STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195249	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation of Pollock	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Residents who are unable to carry out ADLS (Activities of Daily Living) received the necessary services to maintain good grooming and personal hygiene for 3 (#10, #56, #67) of 4(#10, #56, #67, and #90) Residents reviewed for ADLS. The facility failed to ensure Resident #67 received a bath on his scheduled bath day, and failed to ensure Residents #10 and #56 received appropriate nail care. The total sample size was 37. Findings: Review of the facility's undated policy titled: Nail Care Policy and Procedure read in part.Procedure: (1) care of fingernails and toenails is part of the bath. (2) be certain nails are clean. (4) nails are to be clipped and filed smoothly. (NOTE): the podiatrist or licensed nurse clip nails for diabetic residents and residents with peripheral vascular disease. Resident #10 Review of Resident #10's Electronic Health Record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included in part .Dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and Anxiety; Schizoaffective disorder, Depressive type. Review of Resident #10's Quarterly MDS with an ARD of 07/09/2025 revealed in part . Resident #10 had BIMS (Brief Interview Mental Status) of 14, which indicated intact cognition. Resident #10 required supervision/touching assistance for personal hygiene. Observation on 09/29/2025 at 4:14 p.m. revealed Resident #10 had a black substance on her fingers and beneath her nail beds. Observation on 09/30/2025 at 8:00 a.m. revealed Resident #10's fingernails had a black substance beneath her nail beds. Observation on 09/30/2025 at 12:54 p.m. revealed Resident #10's fingernails had a black substance beneath her nail beds. Interview on 09/30/2025 at 2:00 p.m. with S7LPN confirmed Resident #10's fingernails were in need of cleaning and should have been cleaned by staff. Resident #56 Review of Resident #56's Electronic Health Record revealed the Resident was admitted to the facility on [DATE] with diagnoses that included in part .Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side; Morbid (severe) obesity due to excess calories; Polyosteoarthritis. Review of Resident #56's Quarterly MDS with an ARD of 09/17/2025 revealed in part . Resident #56 had BIMS of 13, which indicated intact cognition. Resident #56 required partial/moderate assistance with personal hygiene. Review of Resident #56's Care Plan initiated on 09/27/2024 with a review date of 10/05/2025 revealed in part Resident needed staff assistance for all ADL's. Interventions included: Assist me with hygiene and grooming tasks. Review of Resident #56's physician orders on 09/29/2025 at 3:54 p.m. revealed in part.-09/14/2025-podiatry to evaluate and treat thick nails and perform general foot care evaluation to prevent pain, ulcers, infections and circulatory problems. -07/20/2025-nurse to trim fingernails and toenails weekly as needed. -07/19/2025-inspect feet daily. Notify MD of any signs of injury, infections or other abnormalities. Interview on 09/30/2025 at 4:08 p.m. with Resident #56 stated her toenails had not been trimmed and she wanted them trimmed. Observation at time of interview revealed resident #56's toenails were long in length. Interview on 09/30/2025 at 4:10 p.m. S7LPN confirmed Resident #56's toenails needed to be trimmed. Resident #67 Review of Resident #67's Electronic Health Record revealed the Resident was admitted to the facility on [DATE] and had a re-entry date of 03/01/2024 with diagnoses that included in part . Cerebral Infarction, unspecified; Hemiplegia and Hemiparesis following Cerebral (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
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Infarction affecting right dominant side; and Altered mental status, unspecified. Review of Resident #67's Quarterly MDS with an ARD of 09/03/2025 revealed in part . Resident #67 had a BIMS of 5 indicating Severe Cognitive Impairment. Resident #67 was totally dependent on staff for transfers, toileting, bathing/showers, and bed mobility. Resident #67 had impairment on one side of upper extremity and both sides for lower extremities. Review of Resident #67's Care Plan with an initiate date of 11/17/2024 with review date of 12/13/2025 revealed in part Resident needed staff assistance with activities of daily living. Interventions included in part.Assist me with bathing, and assist me with hygiene and grooming. Interview on 09/29/2025 at 4:18 p.m. with Resident #67 stated he didn't have bath today and he would like shave. Observation at the time of the interview revealed Resident #67 had stubble facial hair. Interview on 09/30/2025 at 8:05 a.m. with Resident #67 stated he didn't have a bath today. Observation at the time of interview revealed Resident #67 had stubble facial hair. Interview with S3 CNA Supervisor on 09/30/2025 at 2:16 p.m. revealed she had bought S11CNA in Resident #67's room yesterday to give Resident #67 a bath, so Resident #67 should have had a bath. Interview with S11CNA on 09/30/2025 at 2:20 p.m. revealed he did not give Resident #67 a bath yesterday. Interview with S5CNA on 09/30/2025 at 2:24 p.m. revealed Resident #67 did not get a bath yesterday. Interview on 10/01/2025 at 9:40 a.m. with S3CNA supervisor revealed Resident #67 had not had a bath on 09/29/2025, but 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to provide pharmaceutical services that assured accurate acquiring, receiving, dispensing and/or administration of medications to meet the needs of each resident. The facility had a total census of 86 residents. The facility failed to: 1. Ensure the on-coming nurse (S4 LPN) documented and signed the Narcotic count sheet at the beginning of shift; and 2. Ensure an accurate account for controlled substance medications were completed at the time of administration by S4 LPN on 1 (Cart A) of 2 (Cart A and Cart B) medication carts for Residents #1, #27, #40, #42, #51, #57, #62, #65, #72, #78, and #91.Findings: Review of an undated facility policy on 10/01/2025 at 11:36 a.m. titled, Narcotics Policy and Procedure revised on 10/2019 revealed the following in part .Policy: All controlled substances shall be counted at the change of each shift. The amount of each controlled substance on hand shall be listed on the Narcotic Count Sheet. Procedure: 1. One (1) licensed nurse from the off-going shift and one (1) licensed nurse from the oncoming shift must count and sign the Narcotic Count Sheet in front of the narcotic box. 6. The oncoming nurse shall sign his/her name on the count sheet. 1. On 10/01/2025 at 10:11 a.m , a controlled medications reconciliation was conducted with S4 LPN of Cart A. At the time of the medication reconciliation, review of the Narcotic Count Record revealed S4 LPN did not sign or document her signature as the oncoming nurse on 10/01/2025. S4 LPN confirmed that she did not sign the record when she came on shift stating I like to wait until the end of shift to sign it. S4 LPN confirmed she should have signed the Narcotic Count Record at the beginning of shift, but did not. 2. On 10/01/2025 at 10:11 a.m., a controlled medications reconciliation was conducted with S4 LPN of Cart A. S4 LPN confirmed she administered the following controlled substances for Residents #1, #27, #40, #42, #51, #57, #62, #65, #72, #78, and #91. Observation of the Individual Controlled Substances Record for the following revealed: -Resident #1-Oxycodone-APAP 7.5-325mg revealed 56 tablets/pills logged, 55 tablets/pills observed in blister pack; Alprazolam 0.25mg 14 tablets/pills logged, 13 tablets/pills observed in blister pack; Belbuca Buccal Film 750mcg 10 patches logged, 9 patches observed in zip-loc bag; -Resident #27-Clonazepam 0.5 mg revealed 28 tablets/pills logged, 27 tablets/pills observed in blister pack; -Resident #40-Lacosamide 200mg revealed 41 tablets/pills logged, 40 tablets/pills observed in blister pack; Tramadol 50mg 25 tablets/pills logged, 24 tablets/pills observed in blister pack; -Resident #42-Hydrocodone/APAP 10-325 mg revealed 2 tablets/pills logged, 1 tablet/pill observed in blister pack; -Resident #51-Hydrocodone/APAP 5-325mg revealed 17 tablets/pills logged, 16 tablets/pills observed in blister pack; -Resident #57-Hydrocodone/APAP 7.5-325 mg revealed 59 tablets/pills logged, 58 tablets/pills observed in blister pack; -Resident #62-Alprazolam 0.25 mg revealed 37 tablets/pills logged, 36 tablets/pills observed in blister pack; -Resident #65-Lorazepam 0.5 mg revealed 10 tablets/pills logged, 9 tablets/pills observed in blister pack; -Resident #72-Hydrocodone 10-325 mg revealed 46 tablets/pills logged, 45 tablets/pills observed in blister pack; -Resident #78-Alprazolam 0.5 mg revealed 10 tablets/pills logged, 9 tablets/pills observed in blister pack; and -Resident #91-Diazepam 5mg revealed 8 tablets/pills logged, observed 7 tablets/pills in blister pack S4 LPN confirmed the above findings and stated she did not sign or document the accurate count of the controlled substances immediately after administering the medications. S4 LPN stated I usually wait to do all of that in one big time. S4 LPN confirmed she should have documented the controlled substance count immediately after administering the medications for Residents #1, #27, #40, #42, #51, #57, #62, #65, #72, #78, and #91, but did not. In an interview on 10/01/2025 at 11:08 a.m., S1 DON stated that controlled substances are to be logged and documented immediately after the nurse administers the medication to residents. S1 DON confirmed that S4 LPN should have documented the Narcotic Count Record at the beginning of shift and should have documented the accurate count of controlled substances on the Individual Controlled Substances Record after administering the controlled substances, but did not.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections by failing to:1. Disinfect reusable medical equipment as required, 2. Maintain soiled linen/soiled items in a sanitary manner;2. Store clean linen in a sanitary manner; and3. Ensure staff were consistent with infection control practices for cleaning/disinfecting the environment. Findings: Review of an undated facility policy titled Infection Prevention and Control- Environmental Services read in part. Environmental Services staff shall follow infection prevention and control procedures applicable to the area he/she is assigned to. Soiled Linen: Soiled linen shall be place in an impervious bag of sufficient strength to contain wet/soiled linen without contaminating the resident environment. Soiled linen shall be bagged, in or near the resident's room, and securely closed prior to transport. Review of an undated facility policy titled Reusable Medical Devices Cleaning Policy and Procedure read in part. Reusable medical devices will be cleaned after each resident use to prevent spread of infection. All surface areas of the machine will be cleaned with disinfectant wipe according to manufacture recommendations. Review required contact time and make sure glucometer is cleansed according to contact time of product. All disinfectant to air dry. Observation on 09/29/2025 at 12:05 p.m. revealed S10 LPN removed a glucometer machine from a container on her medication cart that contained the glucometer meter and lancets. S10 LPN proceeded to a resident's room with the glucometer, performed a finger stick and then walked back to her medication cart, and placed the used glucometer back into the container without sanitizing the equipment. Interview with S10 LPN at time of observation confirmed she should have sanitized the glucometer prior to placing it back into the container on her medication cart, but did not. Observation on 09/30/2025 at 8:20 a.m. revealed S7 LPN removed a glucometer machine from a container on her medication cart that contained the glucometer meter and lancets. S7 LPN proceeded to a resident's room with the glucometer, performed a finger stick and then walked back to her medication cart, and placed the used glucometer back into the container without sanitizing the equipment. Interview with S7 LPN at time of observation confirmed she should have sanitized the glucometer prior to placing it back into the container on her medication cart, but did not.Observation on 09/30/2025 at 8:49 a.m. revealed S5 CNA assisted Resident #84 with ADL care. Observation revealed S5 CNA placed a soiled adult brief and the soiled linen removed from bed directly onto the resident's floor. S5 CNA then walked out of the room and obtained soiled linen barrels on the hall and placed them in front of the door of Resident #84's room. S5 CNA donned gloves and then placed the soiled items within the bins.Observation on 09/30/2025 at 9:10 a.m. of the facility laundry room with S12 Laundry revealed the facility stored clean mechanical lift pads on a shelf on the soiled side of the laundry room. S12 Laundry confirmed there should not be any clean laundered items stored on the dirty side of laundry room. Interview on 09/30/2025 at 9:17 a.m. with S13 HK revealed he used X-Effect disinfectant for cleaning resident's room, non-resident areas, and equipment. S13 HK stated his process for cleaning was that he sprayed the disinfectant on the area, and let it sit for 1 min before wiping. S13 HK stated sometimes he had to wipe the area right away, when he was in a hurry. Observation on 09/30/2025 at 9:22 a.m. of Hall X shower room with S14 CNA revealed she used X-Effect disinfectant for cleaning the shower after each resident use. S14 CNA stated she did not know what the dwell time was for the X-Effect disinfectant, but the Classic disinfectant she had used in the past had a 10 minute dwell time. S14 CNA stated she would have to get with housekeeping to determine the dwell time for X-Effect disinfectant. Observation of the shower curtain with the shower room revealed it had a heavy build up upon the curtain. S14 CNA stated the shower curtain had been there for as long as she could remember and stated it should be replaced. Interview on 09/30/2025 at 9:33 a.m. with S9 HK/Laundry Supervisor confirmed the clean lift pads stored within laundry should not be stored on the soiled side. S9 HK/Laundry Supervisor stated staff used X-Effect disinfectant (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for cleaning and stated the dwell time was 5 minutes. Review of the X- Effect product label revealed a 5 min dwell time. S9 HK/Laundry Supervisor confirmed staff should use a 5 minute dwell time when cleaning. S9 HK/Laundry Supervisor confirmed when handling soiled linen, staff was required to bring in a plastic bag to place the soiled linen in. S9 HK/Laundry Supervisor confirmed staff should never place soiled linen on the floor, and it should be contained in soiled linen bag and then placed in the appropriate container.Interview on 09/30/2025 at 2:05 p.m. with S5 CNA regarding observation on 09/30/2025 at 8:49 a.m. revealed she had forgot to bring in a bag to place the soiled adult brief and soiled linen within. S5 CNA stated she should not have placed the soiled items on the floor, and should have had a bag to contain the soiled items, but had not.Interview on 09/30/2025 at 2:18 p.m. with S3 CNA Supervisor confirmed the process for handling soiled linen/dirty items was that the CNA was to bring in a bag, and place soiled linen and trash into separate bags for transport to soiled room. S3 CNA Supervisor confirmed soiled items should never be placed directly onto the floor.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview and record review the facility failed to promote and facilitate resident self-determination through support of resident choice about aspects of his or her life in the facility that were significant to the resident for 1 (#8) of 37 sampled residents. The facility failed to accommodate Resident #8's choice to have a shower during the mornings instead of during afternoons and evenings.Findings: Review of Resident #8's clinical record revealed an admit date of 01/30/2025 with diagnoses that included: Chronic Obstructive Pulmonary Disease, Major Depressive Disorder, Parkinsonism, Generalized Anxiety Disorder, and Dementia.Review of Resident #8's Quarterly MDS with an ARD of 11/05/2025 revealed a BIMS of 15, which indicated intact cognition. Resident #8 required substantial/maximal assistance with showers and bathing.Review of Resident #8's care plan with a review date of 11/08/2025 revealed Resident #8 required staff assistance with all ADLs. Interventions included in part: I prefer bathing in the tub/whirlpool in the morning. I prefer morning showers. Review of Resident #8's CNA Task flow chart for bathing/showering with a 30-day lookback revealed on the following dates:, 09/07/2025 at 12:14 p.m., 09/11/2025 at 4:18 p.m., 09/20/2025 at 1:25 p.m., 09/25/2025 at 4:10 p.m., and 09/30/2025 at 3:15 p.m. Resident #8 received a shower. Interview on 09/29/2025 at 10:09 a.m., Resident #8 stated she had issues with her bath days. Resident #8 stated she gets a shower or bath on Tuesdays, but that's not up to me. Resident #8 denied getting a shower or bath this morning. Observation of Resident #8 revealed her dressed in an orange shirt, burgundy jogging pants, and black socks.Interview on 09/30/2025 at 8:50 a.m., Resident #8 stated she'll get a bath tonight but prefers to have it in the morning. Resident #8 stated she doesn't get to choose when she gets her baths or showers and denied getting one this morning. Resident #8 had told staff before about wanting to shower or bath in the morning but couldn't remember who she spoke to and stated, They know I prefer mornings. Observation of Resident #8 revealed her still dressed in same dirty orange shirt, burgundy jogging pants, and black socks.Interview on 09/30/2025 at 8:59 a.m., S19 CNA stated Resident #8 gets her baths at night with the nightshift aides. S19 CNA stated Resident #8 doesn't resist care and is very compliant with staff. S19 CNA stated dayshift and nightshift split up the showers and she doesn't know why Resident #8 doesn't get her shower or bath in the mornings.Interview on 09/30/2025 at 3:10 p.m., Resident #8 stated, They said I have to take my baths/showers in the afternoon or at night, I never get a choice to choose when I want it. Resident #8 denied having a shower or bath this morning. Resident #8 observed dressed in same clothing from previous observations (dirty orange shirt, burgundy jogging pants, and black socks).Interview on 09/30/2025 at 3:15 p.m., S14 CNA stated Resident #8 gets a shower on Tuesdays, Thursdays, and Saturday mornings. S14 CNA confirmed Resident #8 did not get a shower until after lunch around 1:00 p.m. This surveyor questioned S14 CNA about not documenting a shower on 09/30/2025 and S14 CNA stated, Oh I forgot, let me chart that now. S14 CNA also stated that she put the same dirty clothing back on Resident #8 after giving her a shower this afternoon. Interview on 09/30/2025 at 3:39 p.m., Resident #8 revealed S14 CNA did not give her a bath today and stated, No I didn't get a bath or shower at all today. Observation of Resident #8 revealed her dressed in same clothing (dirty orange shirt, burgundy jogging pants, and black socks).Interview on 09/30/2025 at 4:11 p.m., S1 DON stated she wasn't aware of why Resident #8's preferences to have a shower in the morning were not honored, but should had been. S1 DON confirmed that after residents are bathe/showered, staff should not dress the resident in the same dirty clothing, unless it's been washed by laundry.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interviews, the facility failed to ensure a resident's PRN order for psychotropic medication was limited to 14 days for 1 (Resident #90) of 5 residents (#3, #8, #10, #33, and #90) reviewed for unnecessary medications. Findings:Review of an undated facility policy titled, Psychotropic Medication Use Policy and Procedure, revealed the following in part.16. PRN orders for psychotropic drugs, excluding antipsychotics, are limited to 14 days. A. Except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days based on evaluation of the resident for the appropriateness of that medication. B. the physician shall document the rationale in the resident's medical record and indicate the duration for the PRN order.Review of Resident #90's medical record revealed an admit date of 05/09/2024 with diagnoses that included in part.Epilepsy, Vascular Dementia, Schizophrenia, Generalized Anxiety Disorder, and Major Depression Disorder. Review of Resident #90's 09/2025 physician's orders revealed an order for Lorazepam oral tablet 0.5 mg, give 1 tablet by mouth every 8 hours as needed for anxiety with an order date of 12/13/2024. Review of Resident #90's Quarterly MDS with an ARD of 11/20/2025 revealed Resident #90 received an antianxiety medication.Review of Resident #90's July, August, and September 2025 eMAR (Electronic Medication Administration Record) revealed documentation that the Lorazepam oral tablet 0.5 mg PRN order was still active and Resident #90 did not receive any dosage during these months. Review of Resident #90's Pharmaceutical Consultant Report dated 07/29/2025 revealed in part. Lorazepam oral tablet 0.5mg (Lorazepam) give 1 tablet by mouth every 8 hours as needed (PRN Psychotropic is limited to an initial 14 days and requires prescriber to evaluate resident prior to extending the order; if extending the order, document the rationale for the extended time period in the medical record). S18 MD wrote: still uses.Further record review revealed no current rationale or evaluation of Resident #90 by a physician or practitioner for the continued use of the Lorazepam PRN psychotropic medication after 07/29/2025.Interview on 09/30/2025 at 4:11 p.m., S1 DON stated Resident #90 doesn't have any behaviors or outbursts. S1 DON reviewed Resident #90's 09/2025 eMAR and confirmed the Lorazepam 0.5mg PRN order should have been discontinued and stated it was overlooked.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to provide respiratory care consistent with professional standards for 1(#14) of 4 (#14, #33, #49, and #75) residents reviewed for respiratory care. The facility failed to ensure respiratory equipment was properly stored. Findings: Review of the facility's undated policy titled, Nebulizer CPAP Machine Cleaning Policy and Procedure read in part . Purpose: To keep nebulizer or CPAP machine and equipment clean. Procedure: 2. Store tubing, mouthpiece, and mask in a plastic bag when not in use. Review of Resident #14's medical record revealed an admit date of 10/24/2023 with diagnoses that included: Quadriplegia, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, and Major Depressive Disorder. Review of Resident #14's 09/2025 Physician Orders read in part 10/24/2023 -Albuterol Sulfate Nebulization Solution (2.5 MG/3ML) 0.083% 1 dose inhale orally via nebulizer every 6 hours as needed for shortness of breath. 09/24/2025-pratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally every 6 hours as needed for shortness of breath/wheezing. An observation on 09/29/2025 at 10:08 a.m. revealed Resident #14's nebulizer mask dated 09/24/2025, lying on the nightstand near nebulizers open to air, not secured in a bag. An observation on 09/30/2025 at 8:18 a.m. of Resident #14's room revealed the nebulizer mask continued to lay on the night stand, not secured in a bag. An interview on 9/30/2025 at 8:30 a.m., S8ADON confirmed that Resident #14's nebulizer mask was lying, open to air, on the nightstand. S8ADON stated that the nebulizer mask should have been bagged after use, but had not been.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation of Pollock	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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Resident with dementia received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for 1 (#10) of 5 (#3,#8,#33,#90) Residents reviewed for Dementia. The total sample size was 37. Findings:Review of the facility's undated policy titled: Care Planning Policy and Procedure read in part.Purpose: to provide a comprehensive 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. Review of Resident #10's Electronic Health Record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses that included in part. Dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and Anxiety; Schizoaffective disorder, Depressive type. Review of Resident #10's Quarterly MDS with ARD of 07/09/2025 revealed in part.Resident #10 had BIMS (Brief Interview Mental Status) of 14 which indicated intact cognition. Resident #10 required setup or clean-up assistance for eating, toileting, and bed mobility and required supervision or touching assistance with transfers. Review of Resident #10's Care Plan initiated on 09/08/2025 with a review date of 11/23/2025 revealed no evidence of dementia care focus with appropriate interventions. Interview on 10/01/2025 at 9:33 a.m. with S6LPN/MDS acknowledged Resident#10's care plan did not include and support dementia with interventions.