elopements revealed in part .the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Review of a Progress Note from the discharging hospital dated 10/21/2021 at 7:15 p.m. revealed Resident #2 was seeking doors to find a way out. Review of Resident #2's medical record revealed she was admitted on [DATE] with diagnoses that included Dementia, Psychosis not due to a substance, Seizures, Hypertension, Constipation and Thyroid Disorder. Review of Resident #2's Elopement Risk assessment dated [DATE] revealed she was at risk for elopement, and a secure care wander guard bracelet was placed on Resident #2 on 10/22/2021. Review of Resident #2's Admission MDS with an ARD of 11/03/2021 revealed a BIMS score of 7, indicating severe cognitive impairment. Further review of the Admission MDS revealed a wander/elopement alarm was coded as being used daily. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #2's Care Plan revealed a problem of Risk for injury related to elopement with wander guard to ankle to prevent leaving out of the front door. The problem onset date was 10/22/2021. Approaches included: census check every 2 hours and every 1 hour after elopement attempt for 24 hours or until settled, observe for behavior episodes and determine any possible underlying cause, code alert bracelet (check every shift for activation and placement), monitor resident for changes in orientation, level of consciousness, increased behavior problems, or changes in dietary habits, orient to surroundings and room number, refer to psych NP as needed, involve structured activities, observe for behaviors or expressions indicating planned elopement, keep picture on chart or computer file to have available if elopement occurs, and orient the (new) resident to surroundings and introduce to other residents. Review of the facility's investigation dated 10/24/2021 at 8:00 a.m. revealed S2 DON reviewed surveillance footage, and documented the following: The resident was seen throughout the night at the nurse's station talking to staff, and up and down the hallways through the night. Resident #2 was at the nurse's station at 5:00 a.m. talking to the nurse and at 5:10 a.m. resident #2 was seen walking down wing 1. Resident #2 was seen running toward the patio door the closer she got to the end of the hallway. She exited the patio door and was not seen on the camera again until 6:22 a.m. when she was brought back into the building through the front door by staff. At 7:30 a.m. S2 DON and S5 Maintenance supervisor walked the facility grounds and found a potential breach in the fence off wing 2 patio. Further review of investigation revealed a written statement from S3 LPN that revealed on 10/23/2021 at 10:30 p.m. she was informed by another resident that there was someone hiding in the bushes outside of wing 3 patio. The documentation revealed Resident #2 was found hiding in the bushes crouched down and stating a man in grey pants was going to shoot her in the face. S3 LPN assured Resident #2 that she was safe. The resident was at the nurse's station throughout the night having delusional thoughts saying that she was from the future, and she continued to have paranoid thoughts that a man in grey pants was after her. At 5:45 a.m. S3 LPN noticed Resident #2 had not been at the nursing station for the past few minutes. She documented that around 5:00 a.m., Resident #2 was seen at the nurse's station and she was confused, thinking she was from the future. Observation revealed Resident #2's bed was made and she was not in the facility. At 6:22 a.m. a staff member left the facility in their vehicle and returned to the facility with Resident #2. Review of local Sheriff's Office report dated 10/24/2021 revealed the following: 6:09 a.m. - Initial call made to Sheriff's office by facility Cannot find Resident #2. 6:20 a.m. - Received call for local store stating Resident #2 turned up there and nursing facility picked her up. 6:21 a.m. - Called local facility to confirm information. 6:23 a.m. - Nursing facility confirmed they found Resident #2 and picked her up from a local pantry. Observation of Resident #2 on 12/03/2021 at 9:50 a.m. revealed her sitting in the dining room at a table visiting with staff. Interview with Resident #2 at that time revealed she was confused, and Resident #2 stated she didn't remember anything about her leaving the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 12/08/2021 at 2:00 p.m. revealed that the facility was located next to a road frequently used by local citizens. Train tracks were observed approximately 1 mile down that road. Interview on 12/07/2021 at 10:44 a.m. with S6 Laundry staff revealed as she was clocking in around 5:00 a. m. on 10/24/2021, she was asked had she seen Resident #2. S6 Laundry staff stated she then left the facility with S7 Transportation in a private vehicle to look for Resident #2. Further interview of S6 Laundry staff revealed Resident #2 had crossed the tracks and was 1.5 miles from the facility at a local gas station. Interview on 12/07/2021 at 3:33 p.m. with S2 DON revealed Resident #2 entered the facility on 10/22/2021 stating I don't live here and I won't be staying. I am dropping someone off. S2 DON stated a wanderguard was placed on Resident #2 at that time because of her statement on admission. S2 DON stated on 10/24/2021 Resident #2 left the facility and was found by staff 1.5 miles from the facility. Interview on 12/07/2021 at 3:40 p.m. with S3 LPN revealed on 10/22/2021 while receiving report from S4 RN, Resident #2 walked up to the nurse's station and stated I got to go. S3 LPN stated that S4 RN informed her on 10/22/2021 that the resident's discharging facility advised him to watch Resident #2 closely because if she could find a way out of the facility, she would leave. S3 LPN stated on 10/23/2021 around 9:30 p.m. 3 male residents sitting on wing 4 patio informed her someone was outside in the bushes. S3 LPN stated Resident #2 exited wing 3 patio door and was found outside between wing 3 and wing 4 hiding in the bushes. S3 LPN stated Resident #2 was paranoid and very delusional, and sat at the nursing station most of the night of her own free will. Around 4:30 a.m. or 4:45 a.m. on 10/24/2021, S3 LPN stated she noticed she had not seen Resident #2 for about 30 minutes, and thought maybe she got tired and went to her room to lay down. S3 LPN stated that Resident #2 was not in her room, and staff could not locate her in the facility. Resident #2 was found by staff at a local gas station 1.5 miles from the nursing home. Interview on 12/08/2021 at 11:10 a.m. with S1 Administrator revealed the facility was not aware of the breach in the gate until after Resident #2 eloped on 10/24/2021. S1 Administrator stated Resident #2 was placed on 1:1 supervision. Interview on 12/08/2021 at 11:34 a.m. with S4 RN revealed he received report regarding Resident #2 from the discharging facility on 10/22/2021, and was told to monitor her closely because she would leave the facility. S4 RN stated he did not inform S1 Administrator or S2 DON of the information that he received from the discharge nurse. Interview on 12/08/2021 at 11:48 a.m. with S8 NP revealed he did a telehealth visit with Resident #2 on 10/25/2021 as a result of her elopement from the facility on 10/24/2021. S8 NP stated he adjusted her medications for delusional thoughts and restlessness, and stated he would have suggested a more secure unit if he would have known Resident #2's intentions to get out of the facility were so strong. Interview on 12/08/2021 at 12:00 p.m. with S5 Maintenance Supervisor revealed he started working at the facility in March 2021, and the facility had several residents with wanderguards. S5 Maintenance Supervisor stated the gate on Wing 2 was used often by the facility to bring in heavy equipment, and confirmed Resident #2 breached the gate and was able to leave the grounds. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with S1 Administrator on 12/09/2021 at 11:53 a.m. revealed the front door and back door had key pad system that would alarm if a resident wearing a wanderguard exited through those doors. S1 Administrator stated wings (1, 2, 3, and 4) that lead to the patio did not have key pad system to alarm if a resident wearing a wanderguard exited through those doors. Review of the facility's investigation dated 11/08/2021 revealed S1 DON reviewed surveillance video footage that revealed the following: On 11/07/2021 at 9:42 p.m., S10 CNA left the facility due to a family emergency. S9 LPN remained 1:1 with Resident #2 until he assisted her to her room for bed at 10:04 p.m. S9 LPN returned to the nurse's station where he had a clear view of Resident #2's room. S9 LPN was observed to make rounds at 10:46 p.m. and 11:27 p.m. At 11:34 p.m. resident #2 exited her room and went out of wing 3 patio door. At 12:48 a.m. surveillance footage showed S9 LPN rounding down wing 3 and he noticed Resident #2 was not in her room. S9 LPN was observed to search other rooms and alert staff by calling a code W (elopement). S9 LPN discovered a chair had been placed against a fence and the decorative spikes where broken on wing 3 patio. S9 LPN was seen to exit the facility on 11/08/2021 at 1:20 a.m., and he was seen to return with Resident #2 at approximately 1:47 a.m. Review of local Sheriff's Office report dated 11/08/2021 revealed the following: 12:51 a.m. - Initial call made to Sheriff's office by reporter. 12:53 a.m. - Reporter headed to Sheriff's Department. 12:57 a.m. - Resident #2 dropped off at the Sheriff's Department. 1:12 a.m. - Nursing Facility called Sheriff's Department looking for Resident #2. 1:13 a.m. - Nursing Facility informed Resident #2 sitting in the lobby of the Sheriff's Department. 1:23 a.m. - Nurse enroute to pick up Resident #2. 1:41 a.m. - Nurse retrieved Resident #2. Interview on 12/07/2021 at 8:55 a.m. with S10 CNA revealed she worked 1:1 with Resident #2 on 11/07/2021. However, on 11/07/2021 around 10:30 p.m. or 11:00 p.m., she received an emergency family phone call and she had to leave the facility. S10 CNA stated Resident #2 was lying in bed, but not asleep, and stated she gave report to S9 LPN before leaving. Interview on 12/09/2021 at 11:53 a.m. with S1 Administrator revealed Resident #2 had been 1:1 since 10/24/2021. She stated on 11/08/2021, S9 LPN thought Resident #2 was asleep and he felt comfortable not to assign someone 1:1 due to Resident #2 sleeping. S1 Administrator stated S9 LPN agreed to monitor the resident until the CNAs completed making rounds. S1 Administrator stated it was the floor nurse's responsibility to ensure a staff monitored the resident, and it would be the nurse's responsibility to provide 1:1 if the nurse was unable to find anyone. S1 Administrator stated the nurse should always call the DON if there was an issue with staffing. S1 Administrator further stated that the DON would call her if it was something that she could not handle. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 12/10/2021 at 9:14 a.m. with S9 LPN revealed Resident #2 was 1:1 after the 10/24/2021 elopement, and he was instructed by S2 DON to make hourly checks on Resident #2 after her elopement on 10/24/2021. S9 LPN stated he worked 6:00 p.m. to 6:00 a.m. on 11/07/2021. When he arrived to work, Resident #2's 1:1 staff was with her, and the resident was saying that she was leaving the facility. S9 LPN stated the facility was short of staff on 11/07/2021; however, everyone usually worked together to provide care. S9 LPN stated Resident #2's 1:1 CNA left; however, another CNA was supposed to take over sitting 1:1 with Resident #2. S9 LPN stated on 11/08/2021 at 12:00 a.m. or 1:00 a.m., he made a room check and Resident #2 was not in the room. Telephone interview on 12/07/2021 at 12:42 p.m. with a local citizen revealed on the night of 11/08/2021(not sure of a the time), he was pumping gas at the local store next to the nursing facility when Resident #2 walked up to his truck and told him she needed a ride to the hospital. He stated he asked Resident #2 did she come from the nursing home next door and she stated No. He stated he called 911 and was told it would be 45 minutes before anyone would arrive, so he dropped Resident #2 off at the Sheriff's Department. Interview on 12/10/2021 at 9:48 a.m. with S2 DON revealed the 1:1 CNA should report off to the floor nurse when 1:1 supervision could not be provided. The floor nurse would be responsible for assigning someone else to provide the 1:1 supervision. If the nurse could not find anyone to provide the 1:1 supervision, then the nurse would have to provide the 1:1 supervision She stated their residents with wander guards have q 2 hour checks; however, if a resident had an actual elopement, licensed staff had to perform q 1 hour checks until the resident was no longer a high risk. She stated S9 LPN was responsible for sitting 1:1 with Resident #2 on 11/08/2021. She stated when she interviewed S9 LPN, he stated Resident #2 was sleeping; therefore, he didn't feel like anyone needed to sit 1:1 with the resident.