

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER Legacy Nursing and Rehabilitation of Pollock		STREET ADDRESS, CITY, STATE, ZIP CODE 8275 Highway 165 Pollock, LA 71467	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38373</p> <p>Based on record review and interview, the facility failed to ensure a resident's comprehensive person-centered care plan was implemented by failing to administer an antidepressant medication as ordered for 1 (#1) of 3 (#1, #2, and #3) sampled residents reviewed for care planning. Findings:</p> <p>Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses that included in part . Depression, Acute Embolism and Thrombosis of deep veins of right upper extremity, Mild Protein-Calorie malnutrition, Type 2 DM, and Unspecified Dementia.</p> <p>Review of Resident #1's Admission MDS with an ARD of 02/09/2025 revealed a BIMS score of 3, which indicated severe cognitive impairment. Review of the MDS revealed Resident #1 required substantial/maximal assistance with eating and rolling left and right and was dependent on staff with toileting hygiene, sitting to lying, sitting to standing, and chair/bed to chair transferring.</p> <p>Review of Resident #1's care plan initiated on 01/28/2025 revealed the resident was care planned for Depression with interventions that included .Administer my medications as ordered by my physician and I need continuity with my care.</p> <p>Review of Resident #1's physician's orders revealed the following:</p> <p>02/12/2025: Trazodone HCL Oral tablet 100mg, give one tablet by mouth one time a day for depression.</p> <p>Review of Resident #1's March 2025 Medication Administration Record revealed Resident #1 did not receive the daily dose of Trazodone 100mg on 03/24/2025, 03/25/2025, 03/29/2025, and 03/30/2025.</p> <p>Review of Resident #1's progress notes revealed S5 LPN made an entry on each of the above dates stating Waiting to receive from pharmacy.</p> <p>In an interview on 04/02/2025 at 9:00 a.m., S5 LPN confirmed Resident #1 did not receive Trazodone on the above dates. S5 LPN stated the resident did not have any Trazodone in the facility, stating she checked the medication cart and the cubby in the medication room. S5 LPN stated the medication was ordered and she didn't know why it hadn't come in.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/02/2025 at 2:30 p.m., S2 DON confirmed Resident #1 did not receive the daily dose of Trazodone as ordered on 03/24/2025, 03/25/2025, 03/29/2025, and 03/30/2025. S2 DON stated the nurse should have called the pharmacy to check on it when it was not available, but did not.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38373</p> <p>Based on record review and interview, the facility failed to ensure a resident's care plan was revised by failing to update fall interventions after each fall for 1 (#2) of 2 (#1 and #2) residents reviewed for falls.</p> <p>Findings:</p> <p>Review of Resident #2's medical record revealed an admitted [DATE] with diagnoses that included in part . Parkinsonism, Major Depressive Disorder, Atherosclerotic Heart Disease, Unspecified Psychosis not due to a substance or known psychological condition, Unspecified fall, Unspecified Dementia, and Generalized Anxiety.</p> <p>Review of Resident #2's MDS with an ARD of 02/05/2025 revealed a BIMS score of 7, which indicated severe cognitive impairment. Review of the MDS revealed Resident #2 required extensive assistance with bed mobility, eating, toileting and transferring.</p> <p>Review of Resident #2's current care plan revealed a focus area of at risk for falls. The care plan documented the resident had falls on 02/13/2025, 02/28/2025, 03/18/2025, and 03/24/2025 (fall occurred on 03/25/2025).</p> <p>Interventions included Educate me on use of my call light, I need a night light on to help me see at night, I use a wheelchair for mobility, Monitor for changes in my condition that may warrant increased supervision/assistance and notify the physician, Place my frequently used items within my reach, and Refer me for therapy screen/evaluation as appropriate. Review of the MDS revealed these interventions were initiated 02/06/2025 with no new interventions put in place after falls on 02/13/2025, 02/28/2025, 03/18/2025, and 03/25/2025.</p> <p>In an interview on 04/02/2025 at 10:55 a.m., S6 MDS confirmed that new, individualized fall interventions are put in place after each fall occurs. S6 MDS confirmed new interventions from falls on 02/13/2025, 02/28/2025, 03/18/2025, 03/25/2025, and 03/28/2025 were not care planned but should have been. S6 MDS stated she had not added the new interventions because she had to wait until the DON closed out the incident report.</p> <p>In an interview on 04/02/2025 at 2:23 p.m., S2 DON reported new interventions should be added to the care plan by MDS nurse after each fall. S2 DON stated the new interventions should be added to care plan even if the incident and accident reports are not closed out. S2 DON confirmed new interventions had not been care planned after Resident #2 had falls on 02/13/2025, 02/28/2025, 03/18/2025, and 03/25/2025.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38373</p> <p>Based on record review and interview, the facility failed to provide services that meet professional standard of practice for 2 (#1 and #2) of 2 sampled residents with falls. The facility failed to ensure neurological checks were completed for 72 hours after an unwitnessed fall or fall with head injury. Findings:</p> <p>Review of facility's undated policy/procedure titled Incident Report Checklist revealed in part .Neuro checks implemented if head injury .</p> <p>Resident #1</p> <p>Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses that included in part . Depression, Acute Embolism and Thrombosis of deep veins of right upper extremity, Mild Protein-Calorie malnutrition, Type 2 DM, and Unspecified Dementia.</p> <p>Review of Resident #1's Admission MDS with an ARD of 02/09/2025 revealed a BIMS score of 3, which indicated severe cognitive impairment. Review of the MDS revealed Resident #1 required substantial/maximal assistance with eating and rolling left and right and was dependent on staff with toileting hygiene, sitting to lying, sitting to standing, and chair/bed to chair transferring.</p> <p>Review of Incident Reports revealed Resident #1 had falls on 02/13/2025, 02/28/2025, and that were unwitnessed or the resident hit his head.</p> <p>Review of neurological observations forms for 02/13/2025, 02/28/2025, and 03/08/2025 revealed the neurological checks were not completed for 72 hours after the resident's falls. Neurological observations were completed for 21 hours on 02/13/2025, 32 hours on 02/28/2025, and 33 hours on 03/08/2025.</p> <p>In an interview on 04/02/2025 at 2:30 p.m., S2 DON stated neurological checks/observations should be completed for 72 hours after any unwitnessed fall or fall with head injury. S2 DON confirmed neurological checks were not completed for 72 hours for Resident #1 on 02/13/2025, 02/28/2025, and 03/08/2025 but should have been.</p> <p>Resident #2</p> <p>Review of Resident #2's medical record revealed an admitted [DATE] with diagnoses that included in part . Parkinsonism, Major Depressive Disorder, Atherosclerotic Heart Disease, Unspecified Psychosis not due to a substance or known psychological condition, Unspecified fall, Unspecified Dementia, and Generalized Anxiety.</p> <p>Review of Resident #2's MDS with an ARD of 02/05/2025 revealed a BIMS score of 7, which indicated severe cognitive impairment. Review of the MDS revealed Resident #2 required extensive assistance with bed mobility, eating, toileting and transferring.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility Incident Reports revealed Resident #2 had falls on 02/28/2025 and 03/25/2025 resulting in head injury.</p> <p>Review of neurological observations forms for 02/28/2025 and 03/25/2025 revealed the neurological checks were not completed for 72 hours after the resident's falls. Neurological observations were completed for 9 hours on 02/28/2025, and 21 hours on 03/25/2025.</p> <p>In an interview on 04/02/2025 at 2:30 p.m., S2 DON stated neurological checks/observations should be completed for 72 hours after any unwitnessed fall or fall with head injury. S2 DON confirmed neurological checks were not completed for 72 hours for Resident #2 on 02/28/2025 and 03/25/2025 but should have been.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38373</p> <p>Based on record review and interview, the facility failed to ensure residents received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent the development of new pressure ulcers for 2 (#1 and #3) of 2 residents investigated for skin issues by failing to:</p> <ol style="list-style-type: none"> 1. Perform weekly wound assessments for Resident #3's DTI and 2. Perform wound care as ordered for Residents #1 and #3. <p>Findings:</p> <p>Review of the facility's undated policy titled, Skin/Wound Documentation Policy and Procedure revealed in part .Skin and wounds will be documented upon admission, readmission, weekly, and as needed. With each dressing change, or at least weekly, the pressure ulcer (injury) wound shall be assessed and documented: date, location of ulcer and staging, size, depth of the wound, presence, location and extent of any undermining or tunneling, presence of exudate, pain, wound bed, description of wound edges and surrounding tissue, and the description of the healing of the pressure ulcer (injury).</p> <p>Resident #1</p> <p>Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses that included in part . Depression, Acute Embolism and Thrombosis of Deep Veins of Right Upper Extremity, Mild Protein-Calorie Malnutrition, Type 2 Diabetes Mellitus, and Dementia.</p> <p>Review of Resident #1's Admission MDS with an ARD of 02/09/2025 revealed a BIMS score of 3, which indicated severe cognitive impairment. Resident #1 required substantial/maximal assistance with rolling left and right and was dependent on staff with toileting hygiene, sitting to lying, sitting to standing, and chair/bed to chair transferring.</p> <p>Review of Resident #1's physician's orders revealed the following:</p> <p>03/26/2025: Cleanse abrasion to the left shin with wound cleanser, apply collagen and cover with dry dressing one time a day.</p> <p>03/13/2025: Cleanse diabetic ulcer to the left 2nd toe with wound cleanser, apply betadine and cover with dry dressing one time a day.</p> <p>03/13/2025: Cleanse diabetic ulcer to the left 3rd toe with wound cleanser, apply betadine and cover with dry dressing, one time a day.</p> <p>03/13/2025: Cleanse diabetic ulcer to the left 4th toe with wound cleanser, apply betadine and cover with dry dressing one time a day.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>03/05/2025: Cleanse diabetic ulcer to the right first toe MTP (metatarsophalangeal joint) medial with wound cleanser, apply collagen with ag (silver) and cover with dry dressing one time a day.</p> <p>03/20/2025: Cleanse shearing wound to the left side of the sacrum with wound cleanser, apply skin prep and cover with dry dressing one time a day.</p> <p>03/05/2025: Cleanse skin tear to the right inner elbow with wound cleanser, apply collagen and cover with dry dressing one time a day.</p> <p>Review of Resident #1's TAR (Treatment Administration Record) for 03/2025 revealed wound care was not completed on 03/29/2025 and 03/30/2025 for the abrasion to left shin; Wound care was not completed on 03/22/2025, 03/23/2025, 03/29/2025, and 03/30/25 for the diabetic ulcers to left second toe, left third toe, left fourth toe, and right first toe MTP; Wound care was not completed on 03/22/2025, 03/23/2025, 03/29/2025, and 03/30/2025 for the shearing wound to left side of the sacrum; Wound care was not completed on 03/22/2025 and 03/23/2025 for the skin tear to right inner elbow.</p> <p>In an interview on 04/02/2025 at 2:30 p.m., S2 DON confirmed Resident #1's wound care was not completed on the weekends on 03/22/2025, 03/23/2025, 03/29/2025, and 03/30/2025, but should have been.</p> <p>Resident #3</p> <p>Review of Resident #3's medical record revealed an admitted [DATE] with diagnoses that included in part . Non-Ischemic Myocardial Injury, Fracture of Right Acetabulum, Fracture of the Right Pubis, Chronic Systolic (Congestive) Heart Failure, Hypothyroidism, Anemia, and Presence of Right Artificial Hip Joint.</p> <p>Review of Resident #3's State Optional MDS with an ARD of 02/08/2025 revealed a BIMS score of 13, which indicated intact cognition. Resident #3 required extensive assistance by one person with bed mobility, toileting, and transferring.</p> <p>Review of Resident #3's physician's orders revealed the following:</p> <p>04/01/2025: Cleanse stage 3 pressure injury to the right lateral malleolus with wound cleanser, pat dry, apply Medi honey, and cover with dry dressing, one time a day.</p> <p>03/17/2025: Cleanse DTI to the right lateral malleolus with wound cleanser, pat dry, paint with betadine, and cover with dry dressing one time a day. Discontinued on 03/31/2025.</p> <p>04/01/2025: Cleanse unstageable pressure injury to the right lateral middle foot with wound cleanser, apply Medi honey and cover with dry dressing one time a day.</p> <p>Review of Resident #3's 03/2025 TAR revealed wound care was not performed for the sacral wound or DTI to the right ankle on 03/23/2025, 03/29/2025, and 03/30/2025.</p> <p>Review of Resident #3's progress notes dated 03/17/2025 revealed no notes regarding new wound/DTI to the right lateral malleolus. Review of NP wound care notes dated 03/17/2025 and 03/25/2025 during nursing home rounds revealed wound to the right lateral malleolus was not addressed. Review of NP wound care notes do not address the right lateral malleolus wound until 03/31/2025.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 04/02/2025 at 10:10 a.m., S4 WCN confirmed Resident #3's DTI was discovered on 03/17/2025 and a new physician's wound care order was initiated at that time. S4 WCN confirmed an assessment with measurements was not completed on 03/17/2025. S4 WCN confirmed the DTI was not assessed and measured until 03/31/2025. S4 WCN stated, It's my fault, I must have missed that.</p> <p>In an interview on 04/02/2025 at 2:30 p.m., S2 DON acknowledged Resident #3's DTI discovered on 03/17/2025 was not assessed until 03/31/2025. S2 DON confirmed Resident #3's wound care was not completed for the sacral wound or the DTI to the right ankle/lateral malleolus on 03/23/2025, 03/29/2025, and 03/30/2025, but should have been.</p>