STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195393	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerfield Nursing & Rehabilitation Center	522 Main Street Delhi, LA 71232

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	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** 13974 Based on record review and interview, the facility failed to protect the resident's right to be free from physical and verbal abuse by staff for 1 (#1) of 3 (#1, #2, #3) residents reviewed for abuse. The facility failed to protect resident #1 from physical and verbal abuse by staff. Findings: Review of the facility abuse and neglect policy dated April 2021revealed it defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. The policy also defined willful as the individual must have acted deliberately, not that the individual must have attended to inflict injury or harm. Review of the facility's incident investigation report dated 06/05/2024, at 5:30p.m., revealed the nurse was called to the smoking patio where she found resident #1 on the floor by his wheelchair. He denied any pain or discomfort. The resident had no injuries. Record review revealed resident #1 was admitted to the facility on [DATE] with diagnoses of muscle weakness and Rhabdomyolysis. Review of resident #1's Minimum Data Set assessment dated [DATE] revealed resident #1 was independent with wheelchair use. The assessment also indicated resident #1 had a Brief Interview for Mental Status score of 15 indicating the resident was cognitively intact. On 06/24/2024 at 2:00p.m., interview with resident #1 reported he was not arguing when S5CNA (certified nursing assistant) pushed him over to the ground from his wheelchair on 06/05/2024. He reported he wasn't injured. He refused to say anything more about the incident. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195393	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerfield Nursing & Rehabilitation Center	522 Main Street Delhi, LA 71232

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	On 06/24/2024 at 1:15p.m., interview with S4CNA revealed she was a witness to the incident on 06/05/2024. She reported resident #1 was being rude and talking disrespectfully to the staff. The staff tried to ignore him but he wouldn't stop speaking disrespectfully and inappropriately. S5CNA instructed resident #1 to stop being rude. Resident #1 threatened S5CNA. S4CNA reported she had turned away and did not see resident #1 swing at S5CNA or her response. When she turned around, resident #1 was on the ground. S4CNA reported she heard S5CNA say to resident #1 Now try to get up Mother _____ before walking away. On 06/26/2024 at 1:20p.m., interview with S5CNA revealed several residents and staff were on the smoking porch on 06/05/2024. Resident #1 was cursing and made several sexually inappropriate remarks to her. S5CNA reported she asked him to calm down several times. S5CNA further reported Resident #1 attempted to hit her and she responded by pushing resident #1 with her arms with the intention of pushing his hands away. Resident #1's wheelchair flipped over resulting in him being on the ground. S5CNA then reported she walked away. On 06/26/2024 at 2:50p.m., interview with S3CNA revealed she was a witness to the incident on 06/05/2024. S3CNA reported resident #1 was on the smoking patio cursing and making sexually inappropriate comments about the staff who were outside with him. S3CNA heard S5CNA repeatedly tell resident #1 to stop making inappropriate remarks. S5CNA then walked over to resident #1. Resident #1 threatened to whoop her butt to which S5CNA replied by telling him to try. Resident #1 swung to hit at S5CNA and S5CNA pushed resident #1 tipping over his wheelchair and sending him to the ground. She reported she heard S5CNA call resident #1 a Mother _____ before walking away. On 06/25/2024 at 11:20a.m., an interview with S1AIT (Administrator in Training) and S7DON (Director of Nursing) confirmed there was incident between resident #1 and S5CNA which resulted in resident #1 falling to the ground.