STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195563	A. Building B. Wing	12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwind Nursing & Rehabilitation Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 49784 Based on record reviews and interviews, the facility failed to ensure a resident was free from verbal and physical abuse for 1 (Resident #R1) out of 4 (Resident #1, Resident #2, Resident #3, and Resident #R1) sampled residents. Findings: On 12/26/2024, a review of the facility's policy titled, Abuse and Neglect Policy and Procedure with a last revision date of 12/19/2024, read in part: Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Examples of verbal abuse may include but are not limited to: Yelling or hovering over a resident, with the intent to intimidate. Physical Abuse includes hitting, slapping, pinching, biting, shoving, and kicking. Resident #R1 Review of Resident #R1's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and Alzheimer's Disease. Review of the Quarterly MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 10/16/2024 revealed Resident #R1 had a BIMS (Brief Interview of Mental Status) score of 8, which indicated she was moderately cognitively impaired. Resident #3 Review of Resident #3's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, unspecified dementia, unspecified severity, with other behavioral disturbance, depression, and anxiety disorder. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Discharge MDS with ARD of 12/10/2024 revealed Resident #3 had a BIMS score of 6, which indicated she was severely cognitively impaired. A review of facility's incident report, dated 12/10/2024 at 7:20 PM, included a note by S2DON (Director of Nursing) that revealed in part: Staff reported they over heard yelling coming from the dining room. Upon entering, Resident #3 noted sitting in her wheelchair, directly in front of Resident #R1, blocking her in. Both residents were arguing at this time. Resident #3 was immediately removed from the area. Family members of another resident stated that Resident #3 went up to Resident #R1, started arguing with Resident #3, pushing Resident #R1 with Resident #3's wheelchair, told Resident #R1 to shut up, and hit Resident #R1 in the face. A review of a facility incident report, dated 12/10/2024, included a statement by S4VIS (Visitor) that revealed in part: Resident #3 went up to Resident #R1 and started arguing and pushed Resident #R1 with her wheelchair. Resident #3 told Resident #R1 that she was going to hit her. Resident #3 hit Resident #R1. A review of a facility incident report, dated 12/10/2024, included a statement by S5VIS (Visitor) that revealed in part: Resident #3 came rolling in the wheelchair and was pushing Resident #R1 with her wheelchair and told Resident #R1 to shut up, and Resident #R1 said she did not have to. Resident #3 then slapped Resident #R1. On 12/23/2024 at 3:54 PM a phone interview was conducted with S4VIS regarding the incident on 12/10/2024 between Resident #3 and Resident #R1. S4VIS stated that Resident #3 was arguing with Resident #R1 because Resident #3 did not want the lady to be in that spot. Resident #3 raised her fist and threatened to hit Resident #R1. Resident #R1 stated she was not going to move and Resident #3 slapped Resident #R1 in the face. On 12/23/24 at 4:28 PM, a phone interview was conducted with S5VIS regarding the incident on 12/10/2024 between Resident #3 and Resident #R1. She stated that Resident #R1 was sitting by the wall, and Resident #3 told Resident #R1 to move, and when Resident #R1 said she would not, Resident #3 raised her fist. S5VIS stated that Resident #R1 could not move because she was stuck. The next thing S5VIS remembers is that Resident #R1's glasses flew off. S5VIS stated that Resident #R1 was minding her own business before the argument. On 12/26/2024 at 12:08 PM, a joint interview was conducted with S1ADM (Administrator) and SDON. Both confirmed that an argument was held between Resident #3 and Resident #R1 on 12/10/2024. Both confirmed that this incident resulted in Resident #3 hitting Resident #R1 in the face and resulted in no injury to either resident.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 49784 Based on interviews, record reviews, and facility policy review, the facility failed to ensure an allegation of physical and verbal abuse was reported to the state survey agency no later than 2 hours after the allegation was made for 1 (Resident #R1) out of 4 (#1, #2, #3 and #R1) residents investigated for abuse. Findings: On 12/26/2024, a review of the facility's policy titled, Abuse and Neglect Policy and Procedure with a last revision date of 12/19/2024, read in part: Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Examples of verbal abuse may include but are not limited to: Yelling or hovering over a resident, with the intent to intimidate. Physical Abuse includes hitting, slapping, pinching, biting, shoving, and kicking. 7. Reporting/Response: The facility administrator or designee shall complete a report to be made to the mandated state agency according to state guidelines upon notification of an alleged abuse. Resident #R1 Review of Resident #R1's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and Alzheimer's Disease. Review of the Quarterly MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 10/16/2024 revealed Resident #R1 had a BIMS (Brief Interview of Mental Status) score of 8, which indicated she was moderately cognitively impaired. Resident #3 Review of Resident #3's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, unspecified dementia, unspecified severity, with other behavioral disturbance, depression, and anxiety disorder. Review of the Discharge MDS with ARD of 12/10/2024 revealed Resident #3 had a BIMS score of 6, which indicated she was severely cognitively impaired. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of facility's incident report, dated 12/10/2024 at 7:20 PM, included a note by S2DON (Director of Nursing) that revealed in part: Staff reported they over heard yelling coming from the dining room. Upon entering, Resident #3 noted sitting in her wheelchair, directly in front of Resident #R1, blocking her in. Both residents were arguing at this time. Resident #3 was immediately removed from the area. Family members of another resident stated that Resident #3 went up to Resident #R1, started arguing with Resident #3, pushing Resident #R1 with Resident #3's wheelchair, told Resident #R1 to shut up, and hit Resident #R1 in the face. On 12/26/2024 at 12:08 PM, a joint interview was conducted with S1ADM (Administrator) and SDON. Both confirmed that an argument was held between Resident #3 and Resident #R1 on 12/10/2024 and was not reported to the state survey agency. Both confirmed that this incident resulted in Resident #3 hitting Resident #R1 in the face and resulted in no injury to either resident.