

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195563	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER Southwind Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 804 Crowley-Rayne Hwy Crowley, LA 70526	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965</p> <p>Based on record review and interviews, the facility failed to ensure that a resident's physician and resident representative (RP) were immediately notified of a change in the resident's condition for 1(#1) of 3 (#1, #2, and #3) sampled residents by failing to notify the physician and RP that the resident had nausea and refused to take her medications in two days.</p> <p>Findings:</p> <p>On 05/07/2024, a review of the facility's undated policy titled Medication Administration - General Guidelines . Policy: Medications are administered in accordance with good nursing principles and practices .Refusals of Medication b. Medication refusal must be reported to the prescriber .</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Constipation, Nausea with Vomiting, Dementia, Overactive Bladder, Muscle Weakness, Protein Calorie Malnutrition, and Atrial Flutter.</p> <p>A review of the resident's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 04/30/2024 revealed she had a BIMS (Brief Interview for mental Status) of 5, indicating severe cognitive impairment.</p> <p>A review of Physician's Orders revealed an order for the following medications ordered on the specified date:</p> <p>11/27/2023 Levothyroxine 88 MCG (microgram) tablet 1 (PO) (by mouth) Q (every) day</p> <p>11/27/2023 Metolazone 2.5 mg (milligram) tablet 1 (PO) Q day</p> <p>11/27/2023 Potassium CL (chloride) ER (extended release) 20 MEQ (mill equivalent) tablet 1 (PO) Q day</p> <p>11/27/2023 Diltiazem 24H ER (Hydrochloride extended release) (CD) (controlled delivery) 300 MG CP (capsule) 1 (PO) Q day</p> <p>11/27/2023 Rivastigmine 4.6 mg/24 hr. (hour) patch - apply 1 patch topically Q day</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>03/25/2024 Celexa 20 mg tablet 1 tab PO Q day.</p> <p>04/16/2024 Mighty Shake supplement with meals.</p> <p>12/14/2023 Pantoprazole SOD DR (Sodium delayed release) 40 mg tab 1 PO Q day.</p> <p>11/27/2023 Ditropan XL (long acting) 5 mg tablet 1 PO Q day for overactive bladder.</p> <p>A review of the resident's April MAR (Medication Administration record) revealed the following medications and supplements were marked N (not given) on the specified dates:</p> <ul style="list-style-type: none"> -Mighty shake supplement on 04/20/2024 at 7:00 a.m. and 5:00 p.m. and on 04/21/2024 at 11:00 a.m. and 5:00 p.m. -Macrobid 100 mg (milligram) capsule on 04/21/2024 at 7:00 a.m. -Celexa 20 mg tablet on 04/20/2024 at 7:00 a.m. and 04/21/2024 at 7:00 a.m. -Levothyroxine 88 MCG on 04/20/2024 and 04/21/2024 at 6:00 a.m. -Pantoprazole SOD DR 40 mg tablet on 04/20/2024 and 04/21/2024 at 6:00 a.m. -Multivitamin tablet on 04/20/2024 and 04/21/2024 at 8:00 a.m. -Clonidine HCL (Hydrochloride) 0.1 mg tablet on 04/20/2024 at 7:00 a.m. and 04/21/2024 at 7:00 a.m. and 3:00 p.m. -Diltiazem 24 H ER (CD) 300 mg CP on 04/20/2024 at 7:00 a.m. and 04/21/2024 at 7:00 a.m. -Potassium CL ER 20 MEQ tablet on 04/20/2024 at 7:00 a.m. and 04/21/2024 at 7:00 a.m. -Ditropan XL 5 mg tablet on 04/20/2024 at 7:00 a.m. and 04/21/2024 at 7:00 a.m. -Metolazone 2.5 mg tablet on 04/20/2024 at 7:00 a.m. and 04/21/2024 at 7:00 a.m. -Lisinopril 10 mg tablet on 04/20/2024 at 7:00 a.m. and 04/21/2024 at 7:00 a.m. -Rivastigmine 4.6 mg/24 hr. patch on 04/20/2024 and 04/21/2024 at 7:00 a.m. <p>A review of the resident's medication administration record notes revealed the above medications were refused by the resident.</p> <p>A review of the resident's progress notes revealed three entries by S2LPN (Licensed Practical Nurse) that were summarized below:</p> <p>On 04/20/2024 at 12:34 p.m. - The resident continued to have bouts of nausea but no vomiting. She was served a clear liquid diet.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/21/2024 at 11:09 a.m. - The resident continued to complain of nausea.</p> <p>On 04/21/2024 at 6:38 p.m. - Gave the resident an 8 ounce cup of water at 5:15p.m. At 5:30 p.m. the resident's daughter is at her bedside and requested her mother sent to the ER for evaluation and treatment because she doesn't see she has improved since her visit on Friday. NP (nurse practitioner) advised order noted to send to ER. Resident was transported to ER at 6:15 p.m.</p> <p>There were no notes in the resident's administration record or progress notes on 04/20/2024 or on 04/21/2024 to indicate that the resident's physician or RP were notified that the resident had not taken her medications in two days.</p> <p>On 04/30/2024 at 4:27 p.m., a phone interview was conducted with the resident's RP. She stated that on 04/21/2024, her daughter went to the nursing home to visit her grandmother and called to let her know that the resident was not feeling well. She stated that when she got there S2LPN informed her that she didn't give the resident her medicines in a couple of days because she was nauseated. The RP stated that no one at the facility had notified her that her mother was nauseated and was refusing her medicines. She stated that her mother was transferred to the hospital and was there for four days then transferred back to the facility.</p> <p>On 05/06/2024 at 3:30 p.m., a phone interview was conducted with S2LPN. She stated that she had been working at the facility for over [AGE] years. She stated that on the 04/20/2024 and 04/21/2024 the resident refused her medications. S2LPN confirmed that she did not call the resident's representative or physician/nurse practitioner to make them aware the resident had nausea and refused her medications.</p> <p>On 05/07/2024 at 9:31 a.m., an interview was conducted with S3NP (Nurse Practitioner). He stated he was not notified that the resident had not taken her medications on 04/20/2024 and on 04/21/2024. He stated if the medications were refused or not taken he probably wouldn't do anything about it, but by noon and evening of 04/20/2024 there was a problem of which he should be notified. S3NP stated that if he had known that the resident did not take her medications for two days, he would have done something sooner.</p> <p>On 05/07/2024 at 10:00 a.m., an interview was conducted with S1DON (Director of Nursing) and S4RN (Regional nurse) who reviewed Resident #1's MAR and administration notes. They both stated a resident should not miss a full day of medications and especially two days. They both confirmed the RP and NP should have been notified of the resident's change in condition.</p>