

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 10/07/2020
NAME OF PROVIDER OF SUPPLIER COLONIAL OAKS SKILLED NURSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP 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 0610 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews and record reviews the facility failed to thoroughly investigate an allegation of inappropriate touching for 1 (#1) of 5 (#1, 2, 3, 4, 5) residents. Findings: Review of the facility incident reports failed to reveal and written statements from staff or residents regarding Resident #2 inappropriately touching Resident #1. During an interview on 10/6/2020 at 2:30 PM S2 DON (Director of Nursing) confirmed there was an allegation that Resident #2 inappropriately touched Resident #1. S2 DON indicated she interviewed the cognitive intact female residents living on the same hall as resident #1. However, S2 DON could not provide any documentation the interviews of the residents had been done. S2 DON confirmed there had been hearsay among the staff about Resident #2 inappropriately touching other residents. S2 DON acknowledged she had not formally interviewed or taken written statements from the staff. S2 DON indicated she was under the impression S1 Administrator had completed the staff interviews. During an interview on 10/6/2020 at 3:45 PM S1 Administrator confirmed written statements from staff and other residents should have been obtained by S2 DON. S1 Administrator indicated S2 DON should have conducted interviews with all staff involved and residents that could have been touched inappropriately by Resident #2 but she did not. S1 Administrator confirmed no interviews were conducted and no written statements were obtained from other residents or staff and they should have been.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.