STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195604	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Oaks Skilled Nursing and Rehabilitation	4921 Medical Drive Bossier City, LA 71112

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide services that met professional standards for 1 (#51) of 36 sampled residents. The facility failed to ensure safe medication administration practices by leaving medication at the bedside. Findings: Review of facility's Self-Administration of Medications policy revised December 2016 revealed in part: Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation: 1. As part of their overall evaluation the staff with the assistance from the practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. 2. In addition to general evaluation of decision-making capacity the interdisciplinary team will perform an assessment of Self-Administration of Medications Form, or equivalent including (but not limited to) the resident's; a. ability to read and understand medication labels; b. Comprehension of the purpose and proper dosage and administration time for his or her medications; c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medication; and d. Ability to recognize risks and major adverse consequences of his or her medications. 4. If the resident is determined to self-administer, then he/she will be capable and willing to assume control and responsibility for his/her medication. The resident must sign the Consent for Administration Of Medication Form regarding and agree to abide by the restrictions for handling and storage of medication according to one of the following plans. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195604	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER: Colonial Oaks Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 4921 Medical Drive Bossier City, LA 71112	

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Any bedside medications will meet all the required labeling specifications and guidelines required of any medications in the facility. 6. All medications are kept in a locked cabinet (night stand) in the resident's room where it is not accessible by other residents. 7. Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for self-administration, . 10. Nursing staff will review the self-administration record (MAR) appropriately noting that the doses were self-administered. 11. The staff will evaluate the resident who wishes to self-administer medications upon request or admission, readmission, routine quarterly, significant change MDS (Minimum Data Set) and PRN (as needed) in order to reevaluate a resident's ability to continue to self-administer medications. Review of resident #51's medical record revealed an admit date of 04/07/2022 with diagnoses that include in part acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, acute pulmonary edema, chronic diastolic (congestive) heart failure, atrial fibrillation, and shortness of breath. Review of resident #51's physician orders revealed in part: 05/05/2025 Nebulizer: Assess after administering Nebulizer Treatment Document Lung Sounds as 1=Clear 2=Rales 3=Congested 4=Crackles 5=Rhonci 6=Rubs 7=Wheezing 8=Diminished six times a day 05/05/2025 Ipratropium-Albuterol Solution 0.5-2.5 (3) MG (milligram)/3ML (milliliter) 3 ml inhale orally six times a day related to chronic obstructive pulmonary disease. Review of resident #51's medical record failed to reveal resident #51 had been assessed for self-administration of medications, to have medications at the bedside or was consented to have medications at the bedside. Review of resident #51's quarterly MDS dated [DATE] revealed in part a brief interview for mental status score of 15 indicating intact cognition. During an interview on 06/04/2025 at 4:45 p.m. S3 DON (Director of Nursing) and S2 Corporate Nurse confirmed resident #51 had been self-administering his nebulizer treatments, had not been assessed for self-administration, did not have a doctor's order for self-administration, and did not have a consent for self-administration of medications and should have. During an interview on 06/05/2025 at 4:40 p.m. resident #51 confirmed he had been self-administering his nebulizer medication daily.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to ensure quarterly statements were provided for 2 residents (#35, #54) of 2 (#35, #54) residents whose personal funds accounts were reviewed. The facility failed to provide quarterly statements to residents and or their responsible parties. Findings: Review of the facility's Resident Trust Fund Agreement included in the facility's admission packet revealed on page 13 the statement: I will receive a statement of any account at least quarterly. Resident #35 Review of Resident #35's medical record revealed an admit date of 02/16/2018 with diagnoses of but not limited to cerebral infarction, chronic obstructive pulmonary disease, polyneuropathy, abnormalities of gait and mobility and anxiety disorder. Review of Resident #35's Quarterly MDS (Minimum Data Set) dated 04/12/2025 revealed a BIMS (Brief Interview Mental Status) score of 15 indicating intact cognition. During an interview on 06/02/2025 at 3:47 p.m. Resident #35 reported she did not receive quarterly statements from the facility. Review of Resident #35's face sheet revealed resident's daughter was Resident #35's RP (responsible party)/emergency contact #1. During a telephone interview on 06/03/2025 at 8:35 a.m. Resident #35's RP reported not recieving quarterly personal funds statements from the facility in the past 6 months to a year. During an interview on 06/04/2025 at 12:45 a.m. S7 BOM (Business Office Manager) reported quarterly statements should have been hand delivered to residents in the facility who were their own responsible party or mailed to the person named on top of the quarterly statement. S7 BOM further reported residents' quarterly statements should have been sent out two weeks after the closing of the quarterly account and reported there was no tracking in place for verification that resident's quarterly statements were mailed out to Resident #35's responsible party. Resident #54 Review of Resident #54's medical record revealed an admit date of 09/20/2021 and a re-admission date of 12/14/2021 with diagnoses of but not limited to primary generalized arthritis, chronic obstructive pulmonary disease, major depressive disorder, essential hypertension and congestive heart failure. Review of Resident #54's Quarterly MDS dated [DATE] revealed Resident #54 revealed a BIMS score of 15 indicating intact cognition. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/02/2025 at 9:05 a.m. Resident #54 reported not ever receiving a quarterly personal funds statement from the facility. During an interview on 06/03/2025 at 12:20 p.m. S7 BOM reported Resident #54 signed a Resident Trust Fund Agreement when admitted and confirmed the facility did not have evidence or documentation showing Resident #54 was provided a quarterly statement of Resident #54's personal trust fund account.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to protect the resident's right to be free from neglect for 1 (#331) of 6 (#25, #75, #231, #281, #331 and #381) residents reviewed for pain. The facility failed to ensure Resident #331 received needed services and treatment for pain management of a right fractured hip by failing to ensure narcotic pain medication was obtained and administered to Resident #331 as ordered. The deficient practice resulted in an Immediate Jeopardy for Resident #331 on 05/28/2025 at 4:45 p.m. when Resident #331 was admitted to the facility for routine surgical healing and therapy after a fractured right hip. Resident #331 was discharged from the hospital on [DATE] with an order for Hydrocodone-acetaminophen (Norco) 10-325 mg (milligrams) po (by mouth) q (every) 4 hours prn (as needed) for pain. Resident #331 called EMS (Emergency Medical Service) on 05/29/2025 at 1:00 a.m. and requested to be taken to the ED (Emergency Department) for unrelieved pain after receiving Tylenol 650 mg. Resident #331 returned to the facility on [DATE] at 4:09 a.m. with instructions related to longstanding chronic pain management. Resident #331 continued to experience severe right hip pain and was only provided standing order pain medication of Tylenol 650 mg. The facility did not administer narcotic pain medication ordered for Resident #331 until 06/02/2025 at 9:00 a.m. when Resident #331 was at a pain level of 10 on a 1-10 pain intensity scale. This deficient practice has the likelihood to affect all other residents with medication orders. S1Administrator and S2Corporate Nurse were notified of the Immediate Jeopardy on 06/05/2025 at 1:45 p.m. The Immediate Jeopardy was removed on 06/05/2025 at 10:00 p.m. The facility implemented an acceptable Plan of Removal as confirmed through onsite observations, interviews and record reviews prior to exit. Findings: Review of the facility's Abuse and Neglect - Clinical Protocol policy revised October 15, 2022 revealed in part: Policy Statement: The facility will ensure that each resident has the right to be free from, among other things, physical or mental abuse and corporal punishment. The facility will provide a safe resident environment and protect residents from abuse. Definitions: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Neglect, as defined at §483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of goods or services that a resident(s) requires but fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress. Treatment/Management: 1. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. Record review of the facility's Administering Pain Medications policy revised July 7, 2019 revealed in part: Purpose: The purpose of this procedure is to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication. 4. Be familiar with the physiologic and behavioral (non-verbal) signs of pain. For example: a. Verbal expressions such as groaning, crying, whining: The following equipment and supplies will be necessary when performing this procedure; a. Explanation of pain scale severities of 0-10 or nonverbal indicators of pain scale; Steps in the Procedure 3. Conduct an abbreviated pain assessment if there has been not change of condition since the previous assessment . b. Verbal and non-verbal signs of pain; 5. Administer pain medications as ordered. Resident #331 was admitted to the facility on [DATE] with diagnoses, which included in part, other fracture of right femur, subsequent for closed fracture with routine healing, pain, depression, and anxiety disorder. Review of Resident #331's Nursing admission assessment dated [DATE] revealed in part, Resident #1 had a BIMS (Brief Interview of Mental Status) score of 15, indicating intact cognition. Further review of Resident #331's Nursing admission assessment dated [DATE] and baseline care plan revealed Resident #331 was totally dependent on staff for bed mobility, transfer, dressing and toilet use. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #331's hospital records dated 05/28/2025 for surgical repair of right hip fracture revealed in part a discharge medication reconciliation for the continuation of Hydrocodone-acetaminophen 10-325 mg; take 1 tablet by oral route every 4 to 6 hours as needed for pain. Review of Resident #331's medical record failed to reveal ED hospital records from 05/29/2025 had been acquired by the facility. Review of Resident #331's ED hospital records dated 05/29/2025 obtained by surveyor revealed in part a history of present illness as: Resident #331 presents to the ED with c.o. (complaint of) right leg pain. EMS reports that they transported patient (Resident #331) from rehabilitation facility for uncontrolled pain. EMS states that patient (Resident #331) recently had hip surgery to the right side, and was discharged from the hospital yesterday. It (Resident #331) reports that she has only received Tylenol from the facility she has been with, but states that it has not been helping . Further review of Resident #331's ED hospital records dated 05/29/2025 revealed in part, Resident #331 had been prescribed longstanding chronic pain medication and last filled a 30 day supply of Hydrocodone-acetaminophen 10-325 mg on 04/30/2025. ED instructions included in part for Resident #331's family to bring Resident #331's bottle of pain medication to the facility to be administered. Review of S13Medical Director's 2025 Standing Orders revealed in part: admission Orders: 1. Continue all orders from hospital including meds, if there are questions, contact NP (Nurse Practitioner)/AP (Advanced Practitioner). PRN Medications: c. Pain/minor complaints/fever: Tylenol 650 mg q 6 hours prn, notify NP if not effective after 2 doses. Review of Resident #331's Physician orders failed to reveal an order for narcotic pain medication until 06/02/2025 when Hydrocodone-acetaminophen tablet 10-325 mg; give 1 tablet by mouth every 4 hours as needed for pain was ordered via an original hard copy prescription (hard script) signed by S19NP. Review of Resident #331's May and June 2025 MARs (Medication Administration Record) revealed in part, on a pain intensity scale of 1 to 10, a pain level of 8 on 05/28/2025's night shift; a pain level of 2 on 05/31/2025's dayshift; and a pain level of 8 on 06/02/2025's evening shift had been documented. Further review of May and June 2025 MARs failed to reveal Tylenol 650 mg or Hydrocodone-acetaminophen 10-325 mg pain medication had been administered. Review of Resident #331's paper Narcotic Administration Record revealed Resident #331 received an initial dose of Hydrocodone-acetaminophen 10-325 mg on 06/02/2025 at 9:00 a.m. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #331's Interdisciplinary notes revealed in part, standing order pain medication was administered on 05/28/2025 at 10:02 p.m. and 05/29/2025 at 10:19 p.m. Further review of Resident #331's Interdisciplinary notes revealed a note by S14LPN (Licensed Practical Nurse) on 05/29/2025 at 1:09 a.m. which read in part: Writer (S14LPN) assessed Resident #331 at beginning of shift. Resident alert and oriented x 3. Complained of right hip pain of an 8 on pain scale. Writer (S14LPN) informed Resident #3 that her pain medication has been ordered but did not come in and offered Tylenol. Tylenol 650 mg administered per S13Medical Director's standing orders. Resident took medication without difficulty . Writer (S14LPN) went to room and Resident #331 was on phone with a 911 (Emergency Medical Services) . Resident #331 stated she needs something for pain because the Tylenol is not helping . Further review of Resident #331's Interdisciplinary notes revealed Resident #331 received Tramadol and Norco in the ED prior to returning to the facility on [DATE] at 4:09 a.m. Further review revealed the Pharmacy was notified of non-delivery of narcotic medication on 05/29/2025 at 10:27 p.m. and a hard script request was faxed to S13Medical Director's office on 05/29/2025 at 10:42 p.m. During an interview on 06/02/2025 at 8:00 a.m., Resident #331 reported she was in severe pain all over and had not received her pain medicine because the facility was out of her medicine. During an interview on 06/03/25 08:08 a.m., Resident #331 reported facility did not have her prescription pain medicine until yesterday, 06/02/2025. Resident #331 further reported she had been given Tylenol and stated it did not help. During an interview on 06/04/2025 at 9:30 a.m. Resident #331 reported she was told by her nurses the facility did not have her pain medication and she felt she was getting the run around. Resident #331 reported her hip pain became unbearable so she called EMS (on 05/29/2025) to come get her. During an interview on 06/04/2025 at 11:00 a.m., S15CNA (Certified Nursing Assistant) reported she took care of Resident #331 on 05/29/2025 and stated Resident #331's pain was through the roof. S15CNA further stated Resident #331 was crying and would scream when staff touched or turned her. During an interview on 06/04/2025 at 11:10 a.m., S16LPN reported the process for a new admit needing pain medication, was for the discharging hospital to send a hard script for the narcotic to be filled by the pharmacist. S16LPN further reported the facility had not received a hard script for Resident #331's narcotic pain medication upon admission and had to wait on S13Medical Director to provide one in order for Resident #331 to receive her pain medication. During an interview on 06/04/2025 at 12:20 p.m., S18PT (Physical Therapist) reported he evaluated Resident #331 on 05/29/2025 for a closed right hip fracture. S18PT further reported Resident #331 exhibited a high level of pain when touched and was unable to participate at the time. During a telephone interview on 06/04/2025 at 1:00 p.m. S14LPN reported she worked the 11-7 shift beginning 05/28/2025 and was informed by the evening nurse a request for hard copy script for pain medication had been sent to S13Medical Director. S14LPN reported Resident #331 had received Tylenol but called EMS to take her to the ED because she was in pain. S14LPN further reported at this time Resident #331 was at an 8 pain level. S14LPN stated I truly believe she was in pain or she wouldn't have called EMS. S14LPN confirmed she was not able to administer Norco without a hard copy script even if available in the emergency back-up system. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/04/2025 at 2:30 p.m., S3DON (Director of Nursing) reported the process for obtaining Narcotics for a new admit was for the nurse to fax the hard script to the facility's pharmacy. S3DON reported the nurse was responsible for contacting the physician to obtain a hard script if one was needed. S3DON further reported nurses cannot give Narcotics from the emergency locked pharmacy system without a hard script for the narcotic in hand. S3DON reported nursing staff should have called S13Medical Director to receive a hard copy script in a timely manner and did not. During a telephone interview on 06/04/2025 at 3:25 p.m., S13Medical Director reported he had been notified numerous times via fax to his phone by the facility regarding Resident #331 needing a hard script for narcotic pain medication. S13Medical Director reported he was out of town and was informed by S19NP Resident #331 was out of the facility on 05/29/2025. S13Medical Director reported he had not been informed of Resident #331's return to the facility. S13Medical Director acknowledged Resident #331 was admitted to the facility on [DATE] and did not receive narcotic pain medication until 06/02/2025 and should have. S13Medical Director reported Resident #331 would have been in significant pain related to her fracture. S13 Medical Director further reported the nurse should have called him or S19NP to get a hard script for Resident #331's narcotic. During a telephone interview on 06/04/2025 at 3:45 p.m., S19NP reported there had been a misunderstanding of Resident #331 being in the facility on 05/29/2025. S19NP reported on the morning of 05/29/2025 he was informed by staff of a new admit from the 05/28/2025 evening shift who had been sent out by EMS. S19NP reported he assumed Resident #331 had been admitted to the hospital and failed to clarify. S19NP acknowledged Resident #331 went without narcotic pain medication from 05/28/2025 to 06/02/2025 and should not have. During an interview on 06/05/2025 at 9:00 a.m., S12LPN reported the first day she was assigned to take care of Resident #331 was 06/02/2025. S12LPN further reported upon initial morning assessment, Resident #331 reported a 10 out of 10 pain. S12LPN further reported Resident #331 informed her she had been asking for pain medication since she was admitted and had not received any narcotic pain medication. S12LPN reported she checked the medication cart and discovered Resident #331 did not have a Norco blister package of doses in the medication cart. S12LPN further reported a request for a hard script for Norco was then faxed to S13Medical Director. During an interview on 06/05/2025 at 9:15 a.m., S19NP confirmed Resident #331 was in the facility on 05/29/2025 when he rounded. S19NP acknowledged he failed to see Resident #331 and provide a hard script for Norco. During an interview on 06/05/2025 at 9:30 a.m., Resident #331 reported she quit asking for pain medicine because she felt like no one was helping her. Resident #331 stated I'm [AGE] years old and I knew Tylenol was not going to work for this kind of pain. Resident #331 reported yesterday, 06/04/2025 was the first day she could tolerate getting out bed to go to therapy. During an interview on 06/05/2025 at 10:45 a.m., S3DON reported she was aware Resident #331 called EMS to get pain medicine and the issue was discussed in the morning meeting on 05/29/2025. S3DON reported S4ADON (Assistant Director of Nursing) was responsible for admit orders and ensuring medications are received and should have taken care of the issue regarding Resident #331's pain medication. S3DON reported she did not follow up and should have. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/05/2025 at 10:50 a.m., S4ADON reported she was aware Resident #331 did not receive ordered pain medication and S5Unit Manager was responsible for obtaining hard script. During an interview on 06/05/2025 at 11:00 a.m. S5Unit Manager reported she was aware resident #331 still did not have pain medication on 06/02/2025 and S4ADON was responsible to ensure a hard script was received. S5Unit Manager further reported she notified the S19NP on 06/02/2025 when she realized Resident #331's Norco had never been delivered. During an interview on 06/05/2025 at 11:50 a.m., S3DON acknowledged there had been a system failure for Resident #331 getting her pain medication at admission. S3DON further acknowledged she was ultimately responsible for following through to ensure Resident #331 received her narcotic pain medication and did not. During an interview on 06/05/2025 at 1:45 p.m. S1Administrator acknowledged there were issues identified for Resident #331 related to pain management and a communication failure between the MD, NP and nursing staff to obtain a hard script for narcotic medication. During an interview on 06/05/2025 at 8:30 p.m., S2Corporate Nurse reported the system failure for Resident #331 was due to S3DON and S4ADON (Assistant Director of Nursing) not following through to ensure Resident #331 received prescribed pain medication by failing to obtain a hard copy script for Norco. S2Corporate Nurse further reported DONs are trained by S2Corporate Nurse upon hire and training includes responsibilities and duties. The facility's Plan of Removal: Resident #331 and all new admissions with narcotic pain medications may be impacted by noncompliance. Staff did not obtain hard script for ordered narcotic pain medication at the time of admission or for 4 days after for Resident #331. Medication audit performed on 06/02/2025 by Administrative nurses to ensure all ordered narcotic medications were on the medication cart and available for residents. On 06/04/2025 all medication cars were audited again by QI (Quality Improvement) Nurse/DON and Administrative nurses and all narcotic medications were present. Medication orders for controlled substance prescriptions policy and procedure will be implemented 06/05/2025 by QI Nurse. To ensure residents are free from neglect and provided with the necessary goods and services of ordered narcotic pain medication DON and LPN/MDS (Minimum Data Set) nurse will be in-serviced on the Medication Orders Controlled Substance Prescriptions policy and procedure by RN (Registered Nurse)/QI Nurse. All other Administrative Nurses and staff nurses will be in-serviced on this policy and procedure by RN DON and/or LPN/MDS. In-service will be completed on 06/05/2025 for all staff nurses currently working on shift. Nurses unavailable for in-service on 06/05/2025 will be unable to work until training has been completed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Oaks Skilled Nursing and Rehabilitation	4921 Medical Drive Bossier City, LA 71112

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Nursing administration will review 24 hour report, which includes resident change in conditions and new physician orders, during morning meeting five days a week x 4 weeks to ensure any pain is addressed and neglect is not present. Any concerns identified will be addressed immediately with parties responsible for correction and reported to the Quality Assurance Committee. An Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting will be held with the Medical Director to review Plan of Removal. The DON will complete Narcotic Audit tool on a monthly basis and report findings to QAPI team along with any concerns identified in monitoring for this Plan of Removal monthly times 3 then as directed by the QAPI team. Date Facility Asserts the Likelihood for Serious Harm to Any Recipient No Longer Exists: 06/05/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195604	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Colonial Oaks Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4921 Medical Drive Bossier City, LA 71112	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to develop resident's comprehensive person-centered care plans with a focus and appropriate approaches on bed rails/side rails for 3 (#8, #12, and #27) of 3 (#8, #12, and #27) residents reviewed for physical restraints. Findings: Resident #8 Review of Resident #8's face sheet revealed an admission date of 05/01/2020 with diagnoses of fusion of lumbar spine, sequelae of cerebral infarction, rheumatoid arthritis, muscle wasting to multiple sites, unsteadiness on feet, lack of coordination, abnormalities of gait and mobility. Review of Resident #8's June 2025 physician orders revealed an order dated 04/04/2025: may have bilateral assist rails to promote independence in bed mobility. Check for placement and functioning. Review of Resident #8's Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed bed rails not in use. Review of Resident #8's care plan failed to reveal a focus with appropriate interventions on bed rails/side rails. Observation on 06/02/2025 at 3:23 p.m. revealed Resident #8 in bed with bilateral side rails raised to head of the bed. During an interview on 06/02/2025 at 3:23 p.m. Resident #8 reported the hand assist rails were used to assist to turn and reposition. Resident #12 Review of Resident #12's face sheet revealed an admission date of 05/01/2020 with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, epilepsy, weakness, contracture of muscle right/left thigh, generalized muscle weakness, cognitive communication deficit, unspecified dementia, severity, with mood disturbance, muscle wasting and atrophy to multiple sites, lack of coordination, and abnormalities of gait and mobility. Review of Resident #12's June 2025 physician orders revealed an order dated 04/04/2025: may have bilateral assist rails to promote independence in bed mobility. Check for placement and functioning. Review of Resident #12's Annual MDS assessment dated [DATE] revealed bed rails not in use. Review of Resident #12's care plan failed to reveal a focus with appropriate interventions on bed rails/side rails. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/02/2025 at 10:00 a.m. revealed Resident #12 in bed with bilateral side rails raised to head of the bed. Observation on 06/04/2025 12:40 p.m. revealed Resident #12 in bed with bilateral side rails raised to head of the bed. Resident #27 Review of Resident #27's face sheet revealed an admit date of 05/08/2023 with medical diagnoses parkinson's disease without dyskinesia, without mention of fluctuations, muscle wasting and atrophy to multiple sites, unspecified abnormalities of gait and mobility, generalized muscle weakness, cognitive functions following cerebral infarction, and epilepsy. Review of Resident #27's June 2025 physician orders revealed an order dated 04/04/2025: revealed may have bilateral assist rails to promote independence in bed mobility. Check for placement and functioning. Review of Resident #27's significant change MDS dated [DATE] revealed bed rails not in use. Review of Resident #27's care plan failed to reveal a focus with appropriate interventions on bed rails/side rails. Observation on 06/02/2025 at 2:34 p.m. Resident #27 revealed raised hand assist rails to both sides of the head of the bed. During an interview on 06/02/2025 at 2:34 p.m. Resident #27 reported the hand assist rails were used while in bed to assist to turn and reposition. During an interview on 06/04/2025 at 3:45 p.m. S6 MDS nurse reviewed Resident #8, #12, and #27's care plan and confirmed Resident #8, #12, and #27's care plan did not have a focus with appropriate interventions for bed rails/side rails.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on record review, observations, and interview the facility failed to provide appropriate treatment and services for 1(#52) resident of 1(#52) resident reviewed for tube feedings. The facility failed to ensure Resident #52's tube feeding bag was changed every 24 hours. Findings: Review of the facility's Enteral Feedings-Safety Precautions policy with a revision date of November 2018 revealed in part: 1. Change administration sets for open-system enteral feedings at least every 24 hours, or as specified by the manufacturer. Review of Resident #52's Physician Orders revealed an order dated 02/01/2024 to enteral feed every shift; Isosource 1.5. 45 ml (milliliter) per hour for 22 hours via feeding pump. Observation on 06/02/2025 at 8:15 a.m. revealed Resident #52's tube feeding bag infusing at 45 ml per hour dated 06/01/2025 at 4:00 a.m Observation on 06/02/2025 at 9:20 a.m. with S5 LPN (Licensed Practical Nurse) MDS (Minimum Data Set) Nurse revealed Resident #52's tube feeding bag infusing at 45 ml per hour and dated 06/01/2025 4:00 a.m During an interview on 06/02/2025 9:20 a.m. S5 LPN MDS Nurse acknowledged Resident #52's tube feeding bag was infusing at 45 ml per hour and dated 06/01/2025 at 4:00 a.m S5 LPN MDS Nurse confirmed the tube feeding bag should have been changed after 24 hours of use.

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(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 - Immediate jeopardy to resident health or safety 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** Based on record review and interviews the facility failed to provide pain management consistent with professional standards of practice for a resident, following a fractured right hip, for 1 (#331) of 6 (#25, #75, #231, #281, #331 and #381) residents reviewed for pain. Nursing staff failed to ensure severe pain was managed for Resident #331 by failing to ensure narcotic pain medication was obtained and administered to Resident #331 as ordered. The deficient practice resulted in an Immediate Jeopardy for Resident #331 on 05/28/2025 at 4:45 p.m. when Resident #331 was admitted to the facility for routine surgical healing and therapy after a fractured right hip. Resident #331 was discharged from the hospital on [DATE] with an order for Hydrocodone-acetaminophen (Norco) 10-325 mg (milligrams) po (by mouth) q (every) 4 hours prn (as needed) for pain. Resident #331 called EMS (Emergency Medical Service) on 05/29/2025 at 1:00 a.m. and requested to be taken to the ED (Emergency Department) for unrelieved pain after receiving Tylenol 650 mg. Resident #331 returned to the facility on [DATE] at 4:09 a.m. Resident #331 continued to experience severe right hip pain and was only provided standing order pain medication of Tylenol 650 mg. The facility did not administer narcotic pain medication ordered for Resident #331 until 06/02/2025 at 9:00 a.m. when Resident #331 was at a pain level of 10 on a 1-10 pain intensity scale. This deficient practice has the likelihood to affect all other residents with medication orders. S1Administrator and S2Corporate Nurse were notified of the Immediate Jeopardy on 06/05/2025 at 1:45 p. m. The Immediate Jeopardy was removed on 06/05/2025 at 10:00 p.m. The facility implemented an acceptable Plan of Removal as confirmed through onsite observations, interviews and record reviews prior to exit. Findings: Review of the facility's Pain Assessment and Management policy revised March 2025 revealed in part: Purpose: The purposes of this procedure are to help the staff identify pain in the residents, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain General Guidelines: 1. The pain management program is based on a facility-wide commitment to resident comfort. 2. Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. 3. Definitions of different pain include: (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Acute Pain refers to pain that is usually sudden in onset and time-limited with a duration of less than 1 month and often is caused by injury, trauma, or medical treatments such as surgery . 2. Possible Behavioral Signs of Pain: a. Verbal expressions such as groaning, crying, whining. Assessing Pain: b. Characteristics of pain: (1) Intensity of pain (Pain scale 0-10 or nonverbal pain). 2. Review the resident's clinical record to identify conditions or situations that may predispose the resident to pain, including: (4) Fractures; and (2) Surgical incision. Record review of the facility's Administering Pain Medications policy revised July 7, 2019 revealed in part: Purpose: The purpose of this procedure is to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication. 4. Be familiar with the physiologic and behavioral (non-verbal) signs of pain. For example: a. Verbal expressions such as groaning, crying, whining: The following equipment and supplies will be necessary when performing this procedure; a. Explanation of pain scale severities of 0-10 or nonverbal indicators of pain scale; Steps in the Procedure 3. Conduct an abbreviated pain assessment if there has been not change of condition since the previous assessment . b. Verbal and non-verbal signs of pain; 5. Administer pain medications as ordered. Resident #331 was admitted to the facility on [DATE] with diagnoses, which included in part, other fracture of right femur, subsequent for closed fracture with routine healing, pain, depression, and anxiety disorder. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #331's Nursing admission assessment dated [DATE] revealed in part, Resident #1 had a BIMS (Brief Interview of Mental Status) score of 15, indicating intact cognition. Further review of Resident #331's Nursing admission assessment dated [DATE] and baseline care plan revealed Resident #331 was totally dependent on staff for bed mobility, transfer, dressing and toilet use. Review of Resident #331's hospital records revealed in part a discharge medication reconciliation dated 05/28/2025 for the continuation of Hydrocodone-acetaminophen 10-325 mg; take 1 tablet by oral route every 4 to 6 hours as needed for pain. Review of S13Medical Director's 2025 Standing Orders revealed in part: admission Orders: 1. Continue all orders from hospital including meds, if there are questions, contact NP (Nurse Practitioner)/AP (Advanced Practitioner). PRN Medications: c. Pain/minor complaints/fever: Tylenol 650 mg q 6 hours prn, notify NP if not effective after 2 doses. Review of Resident #331's Physician orders failed to reveal an order for narcotic pain medication until 06/02/2025 when Hydrocodone-acetaminophen tablet 10-325 mg; give 1 tablet by mouth every 4 hours as needed for pain was ordered via an original hard copy prescription (hard script) signed by S19NP. Review of Resident #331's May and June 2025 MARs (Medication Administration Record) revealed in part, on a pain intensity scale of 1 to 10, a pain level of 8 on 05/28/2025's night shift; a pain level of 2 on 05/31/2025's dayshift; and a pain level of 8 on 06/02/2025's evening shift had been documented. Further review of May and June 2025 MARs failed to reveal Tylenol 650 mg or Hydrocodone-acetaminophen 10-325 mg pain medication had been administered. Review of Resident #331's paper Narcotic Administration Record revealed Resident #331 received an initial dose of Hydrocodone-acetaminophen 10-325 mg on 06/02/2025 at 9:00 a.m. Review of Resident #331's Interdisciplinary notes revealed in part, standing order pain medication was administered on 05/28/2025 at 10:02 p.m. and 05/29/2025 at 10:19 p.m. Further review of Resident #331's Interdisciplinary notes revealed a note by S14LPN (Licensed Practical Nurse) on 05/29/2025 at 1:09 a.m. which read in part: Writer (S14LPN) assessed Resident #331 at beginning of shift. Resident alert and oriented x 3. Complained of right hip pain of an 8 on pain scale. Writer (S14LPN) informed Resident #3 that her pain medication has been ordered but did not come in and offered Tylenol. Tylenol 650 mg administered per S13Medical Director's standing orders. Resident took medication without difficulty . Writer (S14LPN) went to room and Resident #331 was on phone with a 911 (Emergency Medical Services) . Resident #331 stated she needs something for pain because the Tylenol is not helping . Further review of Resident #331's Interdisciplinary notes revealed Resident #331 received Tramadol and Norco in the ED prior to returning to the facility on [DATE] at 4:09 a.m. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/02/2025 at 8:00 a.m., Resident #331 reported she was in severe pain all over and had not received her pain medicine because the facility was out of her medicine. During an interview on 06/03/25 08:08 a.m., Resident #331 reported facility did not have her prescription pain medicine until yesterday, 06/02/2025. Resident #331 further reported she had been given Tylenol and stated it did not help. During an interview on 06/04/2025 at 9:30 a.m. Resident #331 reported she was told by her nurses the facility did not have her pain medication and she felt she was getting the run around. Resident #331 reported her hip pain became unbearable so she called EMS (on 05/29/2025) to come get her. During an interview on 06/04/2025 at 11:00 a.m., S15CNA (Certified Nursing Assistant) reported she took care of Resident #331 on 05/29/2025 and stated Resident #331's pain was through the roof. S15CNA further stated Resident #331 was crying and would scream when staff touched or turned her. During an interview on 06/04/2025 at 11:10 a.m., S16LPN reported the process for a new admit needing pain medication, was for the discharging hospital to send a hard script for the narcotic to be filled by the pharmacist. S16LPN further reported the facility had not received a hard script for Resident #331's narcotic pain medication upon admission and had to wait on S13Medical Director to provide one in order for Resident #331 to receive her pain medication. During an interview on 06/04/2025 at 12:20 p.m., S18PT (Physical Therapist) reported he evaluated Resident #331 on 05/29/2025 for a closed right hip fracture. S18PT further reported Resident #331 exhibited a high level of pain when touched and was unable to participate at the time. During a telephone interview on 06/04/2025 at 1:00 p.m. S14LPN reported she worked the 11-7 shift beginning 05/28/2025 and was informed by the evening nurse a request for hard copy script for pain medication had been sent to S13Medical Director. S14LPN reported Resident #331 had received Tylenol but called EMS to take her to the ED because she was in pain. S14LPN further reported at this time Resident #331 was at an 8 pain level. S14LPN stated I truly believe she was in pain or she wouldn't have called EMS. S14LPN confirmed she was not able to administer Norco without a hard copy script even if available in the emergency back-up system. During an interview on 06/04/2025 at 2:30 p.m., S3DON (Director of Nursing) reported the process for obtaining narcotics for a new admit was for the nurse to fax the hard copy script to the facility's pharmacy. S3DON reported the nurse was responsible for contacting the physician to obtain a hard script if one was needed. S3DON further reported nurses cannot give narcotics from the emergency locked pharmacy system without a hard script for the narcotic in hand. S3DON reported nursing staff should have called S13Medical Director to receive a hard script in a timely manner and did not. During a telephone interview on 06/04/2025 at 3:25 p.m., S13Medical Director reported the nurse should have called him or S19NP to get a hard script for Resident #331's narcotics. During a telephone interview on 06/04/2025 at 3:45 p.m. S19NP acknowledged Resident #331 went without narcotic pain medication from 05/28/2025 to 06/02/2025 and should not have. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 06/05/2025 at 9:00 a.m., S12LPN reported the first day she was assigned to take care of Resident #331 was 06/02/2025. S12LPN further reported upon initial morning assessment, Resident #331 reported a 10 out of 10 pain. S12LPN further reported Resident #331 informed her she had been asking for pain medication since she was admitted and had not received any narcotic pain medication. S12LPN reported she checked the medication cart and discovered Resident #331 did not have a Norco blister package of doses in the medication cart. During an interview on 06/05/2025 at 9:30 a.m., Resident #331 reported she quit asking for pain medicine because she felt like no one was helping her. Resident #331 stated I'm [AGE] years old and I knew Tylenol was not going to work for this kind of pain. During an interview on 06/05/2025 at 11:50 a.m., S3DON acknowledged there had been a system failure for Resident #331 getting her pain medication at admission. S3DON further acknowledged she was ultimately responsible for following through to ensure Resident #331 received her narcotic pain medication and did not. During an interview on 06/05/2025 at 1:45 p.m. S1Administrator acknowledged there were issues identified for Resident #331 related to pain management and a communication failure between the MD, NP and nursing staff to obtain a hard script for narcotic medication. During an interview on 06/05/2025 at 8:30 p.m., S2Corporate Nurse reported the system failure for Resident #331 was due to S3DON and S4ADON (Assistant Director of Nursing) not following through to ensure Resident #331 received prescribed pain medication. S2Corporate Nurse further reported DONs are trained by S2Corporate Nurse upon hire and training includes responsibilities and duties. The facility's Plan of Removal: Resident #331 and all new admissions with narcotic pain medications may be impacted by noncompliance. Staff did not assure that hard script for pain medication was available upon admission and during the first four days of stay. Processes and systems for improvement include admission and administrative follow-up for narcotic availability for all admitting residents. The admission's director will forward hospital discharge orders to all administrative nurses, including the DON. Once hospital discharge orders are received, the ADON will request that copies of hard scripts for all narcotics be emailed to our admission's director and forwarded to administrative nurses. The DON or designee will ensure that all hard scripts are received prior to admission. If the hard script is not received, the DON or designee will contact the medical director to request a hard script for any narcotic order. The DON or designee will communicate with charge nurse, who is assigned to the admitting resident, until the prescribed narcotics are delivered to facility. Training for all nurses began immediately. Nurses in attendance on 06/05/2025 will be educated/in-serviced on the Medication Orders: Controlled Substance Prescriptions Policy and Procedures. All nurses will also be in- serviced on medication availability and proper notification to DON when medications, including narcotics, are not available. Nurses who are unavailable for training on this date will not be allowed to return to work until all training is complete. RN (Registered Nurse) DON and LPN MDS (Minimum Data Set) will provide education/training. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Monitoring by the DON will be in place for receipt of hard scripts and narcotic medications for all admitting patients. The nursing administration will review 24-hour reports which include resident changes of conditions, new physician orders, and any documented indications of pain, during the morning meeting for five days weekly for four weeks. Any concerns identified during the morning meeting will be addressed immediately to the parties responsible for correction and the QA (Quality Assurance) committee. An Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting will be held with the Medical Director, facility administrator, director of nursing, and social worker to review the plan of removal. The DON will complete the nursing audit tool monthly and report the findings to the QAPI team along with any concerns identified in monitoring for this plan of removal monthly times three then as directed by QAPI team. Date Facility Asserts the Likelihood for Serious Harm to Any Recipient No Longer Exists: 06/05/2025.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observations and interviews the facility failed to ensure facility's daily census and nurse/CNA (Certified Nurse Assistant) staffing information was clearly displayed in a visible place for residents and visitors to view at any given time. Findings: Observation of the facility on 06/02/2025 at 2:00 p.m. failed to reveal the facility's daily census/staffing information was posted. Observation of the facility on 06/03/2025 at 10:30 a.m. failed to reveal the facility's daily census/staffing information was posted. Observation of the facility on 06/04/2025 at 2:30 p.m. failed to reveal facility's daily census/staffing information was posted. During an interview on 06/04/2025 at 2:30 p.m. S17 CNA/Ward Clerk reported daily census, nurse/ CNA staffing information should be posted in a locked bulletin board in the facility breezeway. S17 CNA/Ward Clerk reported S1 Administrator had a key to the locked bulletin board and nurse/CNA staffing information was not posted on the weekend and have not been posted this week. During an interview on 06/04/2025 2:30 p.m. S1 Administration confirmed daily census, nurse/CNA staffing information should be posted daily and was not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195604	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER: Colonial Oaks Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 4921 Medical Drive Bossier City, LA 71112	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to provide pharmaceutical services that assure the accurate administering of medications for 2 (#44 and #331) of 2 (#44 and #331) residents whose medications were reviewed. The facility failed to ensure administration of pain medication was accurately documented. Findings: Record review of the facility's Administering Pain Medications policy revised July 7, 2019 revealed in part: Document the following in the resident's medical record: 1. Results of the pain assessment 2. Medication 3. Dose 4. Route of administration; and 5. Results of the medication (adverse or desired). Review of Resident #44's medical record revealed an admit date of 07/22/2023 with diagnoses of but not limited to muscle wasting and atrophy, Parkinson's disease without dyskinesia, Crohn's disease, and primary generalized osteoarthritis. Review of Resident #44's Quarterly MDS (Minimum Data Set) dated 03/27/2025 revealed Resident #44 was assessed to have a BIMS (brief interview mental status) score of 13 indicating intact cognition. Further review revealed Resident #44 was assessed to have received scheduled pain medication during the seven day look back period. Review of Resident #44's June 2025 Physicians Orders revealed an order for Hydrocodone-Acetaminophen (Norco) oral tablet 10-325 mg (milligrams). Give 1 tablet by mouth every six hours for pain. Review of Resident #44's May 2025 MAR (Medication Administration Record) failed to revealed documentation of administration of Resident #44's 2:00 a.m. dose of Hydrocodone 10-325 mg on 05/03/2025, 05/04/2025, 05/06/2025 and 05/31/2025. During an interview on 06/05/2025 at 2:00 p.m. S2 Corporate Nurse confirmed Resident #44's Hydrocodone 325 mg should have been documented as administered on the MAR on 05/03/2025, 05/04/2025, 05/06/2025 and 05/31/2025. Resident #331 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #331 was admitted to the facility on [DATE] with diagnoses, which included in part, other fracture of right femur, subsequent for closed fracture with routine healing, pain, depression, and anxiety disorder. Review of S13Medical Director's 2025 Standing Orders revealed in part: admission Orders: 1. Continue all orders from hospital including meds, if there are questions, contact NP (Nurse Practitioner)/AP (Advanced Practitioner). PRN Medications: c. Pain/minor complaints/fever: Tylenol 650 mg q (every) 6 hours prn (as needed), notify NP if not effective after 2 doses. Review of Resident #331's hospital records revealed in part a discharge medication reconciliation dated 05/28/2025 for the continuation of Hydrocodone-acetaminophen 10-325 mg; take 1 tablet by oral route every 4 to 6 hours as needed for pain. Review of Resident #331's May and June 2025 MARs failed to reveal Tylenol 650 mg or Hydrocodone-acetaminophen 10-325 mg pain medication had been administered. Review of Resident #331's paper Narcotic Administration Record revealed Resident #331 received a dose of Hydrocodone-acetaminophen 10-325 mg on 06/02/2025 at 9:00 a.m. and on 06/03/2025 at 8:00 a.m. Review of Resident #331's Interdisciplinary notes revealed in part, standing order pain medication was administered on 05/28/2025 at 10:02 p.m. and 05/29/2025 at 10:19 p.m. During an interview on 06/04/2025 at 2:30 p.m. S3 DON (Director of Nursing) acknowledged doses of prn pain medication were written in the notes but should have been documented on Resident #331's MAR and were not. During an interview on 06/04/2025 at 3:20 p.m., S2 Corporate Nurse acknowledged the prn pain medication doses and Norco doses should have been documented as administered on Resident #331's MAR. During an interview on 06/05/2025 at 9:00 a.m., S12 LPN (Licensed Practical Nurse) acknowledged she had not documented the 06/02/2025 9:00 a.m. and the 06/03/2025 8:00 a.m. doses of Norco on Resident #331's MAR and should have.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on record review, observation and interviews the facility failed to store, prepare, distribute and serve food under sanitary conditions. The facility failed to ensure: 1. Kitchen staff properly monitored the chemical levels in the third compartment sanitization sink 2. the chest freezer remained free from ice buildup 3. expired/outdated food was removed from the chest freezer and 4. The chest freezer was free of spilled food items. This had the potential to affect any of the 77 residents who received trays out of the kitchen on 06/02/2025. Findings: Review of the facility policy titled Manual Cleaning and Sanitizing Utensils and Portable Equipment dated 10/01/2018 revealed in part: 8. Sanitize all multi-use eating and drinking utensils and the food-contact surfaces of other equipment in the third compartment by one of the following methods: b. Immerse for at least 60 seconds in a clean sanitizing solution containing: i. A minimum of 50 parts per million of available chlorine at a temperature not less than 75 degrees Fahrenheit. 9. Test and record the parts per million concentration of the solution. A sample Test Strip Log for Three-Compartment sink follows this policy. Review of the facility policy titled Refrigerators, Coolers and Freezers dated 10/01/2018 revealed in part: Policy: The facility will maintain refrigerators, coolers and freezers in a clean and sanitary manner to minimize the risk of food hazards. Refrigerators, coolers and freezers will be kept clean on a daily basis and will be thoroughly cleaned every month or more often as needed. 2. Dispose of all outdated food and discard all leftover items greater than 72 hours old. Observation on 06/02/2025 at 8:00 a.m. revealed the following: 1. Accurately monitoring sanitization of the three compartment sink. 2. A large chest freezer with ice buildup all the way around the inside top of the freezer from the seal to approximately 5-10 inches deep. (continued on next page)

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	195604	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Two large bags of frozen okra that appeared discolored and dry/freezer burned with a label dated 02/14/2023 and one large bag of greens that appeared discolored/gray and dry/freezer burned with a label dated 11/04/2024 and 4. open/unbagged frozen vegetables loosely scattered in the bottom of the chest freezer During an interview on 06/02/2025 at 8:42 a.m. S11 Dietary Aide reported she used a thermometer to check the temperature in the third compartment sanitization sink and not a chemistry strip to check the chemicals like she should have. During an interview on 06/02/2025 at 8:30 a.m. S10 Dietary Manager confirmed and agreed with the findings.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to be administered in a manner that enabled its resources to be used effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 (#331) of 6 (#25, #75, #231, #281, #331 and #381) residents reviewed for pain. The facility failed to have an effective system in place to obtain and provide pain management for Resident #331 as ordered. The deficient practice resulted in an Immediate Jeopardy for Resident #331 on 05/28/2025 at 4:45 p.m. when Resident #331 was admitted to the facility for routine surgical healing and therapy after a fractured right hip. Resident #331 was discharged from the hospital on [DATE] with an order for Hydrocodone-acetaminophen (Norco) 10-325 mg (milligrams) po (by mouth) q (every) 4 hours prn (as needed) for pain. Resident #331 called EMS (Emergency Medical Service) on 05/29/2025 at 1:00 a.m. and requested to be taken to the ED (Emergency Department) for unrelieved pain after receiving Tylenol 650 mg. Resident #331 returned to the facility on [DATE] at 4:09 a.m. with instructions related to longstanding chronic pain management. Resident #331 continued to experience severe right hip pain and was only provided standing order pain medication of Tylenol 650 mg. The facility did not administer narcotic pain medication ordered for Resident #331 until 06/02/2025 at 9:00 a.m. when Resident #331 was at a pain level of 10 on a 1-10 pain intensity scale. This deficient practice has the likelihood to affect all other residents with medication orders. S1Administrator and S2Corporate Nurse were notified of the Immediate Jeopardy on 06/05/2025 at 1:45 p. m. The Immediate Jeopardy was removed on 06/05/2025 at 10:00 p.m. The facility implemented an acceptable Plan of Removal as confirmed through onsite observations, interviews and record reviews prior to exit. Findings, Cross reference F600 and F697: During an interview on 06/04/2025 at 2:30 p.m., S3DON (Director of Nursing) reported the process for obtaining Narcotics for a new admit was for the nurse to fax the hard script to the facility's pharmacy. S3DON reported the nurse was responsible for contacting the physician to obtain a hard script if one was needed. S3DON further reported nurses cannot give Narcotics from the emergency locked pharmacy system without a hard script for the narcotic in hand. S3DON reported nursing staff should have called S13Medical Director to receive a hard copy script in a timely manner and did not. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 06/04/2025 at 3:25 p.m., S13Medical Director reported he had been notified numerous times via fax to his phone by the facility regarding Resident #331 needing a hard script for narcotic pain medication. S13Medical Director reported he was out of town and was informed by S19NP Resident #331 was out of the facility on 05/29/2025. S13Medical Director reported he had not been informed of Resident #331's return to the facility. S13Medical Director acknowledged Resident #331 was admitted to the facility on [DATE] and did not receive narcotic pain medication until 06/02/2025 and should have. S13Medical Director reported Resident #331 would have been in significant pain related to her fracture. S13 Medical Director further reported the nurse should have called him or S19NP to get a hard script for Resident #331's narcotic. During a telephone interview on 06/04/2025 at 3:45 p.m., S19NP reported there had been a misunderstanding of Resident #331 being in the facility on 05/29/2025. S19NP reported on the morning of 05/29/2025 he was informed by staff of a new admit from the 05/28/2025 evening shift who had been sent out by EMS. S19NP reported he assumed Resident #331 had been admitted to the hospital and failed to clarify. S19NP acknowledged Resident #331 went without narcotic pain medication from 05/28/2025 to 06/02/2025 and should not have. During an interview on 06/05/2025 at 9:15 a.m., S19NP confirmed Resident #331 was in the facility on 05/29/2025 when he rounded. S19NP acknowledged he failed to see Resident #331 and provide a hard script for Norco. During an interview on 06/05/2025 at 10:45 a.m., S3DON reported she was aware Resident #331 called EMS to get pain medicine and the issue was discussed in the morning meeting on 05/29/2025. S3DON reported S4ADON (Assistant Director of Nursing) was responsible for admit orders and ensuring medications are received and should have taken care of the issue regarding Resident #331's pain medication. S3DON reported she did not follow up and should have. During an interview on 06/05/2025 at 11:50 a.m., S3DON acknowledged there had been a system failure for Resident #331 getting her pain medication at admission. S3DON further acknowledged she was ultimately responsible for following through to ensure Resident #331 received her narcotic pain medication and did not. During an interview on 06/05/2025 at 1:45 p.m. S1Administrator acknowledged there were issues identified for Resident #331 related to pain management and a communication failure between the MD, NP and nursing staff to obtain a hard script for narcotic medication. During an interview on 06/05/2025 at 8:30 p.m., S2Corporate Nurse reported the system failure for Resident #331 was due to S3DON and S4ADON (Assistant Director of Nursing) not following through to ensure Resident #331 received prescribed pain medication by failing to obtain a hard copy script for Norco. S2Corporate Nurse further reported DONs are trained by S2Corporate Nurse upon hire and training includes responsibilities and duties. The facility's Plan of Removal: Resident #331 and all new admissions with narcotic pain medications may be impacted by lack of administrative oversight. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administrator did not ensure that the staff obtained hard script for ordered narcotic pain medication at the time of admission or for 4 days after for Resident #331. The DON did not ensure that nursing responded appropriately for Resident #331's complaints of pain and ensure medication was available. RN (Registered Nurse) QI (Quality Improvement) nurse implemented medication orders for controlled substance prescriptions policy and procedure on 06/05/2025. Administrator will attend the clinical morning meeting with the administrative nurses and DON twice weekly to ensure the 24 hour report was reviewed and pain addressed timely and neglect is not present. Corporate QI RN will in-service Administrator on 06/05/2025 on validating that 24 hour report was reviewed and pain addressed timely and neglect is not present. Corporate QI RN will in-service DON or nursing responsibilities and staff oversight regarding ordering of pain medication. Corporate QI RN will provide oversight that the Administrator has attended the clinical morning meeting and reviewed the morning clinical QA (Quality Assurance) meeting form which includes the 24 hour report review by the DON to ensure accuracy and any issues were followed up on timely and neglect is not present. An Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting will be held with the Medical Director, facility Administrator, Director of Nursing and Social Services Director to review the Plan of Removal. The Administrator will complete the clinical meeting audit tool (which will ensure the 24 hour report was reviewed by DON) weekly times 4 weeks and report findings to QAPI team along with any concerns identified in monitoring for this Plan of Removal monthly times 3 then as directed by QAPI team. Date Facility Asserts the Likelihood for Serious Harm to Any Recipient No Longer Exists: 06/05/2025.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record reviews and interview, the facility failed to electronically submit accurate direct care staffing information, based on payroll, to CMS (Centers for Medicare and Medicaid Services) as required. Findings: Review of PBJ (Payroll Based Journal) Report for FY (Fiscal Year) Quarter 1 2025 (October 1-December 31) revealed triggers for the following: star staffing rating equals 1 and excessively low weekend staffing. Review of the facility's weekend staffing patterns for FY Quarter 1 2025 (October 5, 2024-Decemeber 29, 2024) revealed the facility had adequate amount of staffing hours. During an interview on 06/04/2025 at 11:50 a.m. S1 Administrator reported payroll was completed in the facility and ultimately sent to CMS by the Corporate Office. S1 Administrator reported the facility had above the required staffing hours for FY Quarter 1 2025. S1 Administrator reported the discrepancy with the staffing hours occurred when agency staff do not clock in on the facility clocking system and agency staffing hours have to be manually added to the payroll and/or facility employees have mispunched hours in the clocking system.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interview the facility failed to have the six required staff members present for quarterly QAA (Quarterly Assessment Assurance) Committee meetings. Findings: Review of the facility's Quality Assessment and Assurance Committee Summary meetings 07/23/2024, 10/23/2024, 01/24/2025, and 04/16/2025 sign-in sheets revealed the DON (director of nursing), IP (infection preventionist), MD (medical director), and Administrator were present. Further review failed to reveal the required two additional staff members were present for QAA meetings on 07/23/2024, 10/23/2024, 01/24/2025, and 04/16/2025. During an interview on 06/05/2025 5:30 p.m. S1 Administrator confirmed the required two additional facility staff members were not present for QAA meetings on 07/23/2024, 10/23/2024, 01/24/2025, and 04/16/2025.