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	04/15/2021

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 31206 40882 41124 Based on observation and interview the facility failed to maintain a clean, comfortable, and homelike environment by failing to ensure resident's shower rooms were clean and sanitary for the 54 residents that used the shower rooms and failed to ensure bed linens were clean and odor free for 1 (#2) of 18 sampled residents. The facility census was 81 according to the Resident Census and Conditions form dated 04/11/2021. Findings: Observation of (a) hall shower room on 04/13/2021 at 11:52 AM escorted by S2 Interim DON revealed a wooden storage cabinet that contained resident personal clothing (4 pairs of socks), personal hygiene items including: perfume, body mist spray, deodorant, and lotion. Further observation revealed a gray wash basin on top of the cabinet that contained a pair female underwear with dried yellow stains. Observation on 04/13/2021 at 2:00 p.m. of the (b) hall shower accompanied by S2 Interim DON revealed the shower room door was locked. The door was unlocked by S2 Interim DON and the following was noted: dried, smeared feces on a tile wall upon entering the shower, right shower stall curtain stained with large, brown smears, thick, black mold and mildew to shower stall floor and walls including grout lines, left shower stall curtain black mold and mildew stains covering entire curtain, thick, black mold and mildew to shower stall floor and walls including grout lines. Further observation revealed a shower noted to be stained with urine and feces. Interview with S2 Interim DON at the time of observation confirmed the above findings. Interview on 04/13/2021 at 2:16 p.m. with S3 RN AIT revealed there was no housekeeping supervisor on staff at this time. She stated the Administrator was the acting Housekeeping Supervisor. She further stated housekeepers were supposed to clean shower rooms at the end of the day and CNA's were to clean stalls and shower chairs after each resident. Further interview revealed there were 21 residents that used the shower on the (a) hall and 33 residents that used the shower on the (b) hall. Further interview revealed she was not sure the last time she had been in the facility's shower rooms. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	04/15/2021

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/14/2021 at 1:21 p.m. with S7 Housekeeper revealed he was asked to remove the curtains and clean the shower stalls on the (b) hall yesterday by the DON. He stated the shower curtain from the right shower stall was washed and replaced and the shower curtain with the mold and mildew had to be thrown away. Interview on 04/14/2021 at 1:30 p.m. with S8 Housekeeper revealed the tiles and floors of the shower stalls on the (a) hall had been covered with mildew for atleast 3 weeks or more. She stated when she cleaned the (a) hall shower she cleaned the commode, sink, emptied the trash cans, swept the floor and mopped. She stated CNA's were responsible for cleaning shower stalls after each resident. She further stated she had not reported the condition of the shower stalls and should have. Interview with resident #51 on 04/14/2021 at 1:34 p.m. revealed he showered in the (b) hall shower room three times a week. He stated the shower curtains were always black and dirty and CNA's had to spray out the shower before he got in because there would often be BM on the shower floor and walls. Interview on 04/14/2021 at 1:37 p.m. with S1 Administrator revealed she was the acting Housekeeping Supervisor at this time. She stated CNA's were responsible for cleaning and disinfecting the shower stalls and chairs between residents. She stated housekeepers were responsible for sweeping and mopping shower floors at the end of the day and power washing shower stalls if needed to remove buildup. Further interview revealed she had not supervised the cleaning performed by the housekeepers or the need for power washing stalls and she should have. #2 Observation on 04//11/2021 at 11:45 a.m. revealed Resident #2 was not in his room. His bed was unmade, there was a large yellow brown stain observed on the bed linens and a strong urine smell was noted in the room. His roommate was in the room. Observation on 04/11/2021 at 2:35 p.m. revealed Resident #2 was not in his room and the bed sheets still had a large yellow brown stain and the room still smelled of urine. Observation on 04/11/2021 at 2:50 p.m. accompanied by S19 LPN revealed Resident #2 was lying in his bed. When the resident got up, the bed linens still had the large yellow brown stain. S19 LPN confirmed the bed linens were soiled with urine and should have been changed. Interview on 04/13/2021 at 2:15 p.m. with S20 CNA revealed bed linens are changed every other day, on the resident's bath day, or as needed. She confirmed that Resident #2's bed linens were soiled and she should have changed them when she made rounds but didn't.

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	04/15/2021

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41410 Based on interview and record review, the facility failed to report an alleged incident of abuse to the State Survey agency in accordance with State law for 1 (#48) resident sampled for abuse in a total sample of 18. Findings: Review of the facility's policy titled Seven Step Abuse Prevention Policy revealed, in part . VII. Reporting/Response a) All violations and all substantiated incidents shall be reported to the appropriate agencies as required. Review of resident #48's medical record revealed an admitted [DATE] and a readmitted [DATE], with diagnoses that included Vascular Dementia with Behavioral Disturbance, Bipolar Disorder, unspecified, Unspecified Psychosis not due to a substance or known physiological condition, and Major Depressive Disorder, severe, with psychotic symptoms. Review of resident #48's quarterly MDS with an ARD of 02/10/2021 revealed a BIMS score of 12, indicating moderate cognitive impairment, the use of a wheelchair for mobility, and assistance of 2 people for transfers, bed mobility, dressing, and toileting. Observation of resident #48 on 04/11/2021 at 12:35 p.m. revealed her seated in bed, fully dressed and neatly groomed. She was alert and oriented to person, place, and time. Interview with the resident at this time revealed there was a CNA who cared for her at night who had pinched her on her arms, hit her in her nose with her hand, and put her knee over the resident's right upper leg and told her to shut up and stop reporting her, or else she would hurt her worse. Resident #48 stated she could not recall how long ago this had occurred, but she thought it was over a year ago. She stated she notified S1 Administrator, S3 RN/AIT, the activity director, and the social worker, but nothing had been done. She further stated that last week, the same CNA had rolled up her call light, placed it behind her bedside table, out of her reach, and told the resident to stop calling her. Resident #48 stated the CNA had not been physically abusive to her since the incident about a year to a year and a half ago. Review of a Resident Concern Form dated 10/16/2020 for resident #48, initiated by S21 SSD and signed by S1 Administrator and S3 RN/AIT, revealed the resident verbalized to S21 SSD that 4 CNAs had slapped her and made her go to bed. Further review of the form revealed S21 SSD and S1 Administrator met with the resident to discuss her concerns, and the resident could not give a date for which the incident occurred, but informed them that 5 people, whose names she could not provide, were involved. She further informed S21 SSD and S1 Administrator that her whole face was black and blue following the incident. (continued on next page)

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	04/15/2021

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with S1 Administrator on 04/12/2021 at 1:45 p.m. revealed she had not initiated a SIMS report after being informed by S21 SSD of resident #48's abuse allegation. S1 Administrator stated she turned the investigation over to S3 RN/AIT, who was the facility's DON at the time of the alleged incident, because it was a nursing issue. Review of the facility's Seven Step Abuse Prevention Policy with S1 Administrator at this time revealed her to confirm that any allegations of abuse should be thoroughly investigated and reported to the proper authorities. S1 Administrator stated that she should have completed a SIMS report to inform the State Survey Agency of the allegation and results of the facility's investigation and had not done so.

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	04/15/2021

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41410 Based on interview and record review, the facility failed to conduct a thorough investigation of an alleged incident of abuse for 1 (#48) resident sampled for abuse in a total sample of 18. Findings: Review of the facility's policy titled Seven Step Abuse Prevention Policy revealed, in part . V. Investigation Facility shall investigate events upon being notified of a concern by a resident, staff member, or family member. a) All reported incidents will be investigated. b) Administrator and/or DON will be responsible for the initial reporting and investigation of alleged violations and reporting of results to proper authorities. c) All people working in an area where an allegation has arisen will be questioned. Residents will be questioned with consideration of their ability to be interviewed. The proper authorities will be notified when applicable. Review of resident #48's medical record revealed an admitted [DATE] and a readmitted [DATE], with diagnoses that included Vascular Dementia with Behavioral Disturbance, Bipolar Disorder, unspecified, Unspecified Psychosis not due to a substance or known physiological condition, and Major Depressive Disorder, severe, with psychotic symptoms. Review of resident #48's quarterly MDS with an ARD of 02/10/2021 revealed a BIMS score of 12, indicating moderate cognitive impairment, the use of a wheelchair for mobility, and assistance of 2 people for transfers, bed mobility, dressing, and toileting. Observation of resident #48 on 04/11/2021 at 12:35 p.m. revealed her seated in bed, fully dressed and neatly groomed. She was alert and oriented to person, place, and time. Interview with the resident at this time revealed there was a CNA who cared for her at night who had pinched her on her arms, hit her in her nose with her hand, and put her knee over the resident's right upper leg and told her to shut up and stop reporting her, or else she would hurt her worse. Resident #48 stated she could not recall how long ago this had occurred, but she thought it was over a year ago. She stated she notified S1 Administrator, S3 RN/AIT, the activity director, and the social worker, but nothing had been done. She further stated that last week, the same CNA had rolled up her call light, placed it behind her bedside table, out of her reach, and told the resident to stop calling her. Resident #48 stated the CNA had not been physically abusive to her since the incident about a year to a year and a half ago. (continued on next page)

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	04/15/2021

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Resident Concern Form dated 10/16/2020 for resident #48, initiated by S21 SSD and signed by S1 Administrator and S3 RN/AIT, revealed the resident verbalized to S21 SSD that 4 CNAs had slapped her and made her go to bed. Further review of the form revealed S21 SSD and S1 Administrator met with the resident to discuss her concerns, and the resident could not give a date for which the incident occurred, but informed them that 5 people, whose names she could not provide, were involved. She further informed S21 SSD and S1 Administrator that her whole face was black and blue following the incident. Review of a document typed and signed by S3 RN/AIT, who was the facility's DON at the time, revealed that, on 10/16/2020 at approximately 10:00 a.m., S21 SSD was contacted by an ombudsman, who reported that she had received a telephone call from resident #48 with a complaint of alleged physical abuse. Further review of the documented investigation revealed the resident reported to then DON (S3 RN/AIT) that 4 black CNAs and 1 white CNA slapped her and told her to go to bed and that S14 LPN was in the room watching the incident. S3 RN/AIT asked the resident if she could identify the CNAs, and resident #48 stated she didn't know their names, but could point them out if she saw them. The resident informed S3 RN/AIT that the incident occurred right before the hurricane when we evacuated to New [NAME], and that her whole face was black and blue, with a footprint on the left side of her face. When S3 RN/AIT asked the resident if she reported the incident to anyone at the time, the resident stated, Nobody believes me when I tell them, so it's no reason to tell anyone. Review of further documentation revealed S3RN/AIT to write that resident #48 was evacuated to New [NAME] for Hurricane [NAME], and staff who were present for the duration of the stay (listed were DON, ADON, QA Nurse, 4 LPNs and 6 CNAs) were not aware of bruising or allegations of abuse. S3 RN/AIT documented in conclusion, that, after an internal investigation was completed by DON, interviewing all staff that provided direct care to the resident, it was determined that the allegation of abuse could not be verified. Review of a typed document dated 10/19/2020 and signed by S3 RN/AIT revealed details of a follow-up interview with resident #48 concerning the abuse allegation. The resident was documented to describe the CNAs who allegedly slapped her, pulled her hair, and put a foot print on the side of her face. She informed S3 RN/AIT that the incident occurred 2 months prior, right before the evacuation to New [NAME]. In conclusion, S3 RN/AIT informed the resident to point out the CNAs who allegedly abused her to the ward clerk scheduled to work the night of 10/19/2020, and the resident replied, yes I'll let him know who they are so he can tell you their names. Interview with S1 Administrator on 04/12/2021 at 1:45 p.m. revealed she had not initiated a SIMS report after being informed by S14 SSD of resident #48's abuse allegation. S1 Administrator stated she turned the investigation over to S3 RN/AIT, who was the facility's DON at the time of the alleged incident, because it was a nursing issue. Review of the facility's Seven Step Abuse Prevention Policy with S1 Administrator at this time revealed her to confirm that any allegations of abuse should be thoroughly investigated and reported to the proper authorities. S1 Administrator stated that she should have completed a SIMS report to inform the State Survey Agency of the allegation and results of the facility's investigation and had not done so. Interview with S1 Administrator on 04/12/2021 at 1:45 p.m. revealed that, after meeting with S21 SSD and resident #48 regarding the abuse allegation recieved by an ombudsman, she had turned the investigation over to S3 RN/AIT, who was the facility's DON at the time of the alleged incident, because it was a nursing issue. S1 Administrator stated she had not conducted any staff interviews and had not reported the allegations to the State Survey agency. (continued on next page)

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	04/15/2021

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with S3 RN/AIT on 04/12/2021 at 2:15 p.m. revealed she had interviewed the resident after the allegation of abuse was called in to the ombudsman by resident #48 on 10/16/2020. S3 RN/AIT stated she had interviewed 3 of the nurses from the facility who had evacuated with the residents and cared for resident #48 during her stay at the New [NAME] facility. She further stated that she recalled speaking with some of the CNAs who evacuated with the residents, but she had not obtained written statements from them and had no documentation of the CNA interviews. S3 RN/AIT stated that when she conducted a follow-up interview with resident #48 on 10/19/2020, she asked the resident to notify the ward clerk on duty that night if she saw any of the CNAs who were abusive to her. She further stated that when she spoke to the ward clerk on 10/20/2020, he told her that resident #48 had not seen any of the CNAs in question the previous night. She stated she had no documentation of this interview. Review of the facility's Seven Step Abuse Prevention Policy with S3 RN/AIT at this time revealed her to confirm that any allegations of abuse should be thoroughly investigated and that all people working in the area where the allegation had arisen would be questioned. S3 RN/AIT stated that she had not conducted a thorough investigation, had not interviewed all staff who cared for resident #48 prior to and during the evacuation, had not interviewed S14 LPN, whom the resident named in the allegation, and had not obtained statements from or documented interviews with any of the facility CNAs and should have.

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	04/15/2021

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41410 Based on observations, interviews, and record reviews, the facility failed to ensure a resident receives care consistent with professional standards of practice to prevent the development of avoidable pressure ulcers for 1 (#78) of 4 (#31, #63, #71, #78) sampled residents reviewed for pressure ulcers by failing to perform weekly body audits on a resident at risk for developing pressure ulcers. Findings: This deficient practice resulted in an actual harm for Resident #78 on 04/11/2021, when during an observation with S11 Treatment Nurse and S12 RN/Weekend Supervisor, Resident #78 was observed to have an undated, yellow, soiled gauze to the left heel. When the gauze was removed, there were two unstageable, foul-smelling pressure ulcers to the bottom and lateral side of the left heel. Both of the pressure ulcers contained gray and yellowish tissue, greenish-brown drainage, and redness around the ulcers. S11 Treatment Nurse stated he was responsible for conducting weekly body audits, and he could not recall the last time he performed a head to toe body audit on Resident #78. Findings: Review of the facility's Policy for Prevention of Pressure Ulcers revealed, in part Risk Assessment: 1. Assess the resident on admission (within 8 hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. 2. Use a standardized pressure injury screening tool to determine and document risk factors. Skin Assessment: 1. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers. 2. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. Review of the resident's medical record revealed an admitted [DATE], and a re-admitted [DATE]. Diagnoses included, in part .Displaced Intertrochanteric Fracture of left femur, Sequela, Chronic Pain Syndrome, Bipolar Disorder unspecified, Schizoaffective Disorder unspecified, Unspecified Dislocation of Left Hip unspecified, Stage 3 Pressure Ulcer of sacral region, and Protein-Calorie Malnutrition unspecified. (continued on next page)

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	04/15/2021

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 0686 Level of Harm - Actual harm Residents Affected - Few	Further review of the resident's medical record revealed an Assessment of Pressure Sore Potential Form dated 10/08/2020, that revealed a risk score of 8. Further review of the document revealed a score of 7-39 required implementation of the facility's Pressure Sore Protocol. There were no pressure sore risk assessments completed after 10/08/2020 in the resident's medical record. Review of the facility's Pressure Ulcers/Skin Breakdown clinical protocol revealed, in part . Assessment and Recognition: 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers. 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces; and e. All active diagnoses. 3. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. Review of the resident's Braden Risk Assessment Report, the standardized assessment tool used by the facility, dated 12/10/2020 and documented as an Admission Assessment, revealed a risk score of 15, which indicated the resident's risk for skin impairment was mild. Further review of the resident's medical record revealed there were no other risk assessments completed after 12/10/2020. Review of resident #78's Significant Change MDS Assessment with an ARD of 03/05/2021 revealed a BIMS score of 3, indicating the resident had severe cognitive impairment. Further review revealed the resident required extensive assistance of 2 or more persons for transfers, bed mobility, dressing and toileting, and was totally dependent on staff for bathing and personal hygiene. The resident used a manual wheelchair for mobility. Review of the resident's Comprehensive Care Plan with a target date of 06/05/2021, revealed the resident had a problem of Actual Skin Impairment, which included: Stage 3 PU to sacrum (02/15/2021), and Stage 3 Left Heel resolved (02/26/2021). Approaches included: Braden risk assessment quarterly, annually, and with significant change, Use pillows or wedges to reposition resident, float heels, and protect bony prominences. (continued on next page)

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	04/15/2021

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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's Physician's Orders for April 2021 revealed, in part .NWB to LLE, Bilateral heel protectors to be worn in bed, cleanse wound to right hip with wound cleanser, apply betadine and cover with dressing daily until healed; and Cleanse stage 3 pressure ulcer to sacral area with NS or wound cleanser and apply zinc oxide daily and prn until resolved (start date of 02/24/2021). There were no orders for wound care to the left heel documented. Review of the resident's March eTAR revealed an order dated 02/24/2021 for application of a bulky dressing to the left heel as a protective measure every Monday and Thursday and as needed for 2 weeks. Further review of the March eTAR revealed the order was discontinued on 03/26/2021. Review of resident #78's eMARs and eTARS, for the months of February 2021, March 2021, and April 2021 revealed no order for or documentation of weekly body audits. Body audits were documented in the eMAR or eTAR for residents for whom weekly body audits were ordered. Resident #78's Wound Assessment Reports completed by S11 Treatment Nurse with the following dates revealed in summary: 02/26/2021- Stage 3 pressure ulcer to the left heel was resolved. 03/08/2021- Assessment of a Stage 3 pressure ulcer to the left heel; identified on 10/09/2020 was present upon admission. Wound resolved. Review of the resident's medical record revealed there were no weekly skin assessments documented after the left heel stage 3 pressure ulcer was documented as resolved on 03/08/2021. Review of the resident's nurses' notes revealed she was transferred to a local hospital'sER on [DATE] at 12:45 p.m., for difficulty breathing, remained in the ER for observation for 13 hours, then was returned to the facility. Review of a Facility to Hospital Transfer form dated 04/04/21 at 12:33 p.m. revealed the section labeled Risk Alerts contained check marks next to falls, aspiration, pressure ulcers, and limited/non-weight bearing. There were no risk alerts for the section labeled Skin/Wound Care (pressure ulcer stage, location, appearance, treatments). Review of a Non-Trauma EMS Field Report for resident #78 dated 04/04/2021 at 1:12 p.m. revealed the resident had edema to LLE, and bleeding to her left ankle. Review of resident #78's Emergency Patient Record notes dated 04/04/2021 at 1:39 p.m. revealed documentation by the ER RN that stated foul smelling decubitus ulcer noted to left heel. Further review of the ER record, including the discharge assessment, revealed no further documentation of care to the resident's left heel and no wound care orders. (continued on next page)

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	04/15/2021

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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of resident #78's nurses' notes dated 02/24/2021 at 2:09 a.m. and documented by S14 LPN revealed the resident was readmitted to the facility on [DATE] at 6:30 p.m. after a hospitalization . S14 LPN documented that a full body assessment was completed, with scabbing noted to left knee and a dressing in place to left heel. No Braden Risk Assessment was observed to be completed after the resident's readmission, and no order for weekly body audits was obtained. Review of resident #78's nurses' notes dated 04/05/2021 at 2:16 a.m. by S15 LPN revealed the resident returned to the facility after being transferred to a local ER for evaluation and treatment of a UTI. Further review of the nurses' notes revealed there was no documentation of any skin abnormalities or dressings that were in place. Observation of resident #78 on 04/11/2020 at 10:51 a.m. revealed her lying on a low bed with her legs and feet uncovered. She was alert and confused. Her left heel was wrapped with a gauze dressing that covered the ball of her foot to just below her ankle. The dressing was unraveled in some areas, yellow in color, soiled and not dated. The area of dressing that covered the heel was noted to have a baseball sized area of brown discoloration and drainage that had seeped through the layers of the gauze dressing, and a foul odor was present. The resident was not wearing heel protectors, and none were observed in her room. The resident's heels were not floated. Interview with S22 CNA on 04/11/2021 at 3:25 p.m. revealed she was the CNA assigned to resident #78 and dressed the resident, placed socks on both of her feet, and transferred her into her wheelchair this morning. She stated she saw the brownish discoloration on the heel of the dressing, but did not report it because she thought the treatment nurse was taking care of it. Interview with S11 Treatment Nurse on 04/11/2021 at 2:30 p.m. revealed he worked Monday through Friday and every other week-end as treatment nurse. S11 Treatment Nurse stated that he was responsible for performing weekly skin audits on residents who were at risk for pressure ulcers. He stated that resident #78 had a Stage 3 PU to her sacrum, and a DTI on her right hip that was discovered on 04/10/2021. S11 Treatment Nurse stated the resident currently had no other pressure ulcers. Interview with S12 RN/Weekend Supervisor on 04/11/2021 at 2:35 p.m. revealed she worked every other week-end and performed wound care treatments. She stated she had applied a dressing to resident #78's right hip wound and had observed the sacral area and applied zinc to it today (04/11/2021). S12 RN/Weekend Supervisor stated she was not aware of a PU on the resident's left heel, and there were no orders for wound care to the resident's left heel. Observation of resident #78 on 04/11/2021 at 2:40 p.m. with S11 Treatment Nurse and S12 RN/Weekend Supervisor revealed the resident lying in bed, fully dressed and wearing socks. This surveyor requested the resident's socks to be removed, that revealed a yellowed, undated gauze dressing to her left heel. A baseball sized area of brown discoloration was noted to the entire heel of the dressing, and a foul odor from the area was apparent. S11 Treatment Nurse removed the dressing to reveal two pressure ulcers to the bottom and lateral side of the heel that contained gray and yellowish tissue, foul smelling greenish-brown drainage, and redness to the skin that surrounded the ulcers. S11 Treatment Nurse was observed to gather supplies, and as he began to clean the ulcers with gauze and wound cleanser, resident #78 called out, no, no, stop! The areas were measured and staged by S11 Treatment Nurse as follows: 1. Left heel - 4.1cm L x 5cm W x 0.2cm D, with 100% Slough and Unstageable. (continued on next page)

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	04/15/2021

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 0686 Level of Harm - Actual harm Residents Affected - Few	2. Lateral aspect of left foot/heel - 2.5cm L x 2.4 cm W x 0.2cm D, with 90% Eschar and 10% Slough, and Unstageable. Interview with S11 Treatment nurse on 04/11/2021 at 2:48 p.m. revealed he was not aware of the dressing and pressure ulcers to resident #78's heel and that he had resolved a left heel pressure injury weeks ago. S11 Treatment nurse stated there were no orders for wound care in place for resident #78's left heel. He stated he last observed the resident's left heel on 03/08/2021, and it contained 100% epithelial tissue. He further stated he continued dressing the heel with a bulky dressing twice weekly, after it was documented as resolved on 03/08/2021, as a protective measure, until the order was discontinued on 03/26/2021. He confirmed the dressing removed from the resident's heel on 04/11/2021 had no date or initials on it and stated he didn't know how long the dressing had been in place. He stated he was responsible for performing weekly body audits on residents, in which he assessed the residents' skin from head to toe. He stated he did not recall when he had last performed a body audit on resident #78. When questioned regarding a Wound Assessment Report that revealed the left heel wound was resolved on 02/26/2021, and another Wound Assessment Report that revealed the wound was resolved on 03/08/2021, S11 Treatment Nurse stated the left heel wound was resolved on 03/08/2021, with no further comment. Interview with S15 LPN on 04/11/2021 at 5:10 p.m. revealed he worked 6:00 p.m. - 6:00 a.m. shifts and worked the night of 04/05/2021 when the resident returned from an ER visit. S15 LPN stated the resident had a dressing on her left heel. He further stated he could not recall a time when her heel wasn't dressed. He stated he didn't really pay attention to the dressing because he was not responsible for assessing existing wounds. S15 LPN stated he had never observed resident #78's heel and had never applied a dressing to it, because the treatment nurse was responsible for that. Interview on 04/11/2021 at 4:00 p.m. with S2 Interim DON and S3 RN AIT confirmed that resident #78 had no current orders for wound care to her left heel, and no documentation that the resident currently had wounds on her left heel. S2 Interim DON stated that the facility's wound care doctor would have to be notified because she felt the resident would need some type of debridement therapy for her heel. She stated it was the responsibility of the nurse who admitted /readmitted and assessed the resident to perform the Braden assessment, and if the assessment indicated the resident was at moderate or high risk for pressure ulcers, then it was a nursing measure to initiate weekly body audits. She further stated that if a resident was admitted /readmitted with wounds, it was the admitting nurse's responsibility to notify the treatment nurse, who was responsible for the assessment and care of the wound. S2 Interim DON confirmed that weekly body audits were not being performed on resident #78 and should have been. S2 Interim DON confirmed that the last Braden assessment performed on resident #78 was dated 12/10/2020. She stated the resident had not had a Braden assessment performed from the time she returned to the facility from a hospital stay on 02/23/2021, or quarterly, and should have. Both S2 Interim DON and S3 RN AIT stated that S14 LPN and S11 Treatment Nurse had not followed the facility's policy for completion of skin and risk assessments, as specified in the Pressure Ulcer Prevention policy, and that resident #78's pressure ulcer could have been prevented. (continued on next page)

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	04/15/2021

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 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with S14 LPN on 04/12/2021 at 1:30 p.m. revealed she readmitted resident #78 upon her return from the hospital on 02/23/2021. S14 LPN stated she completed a full body assessment on the resident when she returned from the hospital, and the resident had a dressing to her left heel. She stated she could not recall if the dressing was dated or timed. She stated the treatment nurse was responsible for evaluating wounds, and she did not remove the dressing. She further stated she could not recall a time when the resident did not have a dressing to her left heel. S14 LPN stated she had not completed a Braden risk assessment, nor had she entered an order for weekly body audits on the resident upon re-admission. She further stated she thought it was the treatment nurse's responsibility to complete Braden assessments and to order and perform weekly body audits.

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	04/15/2021

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39829 Based on observation, interview and record review the facility failed to implement recommended restorative nursing services for 1 (#11) of 18 sampled residents. The facility census was 81 according to the Resident Census and Condition of Residents dated 04/11/2021. Findings: Review of the medical record revealed that resident #11 was admitted on [DATE] with diagnoses that include; Hemiplegia of left non-dominant side, Contracture of muscle multiple sites and left hand contracture. Review of the Quarterly MDS with an ARD of 12/23/2020 revealed that the resident required extensive assistance for transfers, bed mobility, toileting, personal hygiene and bathing. Further review of the MDS revealed the resident received the following therapies in the 7-day look back: Speech Therapy - 4 days, 109 minutes, Occupational Therapy - 3 days, 145 minutes, and Physical Therapy - 3 days, 147 minutes. Review of the Physician Orders for the month of April 2021 revealed the following orders: Speech Therapy to treat 3 times a week for cognition Occupational Therapy to treat 3 times a week for therapeutic exercise, therapeutic activity, neuro re-education, group and modalities. Physical Therapy to treat 3 times a week for therapeutic exercise, range of motion, therapeutic activity, neuro re-education, group treatment and modalities as indicated. Review of the Occupational Therapy Discharge Summary revealed that resident #11 was discharged from therapy on 03/18/2021. Review of the Therapy Pending Planned Discharges dated 02/24/2021 revealed that resident #11 had a planned discharge date of [DATE] with a recommendation for the Restorative Nursing Program. Interview on 04/14/2021 at 11:45 a.m. with S4 COTA revealed that the resident was discharged from Occupational Therapy services on 03/18/2021. She stated that therapy included range of motion & stretching to left hand. She stated that the resident was non-compliant with hand roll but would hold hand weights and ride the hand bike using his left hand. She stated that the resident's goals were met and he was discharged from all therapies with recommendation for restorative. Further interview revealed that therapy discharge meetings are held on Thursdays. She stated that S2 Interim DON and S9 MDS Nurse were included in these meetings. She stated that she also sends an email of pending therapy discharges with these recommendations to S2 Interim DON and S9 MDS Nurse. (continued on next page)

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	04/15/2021

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/14/2021 at 11:55 a.m. with S10 CNA providing care for the resident revealed that she was not providing restorative for this resident. Further interview revealed that she thought the resident was still admitted to therapy services. She stated that S2 Interim DON or S9 MDS Nurse let her know when a resident was added to restorative care. Interview on 04/15/2021 at 8:25 a.m. with S2 Interim DON confirmed that the restorative task was not added to the kiosk for the CNA staff in March 2021 and should have been. She further confirmed that she received the email from therapy on 03/03/2021 with the resident's discharge and recommendation for restorative. She also confirmed that the information from this email and the therapy discharge meeting on Thursdays is used to order the restorative treatments. She stated that S9 MDS Nurse was included in the Thursday meetings and the email. She stated that S9 MDS Nurse was responsible for updating the care plan and adding the task to the CNA kiosk. Interview on 04/15/2021 at 8:37 a.m. with S9 MDS Nurse confirmed that she received that email from therapy on 03/03/2021 and also attended that Thursday therapy discharge meeting. She further confirmed that she had not added the restorative task and should have. She confirmed that she put the orders in the system to discontinue the therapies yesterday (04/14/2021) and was updating the care plan and kiosk tasks today. Review of the completed CNA kiosk tasks for March 2021 to present date with S9 MDS Nurse further confirmed that the restorative tasks had not been documented on.

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	04/15/2021

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41124 Based on observation, interview, and record review the facility failed to provide respiratory care consistent with professional standards for 2 (#49 and #50) of 2 residents reviewed for respiratory care. The facility failed to ensure respiratory equipment was properly changed, labeled, and stored. The total facility census was 81 according to the Residents Census and Conditions of Residents Form dated 04/11/2021. Findings: Review of the facility's Oxygen Administration Policy revealed in part . Steps in the Procedure 10. Tubing change weekly per facility practice. 14. Periodically re-check water level in humidifying jar. Default change every 7 days per facility practice. #49 Observation on 04/11/2021 at 11:00 a.m. revealed resident #49 laying in bed with a nasal cannula in her hand. The nasal prongs were noted to have a yellow discoloration. No date was noted on the oxygen tubing and the humidifier bottle attached to the concentrator was noted to be empty. Observation of the resident on 04/12/2021 revealed she was asleep in bed with oxygen in progress via a nasal cannula. No date was noted on the oxygen tubing and the humidifier bottle attached to the concentrator was noted to be empty. Observation of the resident on 04/13/2021 at 12:07 p.m. accompanied by S6 LPN revealed the resident was awake in bed eating lunch. A nasal cannula attached to a concentrator with yellow discolored prongs was observed on the floor next to the residents bed. There was no date noted on oxygen tubing, no storage bag and the humidifier bottle was noted to be empty. Interview with S6 LPN at the time of observation confirmed the above findings. She stated cannulas and humidifiers were supposed to be dated and changed out weekly. She also stated cannulas were supposed to be stored in ziploc bags when not in use and the resident's was not. Interview on 04/13/2021 at 12:24 p.m. with S3 RN AIT revealed cannulas and humidifiers were to be dated and changed out weekly on Saturdays by the weekend RN. Review of physicians orders for resident #49 revealed an order dated 01/05/2019 that stated: Change O2 tubing and humidifier q week on Saturday. #50 Review of Resident #50's Face Sheet revealed an admitted [DATE]. Review of Resident #50's Plan of Care with target date 05/16/2021 revealed care plans that included: Potential impaired airway clearance related to diagnoses Emphysema, history of Pneumonia. Interventions included: change O2 tubing, cannula, humidifier weekly and keep in bag when not in use. (continued on next page)

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	04/15/2021

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/11/2021 at 12:00 p.m. revealed Resident #50 was sitting on the side of his bed wearing a nasal cannula delivering oxygen at 2 liters per minute. The O2 tubing and the humidification bottle were not dated. He stated the O2 tubing had not been changed since he was admitted here. Interview on 04/11/2021 at 12:05 p.m. with S18 LPN confirmed the O2 tubing and the humidification bottle were not dated and she was not sure when the O2 tubing had been changed last. Interview on 04/14/2021 at 1:20 p.m. with S2 Interim DON revealed O2 tubing and humidification bottle changes are documented in the ETAR. Review of Resident #50's February, March, and April 2021 ETARs revealed no documentation that the resident's O2 tubing or humidification bottle had been changed. Interview on 04/15/2021 at 10:20 a.m. with S2 Interim DON confirmed there was no documentation on the ETAR indicating when the resident's O2 tubing and humidification bottle had been changed since admission.

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	04/15/2021

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40882 Based on interview and record review, the facility failed to provide pain management in accordance with the resident's comprehensive care plan by failing to administer oral pain medication in a timely manner and failing to accurately document narcotic administration and effectiveness for 1 (#48) resident sampled for pain in a total sample of 18. Findings: Review of the facility's policy and procedure titled Administering Pain Medication revealed it was developed to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication. Further review of the policy revealed, in part . 1. Pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. 2. Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. 3. Conduct a pain assessment, and evaluate and document the effectiveness of non-pharmacologic interventions (repositioning, warm or cold compresses, etc.) prior to medication administration. 4. Administer pain medication as ordered. 5. Document the following in the resident's medical record: results of pain assessment, medication, dose, route, and results of medication (adverse or desired). Review of resident #48's clinical record revealed an admitted [DATE] and a re-admitted [DATE], with diagnoses that included: Chronic Pain, Degenerative Joint Disease, Spinal Stenosis, Diabetic polyneuropathy, Myalgia, and Right Shoulder Osteoarthritis. Review of resident's quarterly MDS assessment with an ARD of 02/10/2021 revealed a BIMS score of 12, resident understands and is understood, and has frequent pain rated as severe, with use of prn pain medication 7 of the 7 days during the MDS look-back period. Review of resident #48's Comprehensive Care Plan with a target date of 05/10/2021 revealed, in part, a problem of pain, with goals to be free of pain/discomfort and that the resident will report onset of pain immediately. Approaches included: encourage to report any pain, administer pain medication as ordered, and assess effectiveness of pain meds. Interview with resident #48 on 04/14/2021 at 10:30 a.m. revealed she had a horrible night. She stated she called for pain medication several times during the night, but did not receive it until 5:15 a.m. this morning. She stated she pressed her call light, and a CNA would come in her room and cancel the call light. She further stated the CNA told her that it was not time for her pain medication, but she would tell her nurse. Resident #48 stated her call light stayed on for hours during the night, and the nurse never came into her room. (continued on next page)

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	04/15/2021

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #48's April 2021 eMAR and narcotic usage log with S13 LPN on 04/14/2021 at 10:35 a.m. revealed Hydrocodone/APAP 10-325 mg was signed out on the narcotic log on 04/13/2021 at 9:21 p.m. by S15 LPN, but was not documented as given on the resident's eMAR. Review of resident #48's nurses notes on 04/14/2021 at 10:50 a.m. revealed no documentation on 04/13/2021 at 9:21 p.m. by S13 LPN of assessment of the resident's pain, use of other measures to manage pain, or administration of any pain medication. Review on 4/14/2021 at 11:30 a.m. with S1 Administrator of the facility's video footage for dates 04/13/2021 from 8:30 p.m. through 04/14/2021 at 5:20 a.m. of resident #48's room door revealed the resident's call light first came on above her door at 1:00 a.m. on 04/14/2021. A CNA identified by S1 Administrator as S16 CNA was observed to enter the room at 1:45 and exit in less than 1 minute after cancelling the call light. The resident's call light came on again at 2:36 a.m. and remained on until 4:25 a.m., when a CNA identified by S1 Administrator as S17 CNA entered the room and exited in less than 1 minute after cancelling the call light. At 4:31 a.m., the resident's light came on, and at 4:38 a.m., S16 CNA entered the room and immediately exited after cancelling the call light. At 5:15 a.m., S15 LPN was observed to propel his medication cart next to the resident's room, prepare medication, and enter the resident's room. Upon completion of viewing the video recording from 04/13/2021 at 8:30 p.m. until 04/14/2021 at 5:20 a.m., S1 Administrator confirmed at this time that S15 LPN had not entered resident #48's room until 5:15 a.m. and was not observed to administer medication to her on 04/13/2021 at 9:21 p.m., as documented on the resident's narcotic log. Review of resident #48's narcotic usage log for Hydrocodone/APAP 10-325 mg, dated 04/03/2021 at 9:03 p. m. through 04/14/2021 at 5:20 a.m. revealed 33 administration entries, 6 of which were documented on the log sheet as wasted by S13 LPN. Further review of the administration dates and times on the resident's narcotic usage log against the resident's April eMAR administration dates and times revealed 17 of the 33 entries were not recorded on the eMAR. Interview with S2 Interim DON on 04/15/2021 at 10:55 a.m. confirmed the 17 discrepancies in resident #48's April 2021 narcotic administration record and eMAR. S2 Interim DON stated that all medication administered should have been documented on the resident's eMAR and narcotic usage log immediately after it was given, and it had not been. She further stated resident #48 had not been given her pain medication according to the facility's policy and procedure for pain medication administration.

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	04/15/2021

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 31206 41124 Based on observation and interview the facility failed to ensure that the nurse staffing pattern was posted daily and readily accessible for residents and visitors. The facility census was 81 according to the Resident Census and Conditions form dated 04/11/2021. Findings: Observations on 04/11/2021, 04/12/2021, 04/13/2021, 04/14/2021. and 04/15/2021 revealed the posted staffing pattern was dated 03/12/2021. Interview on 04/15/2021 at 1:20 p.m. with S2 Interim DON confirmed the above findings. She stated the ward clerk was responsible for updating the posted staffing pattern daily and had not done so since 03/12/2021.

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	04/15/2021

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41124 Based on observation and interview the facility failed to follow food storage and handling practices to prevent food borne illnesses. This practice had the potential to affect 80 of 81 residents receiving meals prepared in the facility's kitchen. Review of the Resident Census and Conditions of Resident's form dated 04/11/2021 revealed the facility's total census was 81. Findings: Observation on 04/11/2021 at 9:45 a.m. of the cooler in the facility's kitchen accompanied by S5 Cook revealed the following: (1) 4 pack of Jello with an expiration date of 03/25/2021, 1 opened 1 gallon container of cole slaw dressing, 1 opened, undated, 16 oz. bottle of fruit punch, 1 opened, undated, gallon of BBQ sauce, 1 opened, undated, gallon container of mayonnaise, 1 opened, undated, 5lb bucket of creamy peanut butter, 1 opened, undated, 4 lb. container of pimento cheese spread, 1 opened, undated, plastic ice cream container that contained tuna,1 personal insulated drinking cup with an inserted straw and one styrofoam drinking cup with a straw inserted. Further observation of the kitchen area revealed a plastic bin that contained an opened, undated ziploc bag of cornmeal and an opened 10lb bag of flour. Interview at the time of observation with S5 Cook confirmed the above observations. She stated the staff person opening the containers were responsible for dating items as they are opened. She further stated that personal drink items should not be stored in the cooler. Interview on 04/11/2021 at 10:31 a.m. with S2 Interim DON confirmed the above findings. She stated opened personal drinks should not be stored with facility food items. She also stated all food items should be dated after they are opened and before being stored.