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	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwind Nursing & Rehabilitation Center	804 Crowley-Rayne Hwy Crowley, LA 70526

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44418 Based on observations, interview, and record review, the facility failed to provide reasonable accommodations of the resident's needs by failing to ensure the call bell in the resident's room was in reach for 1 (#88) resident. The deficient practice had the potential to effect a census of 101. Findings: Review of facility's policy titled Call lights-use of, with a review date of 04/06/2024, read in part, Purpose: to provide the resident with a call light to notify staff to meet the need of the resident. Procedure: 10. Be sure all call lights are placed in reach. Resident #88 was admitted to the facility on [DATE] with diagnoses including: Dysphagia, Shortness Of Breath, Protein-Calorie Malnutrition, Major Depressive Disorder, Anxiety, Dependent on Dialysis, Cervical Disc Disorder at C4 (Cervical) - C5 with Myelopathy, Fracture at 1st Lumbar Vertebra, Encephalopathy and Pain. Review of Resident #88's Quarterly MDS (Minimum Data Set) dated 07/18/2024 revealed the resident had a BIMS (Brief Interview of Mental Status) score of 08, indicating a moderately impaired cognition. Section G revealed the resident requires Extensive Assistance with 2 person assist for bed mobility and toileting and total dependence with two person assist for transfers. On 10/14/2024 at 11:15 a.m., during an interview with Resident #88 he stated the staff puts his call bell too far for him to reach. An observation was made of the resident at the same time, and he was sitting up in his geri-chair. His call bell was laying across his bed, which was behind him, under the incontinent pad. Resident then attempted to reach the call light and was unable to. On 10/14/2024 at 11:36 a.m., an interview was conducted with S9LPN (Licensed Practical Nurse),. She observed Resident #88 reaching for his call light, as it was laying across his bed, which was behind him, under the incontinent pad and confirmed the call light was not in reach for the resident.

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: 195563	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024

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F 0584

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47251

Based on observations, interviews, and record review, the facility failed to ensure all areas or equipment were in good repair as evidenced by failing to ensure a resident's toilet was secured to the floor for 1 (#305) out of 8 (#13, #53, #61, #69, #83, #88, #100, #305) residents investigated for environment.

Findings:

On 10/16/2024 a review of the facility's policy titled Preventive Maintenance of Resident Equipment with a review date of 4/06/2024 was done. The policy read in part, Purpose: To provide a safe environment for residents and to meet safety guidelines. Policy: It is the job of all staff to identify areas of concern regarding the maintenance of resident equipment and building. Procedure: Preventive maintenance will occur throughout the year.

Review of Resident #305's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses that included, but were not limited to Shortness of Breath, Bipolar Disorder, Hypertensive Heart Disease Without Heart Failure and Anxiety.

Review of Resident #305's quarterly MDS (Minimum Data Set) with an ARD (Assessment Review Date) of 09/12/2024 revealed she had a BIMS (Brief Interview for Mental Status) of 13 which indicated she was cognitively intact. Further review of her MDS revealed she required supervision or touching assistance for toilet transfer.

On 10/14/2024 at 08:14 a.m., an observation was made of Resident # 305's bathroom. Resident # 305's toilet bowl was loose and moved easily with a gentle nudge. Resident #305 stated that she went to the bathroom without assistance.

On 10/15/2024 at 1:15 p.m., a second observation was made of Resident #305's toilet bowl. It was still loose and moved easily.

On 10/15/2024 at 1:34 p.m., an interview was conducted with S7Maint (Maintenance Supervisor) and he stated that maintenance checks were done on rooms monthly. He stated that maintenance in residents' rooms were also done when he was notified by the residents and/or staff. S7Maint stated that he was not aware of a loose toilet in Resident #305's room.

On 10/15/2024 at 1:40 p.m., an interview and record review was conducted with S1ADM (Administrator). He stated daily QA (Quality Assurance) were done throughout the facility by designated staff, which included checking the residents' rooms. A review was conducted with S1ADM of the QA document for 10/15/2024 revealed there were maintenance issues that included loose toilets. S1ADM confirmed that a QA was not conducted on 10/14/2024.

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NAME OF PROVIDER OR SUPPLIER: Southwind Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 804 Crowley-Rayne Hwy Crowley, LA 70526	

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47123 Based on record review and interview, the facility failed to ensure a resident identified with a qualified mental disorder was referred to the appropriate state-designated authority for Level II PASARR (Preadmission Screening and Resident Review) evaluation and determination for 2(#6, and #76) of 5 (#6, #8, #66, #76, and #81) residents sampled for PASARR, out of a total sample of 34 residents. Findings: On 10/16/2024, a review of the facility's policy titled, Pre-Admission Screening and Resident Review, reviewed date of 07/05/2024, read in part, . The facility is to review resident diagnosis and medications upon admission and throughout the resident stay to determine if a Level II request for resident review is to be completed. Resident #6 A review of Resident #6's medical record revealed that she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Depression, and Unspecified Psychosis. Further review of the resident's medical record revealed she was diagnosed with Unspecified Psychosis Disorder on 04/10/2024 and there was no written evidence a resident review had been submitted for a Level II PASARR evaluation and determination. On 10/15/2024 at 1:51 p.m., an interview conducted with S13SSD (Social Service Director) who confirmed she was responsible for submitting reviews to the OBH (Office of Behavioral Health) when a resident had a new qualifying mental illness. S13SSD confirmed that on 04/10/2024 Resident #6 had a new diagnosis of Unspecified Psychosis. She confirmed that she did not submit a Level II PASARR evaluation and determination review to OBH for Resident #6 and that she should have. 47251 Resident #76 A review of Resident #76's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses that included, but were not limited to Depression and Wernicke's Encephalopathy. Further review of Resident #76's medical record revealed she was diagnosed with Bipolar Disorder on 10/05/2022. There was no written evidence a resident review had been submitted for a Level II PASARR evaluation and determination. On 10/15/2024 at 4:08 p.m., an interview was conducted with S13SSD who confirmed that she was responsible for submitting reviews to the OBH when a resident had a newly qualifying mental illness. S13SSD confirmed that Resident #76 on 10/05/2022 had a new diagnosis of Bipolar Disorder. She confirmed that she did not submit a Level II PASARR evaluation and determination review to OBH for Resident #76 and that she should have.

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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 - Few	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** 47965 Based on observation, interviews, and record reviews, the facility failed to develop and implement a person centered care plan for 1 (#100) out of 34 sampled residents, by failing to ensure Resident #100 was care planned for repeatedly pulling her call bell station off the wall. The facility's census was 101. Findings: On 10/16/2024, a review of the facility's policy titled Care Plan Policy and Procedure with a review date of 04/08/2024, revealed in part, Purpose: To provide a comprehensive person-centered plan of care addressing resident's needs, strengths, goals and approaches. Policy: each resident's care plan will remain current and inform staff of resident's needs, strengths, goals and approaches . A review of Resident #100's medical records revealed that she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to Diabetes and Gastroesophageal Reflux Disease. Further review of the recent Quarterly Set (MDS) dated [DATE], revealed the resident had a BIMS (Brief Interview for Mental Status) of 8, which indicated moderate cognitive impairment. On 10/15/2024 at 9:10 a.m., an observation was made of the resident in her bed. The resident's call bell bed station was observed dislodged and hanging off the wall. The resident was not able to reach the wall station from her bed. The resident stated that the bed station kept falling off the wall. On 10/15/2024 at 9:10 a.m., S3DON (Director of Nursing) came to Resident # 100's room and confirmed the resident's call bell bed station was hanging off the wall and stated it should not be like that. The resident stated it was always like that and staff came in to put it back on the wall but did not fix it. She also stated that her call bell works and she was able to call for help but unable to reach the wall station to put it back on when it fell off. On 10/15/2024 at 9:15 a.m., S4RNSup (Registered Nurse Supervisor) confirmed the resident's call bell bed station was hanging off the wall. He stated that there was a proper way to place the bed station on the wall and if it was not placed properly it will keep falling off. On 10/15/2024 at 9:18 a.m., S1ADM (Administrator) walked in Resident #100's room and confirmed the call bell bed station was off the wall. He stated they have been having trouble with the resident pulling off the bed station, and it had been an ongoing problem. S1ADM also stated that the resident should be care planned for frequently pulling her call bell bed station from the wall. On 10/15/2024 at 12:36 p.m., an interview was conducted with S7Maint (Maintenance). He stated he was in-charge of maintenance and was aware that Resident #100 had been pulling her call bell bed station off the wall. He stated that the company showed him how to reapply it to the wall if she pulled it off. He stated that the company replaced the whole thing before but she pulled it off again. He stated he showed S4RNSup how to reapply it but preferred staff calling him when S4RNsup was not there because it had to be placed properly. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident's #100 medical record revealed she was not care planned for frequently pulling her call bell station from the wall. On 10/15/2024, at 1:14 p.m., an interview was conducted with S2RNCorp (Corporate Nurse) who confirmed Resident #100 was never care planned for frequently pulling her call bell off the wall until surveyors brought it to staff's attention.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50950 Based on observation and interview, the facility failed to properly store drugs as evidenced by loose pills found in the bottom of the medication cart drawers for 1 (Cart #4) of 2 (Cart #1, #4) medication carts observed. The facility had a total of four medication carts. Findings: Review of the facility's policy on 10/16/2024 titled Medication Storage Policy and Procedure dated 06/18/2024 read, in part, Purpose: To properly secure medications and biologicals according to CMS (Centers for Medicare & Medicaid Services) guidelines. Procedure: 2. Medication carts will be checked weekly for expired medications, loose pills, cleanliness and compliance with storage guidelines. a. Any expired medications or loose pills will be destroyed according to the standard guidelines. On 10/16/2024 at 11:08 a.m., Cart #4 was inspected with S9LPN (Licensed Practical Nurse). Two yellow oblong pills were observed loose on the bottom of the second drawer on the left side of the cart, one white oblong pill and a half of a white pill were observed loose on the bottom of the second to last drawer on the right side of the cart. The pills were observed underneath resident medication blister packages. S9LPN confirmed the loose pills at the bottom of the drawers. S9LPN stated these loose pills should not have been in the bottom of the medication cart. On 10/16/2024 at 11:15 a.m., S3DON (Director of Nursing) confirmed the loose pills in the bottom of the drawers of the medication cart 4. She stated these loose pills should not have been in the bottom of the medication cart.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 46149 Based on observations, interviews, and record reviews, the facility failed to ensure the provided diet met the nutritional needs of each resident as evidenced by failing to ensure dietary staff provided the appropriate portion sizes according to the recipe for 2 (#33, #97) out of 7 residents who received pureed meals. Findings: Review of the facility's policy titled Accuracy and Quality of Tray Line Service Policy and Procedure, with a last reviewed date of 05/09/2024, read in part: 7. Each meal will be checked for: .Proper portion sizes. On 10/14/2024 at 11:40 a.m., an observation was made of the food service line during lunch. Pureed food items (rice, turnip greens, beans and sausage, cornbread) were being served with a 1/2 cup scoop. Review of the recipe and diet spread sheet revealed pureed beans and sausage were to be served with a 3/4 cup or 6 oz (ounce) spoodle. S10Cook stated that she was instructed to serve all pureed food items with a half cup scoop. S8DM (Dietary Manager) was asked how the staff knew which serving scoops to use, and she stated the staff should have followed the recipes and recipe spreadsheets that lists the appropriate serving sizes. S8DM confirmed the wrong scoop size was being used to serve the pureed beans and sausage.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 46149 Based on observation and interview, the facility failed to ensure food was prepared and served in a form to meet individual needs for residents who received pureed diets as evidenced by: 1. Failing to ensure food items were pureed to the appropriate consistency; 2. failing to ensure rice was pureed according to recipe, and 3. failing to ensure regular textured beans and sausage were not placed on Resident #33's meal tray. This deficient practice had the potential to effect the 7 residents who received pureed diets. Findings: Review of the facility's policy titled Accuracy and Quality of Tray Line Service Policy and Procedure, with a last reviewed date of 05/09/2024, read in part: 5. Staff will refer to the meal identification (ID) card/ticket for food dislikes, allergies, and other details and substitute appropriately for those items .7. Each meal will be checked for: Accuracy of following the therapeutic diet extension. On 10/14/2024 at 10:17 a.m., an observation was made of S10Cook puree parboiled rice for the 7 residents who received pureed diets. S10Cook added 5 and 3/4 cup of rice and 1 and 2/3 cups of milk to the food processor. S10Cook was asked how she knew she was pureeing the correct amount of rice. She stated that she followed the recipe for 10 servings. Review of the recipe for pureed rice revealed the following: Ingredients- Pureed rice instant, 10 servings, 1 and 2/3 cup. Instructions: Bring water and salt (if desired) to a boil, whisk in pureed rice mix according to the product chart, whisk in butter, margarine, or oil if desired. Cover and place on steam table for 30 to 45 minutes. S10Cook stated that they did not use instant rice mix, but use parboiled rice and pureed it with milk instead. S10Cook proceed to puree the parboiled rice with milk and placed the finished product in a pan. Whole grains of rice were observed, and the rice had a sticky texture. S10Cook then covered the pan and placed in the holding oven. On 10/14/2024 at 10:30 a.m., an observation was made of S10Cook puree turnip greens with added bacon bits. At 10:36 a.m., an observation was made of the pureed turnip greens. Bacon bits and stems were visible in the pureed greens. S10Cook stated that she was finished pureeing the turnip greens. On 10/14/2024 at 11:07 a.m., an observation was made of the pureed turnip greens and pureed rice with S8DM (Dietary Manager). She confirmed that there were still grains of rice in the pureed rice and it was not smooth or pureed to the appropriate consistency. She also confirmed that bacon bits and stems were visible in the turnip greens and was not pureed to the appropriate consistency. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/14/2024 at 11:34 a.m., the recipe for pureed rice was reviewed with S8DM. She stated that the facility did not have instant rice mix although the recipe for pureed rice using instant rice mix was followed. She confirmed S10Cook did not use the correct recipe to puree parboiled rice, and the recipe for instant rice mix was not equivalent. On 10/14/2024 at 12:00 p.m., an observation was made of dietary staff prepare Resident # 33's lunch meal tray. The resident's meal ticket read: regular/puree, indicating the resident had a regular pureed texture diet. Pureed beans and sausage, turnip greens, rice, and cornbread were observed on the resident's plate. S11Dietary proceeded to scoop regular textured beans and sausage and placed on top of the resident's pureed beans and sausage. S11Dietary was asked what kind of diet the resident was on, and she stated pureed. She was then asked if there was a reason she placed regular textured beans and sausage on top of Resident #33's pureed beans and sausage, and she stated because the resident wanted extra juice/gravy from the regular textured beans. S8DM confirmed that the staff member should not have placed the regular textured beans and sausage on the resident's plate as the resident was on a pureed diet.