STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195343	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation of Plaquemine	59215 River West Drive Plaquemine, LA 70764

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 - 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** 30587 Based on record review and interview the facility failed to ensure a resident remained free from resident to resident physical abuse when the facility failed to increase supervision when residents displayed an increase in behaviors for 2 (Resident #4 and Resident #5) of 4 (Resident #1, Resident #3, Resident #4, and Resident #5) sampled residents reviewed for abuse. This deficient practice resulted in actual harm on 03/30/2024 at 8:20 a.m. when Resident #4 attacked Resident #5 with a belt and Resident #5 sustained scratches to the right side of his neck and his right thumb which required daily wound care. Resident #4 and Resident #5 were both identified by staff to have had increased behaviors of agitation prior to the altercation with no increase in supervision. Findings: Review of the facility's policy and procedure titled Abuse Prevention and Prohibition with a review date of 03/01/2024 revealed, in part, each resident has the right to be free from abuse. Residents must not be subjected to abuse by anyone, including but not limited to other residents. Further review revealed physical abuse may include an aggressive act, including inappropriate physical contact that is harmful or likely to cause injury or harm to a resident, and included examples of physical abuse included, in part, hitting, slapping, pinching, biting, shoving, and kicking. Resident #4 Review of Resident #4's record revealed he was admitted to the facility on [DATE] with diagnoses, in part, delusional disorder, anxiety disorder, and paranoid personality disorder. Review of Resident #4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 03/13/2024 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 14 (a score of 13-15 indicated the resident was cognitively intact). Further review revealed Resident #4 had diagnoses, in part, non-traumatic brain dysfunction, and paranoid schizophrenia. Review of Resident #4's undated Care Plan revealed Resident #4 had potential to be verbally aggressive due to mental and emotional illness of schizophrenia, delusional/paranoid personality disorder with approaches, in part, when Resident #4 becomes agitated, intervene before agitation escalates, and guide away from source of distress. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #4's Nursing Note dated 08/15/2023 revealed Resident #4 was very delusional, and voiced his roommate (Resident #5) was trying to kill him and Resident #5 had a knife. Further review revealed Resident #5 was placed on a physician emergency certificate for psychiatric treatment. Review of Resident #4's Nursing Notes dated 03/26/2024 at 4:03 p.m. revealed Resident #4 was pacing up and down the hall yelling he would call the Central Intelligence Agency (CIA) and Federal Bureau of Investigations (FBI). Review of Resident #4's Nursing Note dated 03/30/2024 at 8:20 a.m. revealed Resident #4 was walking around the hall with a belt and a lock in his hand stating his roommate attacked him. Further review revealed Resident #4's roommate, Resident #5, voiced they were fighting. Review of Resident #4's Nursing Note dated 03/30/2024 at 12:43 p.m., revealed S3Licensed Practical Nurse (LPN) was summoned to Resident #4's room and Resident #4 voiced Resident #5 had tried to break his neck and put Fentanyl (narcotic medication) in his coffee. Further review revealed, per staff, Resident #4 had been in a manic phase for the last couple of days. Review of the facility's Investigation of Incident dated 03/30/2024 revealed S1Administrator received a call regarding an altercation between Resident #4 and Resident #5. S9Registered Nurse (RN)/Weekend Supervisor indicated it was reported to her that Resident #5 went into his room to use the bathroom and Resident #4 started yelling at him to get out of his room. Review revealed Resident #4 took his belt off, Resident #5 then grabbed Resident #4's arm and then wrestled Resident #4 to the bed. Further review of the Investigation of Incident revealed a predisposing situation factor was Resident #4 disliked the roommate. In an interview on 04/03/2024 at 2:19 p.m., S10Certified Nursing Assistant (CNA) indicated last week Resident #4 was more active, and he was repeatedly saying he was going to call the FBI, and when Resident #4 was pacing and was talking about calling the FBI we knew his mental status was worsening. In an interview on 04/03/2024 at 2:26 p.m., S11CNA indicated last week Resident #4 was having issues with his behaviors. Resident #4 was observed by staff to be walking around with a belt in his hand. S11CNA further indicated Resident #4 did not usually walk around with a belt in his hand, and appeared to be talking in codes. In an interview on 04/03/2024 at 2:34 p.m., S12CNA Supervisor indicated on 03/30/2024 Resident #4 had been pacing back and forth and was not easily redirected. S12CNA Supervisor indicated Resident #4 had appeared agitated during the day while walking around with the belt buckle in his hand. S12CNA Supervisor indicated with the change in Resident #4's behavior the staff was not informed to increase supervision or do anything differently other than redirect him. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 04/03/2024 at 2:53 p.m., S3Licensed Practical Nurse (LPN) indicated around 04/26/2024 Resident #4 was pacing and acting differently than usual. S3LPN indicated on Saturday, 03/30/2024, Resident #4 was yelling and then stated someone tried to break his neck. S3LPN indicated Resident #5 had stated he was going into their room and this was when he was attacked by Resident #4. S3LPN indicated she observed Resident #5 had scratches to his hand and neck. S3LPN indicated about 7 months ago she suggested to the previous Director of Nursing (DON) to separate Residents #4 and #5 related to another incident, however, there were no interventions such as increased supervision to prevent another occurrence. In an interview on 04/04/2024 at 11:28 a.m., S2DON indicated staff had notified her of an increase in Resident #4's behaviors the week of 04/25/2024. S2DON indicated Resident #4 was observed pacing with increased agitation and redirected. S2DON indicated the facility had not increased supervision until after the incident because to her knowledge Resident #4 had never had issues with other residents. S2DON indicated she was not aware of the incident that happened in August 2023. In an interview on 04/04/2024 at 12:39 p.m., S1Administrator indicated she was not made aware Resident #4 had an increase in behaviors and was pacing more frequently. S1Administrator indicated she was not aware of the issues Resident #4 and Resident #5 had in August 2023 and Resident #4 and Resident #5 should not have been roommates after August 2023. S1Administrator indicated the staff who witnessed Resident #4 pacing with the belt in his hands should have notified the supervisor to ensure something was done to monitor him. In an interview on 04/04/2024 at 2:23 p.m., Resident #4's psychiatric counselor indicated he was not aware of Resident #4's delusions in August 2023 of Resident #5 trying to harm him. Resident #4's psychiatric counselor further indicated if he would have been notified of these issues, he would have recommended that Resident #4 and #5 be separated to prevent Resident #4 being triggered by Resident #5. Resident #5 Review of Resident #5's record revealed he was admitted on [DATE] with diagnoses, in part, bipolar disorder, major depressive disorder, and paranoid personality disorder. Review of Resident #5's MDS with an ARD dated 02/14/2024 revealed Resident #5 had a BIMS of 15 which indicated Resident #5 was cognitively intact. Review of Resident #5's Care Plan revealed problem of, in part, Resident #5 display of aggressive behavior with a target date of 05/14/2024. Further review revealed a revision on 03/27/2024 related to Resident #5 observed on the patio yelling and making racial slurs to staff and others. Following this incident, the care plan was revised to include staff education on de-escalation techniques with documentation of Resident #5's behavior. Review of Resident #5's March 2024 and April 2024 Physician's Orders revealed, in part, cleanse the scratch to the right side of Resident #5's neck with wound cleanser, pat dry and apply topical antibiotic ointment every shift with start date of 03/30/2024; and cleanse the scratch to Resident #5's right thumb with wound cleanser, pat dry, apply topical antibiotic ointment and cover with a dry dressing with a start date of 03/30/2024. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #5's March 2024 Medication Administration Record (MAR) revealed on 03/29/2024 Resident #5 had a 17 coded for behaviors which indicated aggression to residents. Review of Resident #5's Nurses Notes dated 03/23/2024 at 2:30 p.m. revealed Resident #5 was down hallway yelling he was going to knock a resident in the head, but was redirected. Review of Resident #5's Nurse's Notes dated 03/27/2024 at 4:00 p.m. revealed the nurse was called to the patio due to Resident #5 making racial slurs. In an interview on 04/02/2024 at 2:28 p.m., Resident #5 indicated on 03/30/2024 Resident #4 was really mad about something. Resident #5 indicated he was going to the restroom and all he could understand Resident #4 say was he, Resident #4, was going to whoop my a** and then he got on the bed and took off his belt and wrapped it around his hand. Resident #5 indicated Resident #4 jumped off the bed at him, and when Resident #4 swung his arm back like he was winding up to hit Resident #5, Resident #5 grabbed Resident #4's hand, and then we fell on the bed and wrestled for approximately 20 seconds. Resident #5 indicated the thing that worried him the most was he had no idea what set Resident #4 off that morning. Resident #5 indicated Resident #4 had been acting off for a while and another resident in the hall had even warned him not to go into the room. Resident #5 indicated he left the room after the fight and notified the nurse. Observation on 04/02/2024 at 2:28 p.m. revealed a brown linear scab like tissue to Resident #5's right thumb base. In an interview on 04/03/2024 at 2:53 p.m., S3LPN indicated even though no one saw the fight between Resident #4 and Resident #5, she had assessed Resident #5 to have a scratch to his neck and on his right hand. In an interview on 04/04/2024 at 1:21 p.m., S2DON indicated she was not aware of either issue on 03/23/2024 or 03/27/2024, and she would have implemented something new to his care due to his behaviors. In an interview on 04/04/2024 at 12:39 p.m., S1Administrator indicated she was not made aware of any behaviors for Resident #5 and therefore did not increase supervision for Resident #5.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 30587 Based on record review and interview the facility failed to ensure an allegation of resident to resident abuse was reported to the State Survey Agency within 5 working days for 2 (Resident #4 and Resident #5) of 4 (Resident #1, Resident #3, Resident #4, and Resident #5) sampled residents reviewed for abuse and neglect. Findings: Resident #4 Review of Resident #4's record revealed he was admitted to the facility on [DATE] with diagnoses, in part, delusional disorder, anxiety disorder, and paranoid personality disorder. Review of Resident #4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 03/13/2024 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 14 (a score of 13-15 indicated the resident was cognitively intact). Further review revealed Resident #4 had diagnoses of, in part, non-traumatic brain dysfunction, and paranoid schizophrenia. Review of Resident #4's undated Care Plan revealed Resident #4 had potential to be verbally aggressive due to mental and emotional illness of schizophrenia, delusional/paranoid personality disorder with approaches, in part, when Resident #4 becomes agitated, intervene before agitation escalates, and guide away from source of distress. Review of Resident #4's Nursing Note dated 03/30/2024 at 8:20 a.m. revealed Resident #4 was walking around the hall with a belt and a lock in his hand stating his roommate attacked him. Further review revealed Resident #4's roommate, Resident #5, voiced they were fighting. Review of Resident #4's Nursing Note dated 03/30/2024 at 12:43pm revealed the nurse was summoned to Resident #4's room and Resident #4 voiced Resident #5 had tried to break his neck and put fentanyl in his coffee. Review of the facility's Investigation of Incident dated 03/30/2024 revealed S1Administrator received a call regarding a possible altercation between Resident #4 and Resident #5. S9Registered Nurse (RN)/Weekend Supervisor indicated it was reported to her that Resident #5 went into his room to use the restroom and Resident #4 started yelling at him to get out of his room. Review revealed Resident #4 took his belt off, Resident #5 then grabbed Resident #4's arm and then wrestled Resident #4 to the bed. Resident #5 Review of Resident #5's record revealed he was admitted on [DATE] with diagnoses of, in part, bipolar disorder, major depressive disorder, and paranoid personality disorder. Review of Resident #5's MDS with an ARD dated 02/14/2024 revealed Resident #5 had a BIMS of 15. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's Care Plan revealed problem of, in part, Resident #5 displayed aggressive behavior with revision on 03/27/2024 of Resident #5 was on the patio yelling and making racial slurs to staff and others with a target date of 05/14/2024. Further review revealed approaches of, in part, staff educated on de-escalation techniques, resident's behavior was to be documented. Review of Resident #5's March 2024 and April 2024 Physician Orders revealed, in part, cleanse the scratch to the right side of Resident #5's neck with wound cleanser, pat dry and apply topical antibiotic ointment every shift with start date of 03/30/2024; and cleanse the scratch to Resident #5's right thumb with wound cleanser, pat dry, apply topical antibiotic ointment and cover with a dry dressing with a start date of 03/30/2024. In an interview on 04/02/2024 at 2:28 p.m., Resident #5 indicated on 03/30/2024 Resident #4 was really mad about something. Resident #5 indicated he was going to the restroom and all he could understand Resident #4 say was he, Resident #4, was going to whoop my a** and then he got on the bed and took off his belt and wrapped it around his hand. Resident #5 indicated Resident #4 jumped off the bed at him, and when Resident #4 swung his arm back like he was winding up to hit Resident #5, Resident #5 grabbed Resident #4's hand, and then we fell on the bed and wrestled for approximately 20 seconds. Resident #5 indicated the thing that worries him the most was he had no idea what set Resident #4 off that morning. Resident #5 indicated Resident #4 had been acting up for a while and another resident in the hall had even warned him not to go into the room. Resident #5 indicated he left the room after the fight and notified the nurse. Observation on 04/02/2024 at 2:28 p.m. revealed a brown linear scab like tissue to Resident #5's right thumb base. In an interview on 04/03/2024 at 2:53 p.m., S3LPN indicated even thought the incident between Resident #4 and Resident #5 was unwitnessed, she had assessed Resident #5 to have a scratch to his neck and on his hand. In an interview on 04/04/2024 at 12:39 p.m., S1Administrator indicated the incident was not reported to the state agency and she should have notified the state agency of Resident #4 and Resident #5's physical altercation.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 30587 Based on record review and interview the facility failed to ensure a resident had a crisis intervention plan developed per the resident's pre-admission screening and resident review (PASRR) for 1 (Resident #4) of 5 (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) sampled residents reviewed for care and services. Findings: Review of Resident #4's record revealed he was admitted to the facility on [DATE] with diagnoses, in part, delusional disorder, anxiety disorder, and paranoid personality disorder. Review of Resident #4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 03/13/2024 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 14 (a score of 13-15 indicated the resident was cognitively intact). Further review revealed Resident #4 had diagnoses, in part, non-traumatic brain dysfunction, and paranoid schizophrenia. Review of Resident #4's Office of Behavioral Health PASRR Level II Evaluation Summary and Determination Notice for period of 03/08/2023 through 03/06/2024 revealed the nursing home was to facilitate the development of a crisis intervention plan/safety plan. Review of Resident #4's Office of Behavioral Health PASRR Level II Evaluation Summary and Determination Notice for period of 03/19/2024 through 03/18/2025 revealed the nursing home was to facilitate the development of a crisis intervention plan/safety plan. Review of Resident #4's record revealed no documented evidence and the facility presented no documented evidence of a crisis intervention plan/safety plan had been developed for Resident #4. In an interview on 04/04/2024 at 2:23 p.m., Resident #4's psychiatric counselor indicated the contracted psychiatric services company he worked for had not developed and/or assisted in the development of a crisis intervention plan/safety plan for Resident #4. In an interview on 04/04/2024 at 3:11 p.m., S2Director of Nursing indicated the facility was unable to present the surveyor with evidence a crisis intervention plan/safety plan had been developed for Resident #4.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 45877 Based on observation, record review, and interview, the facility failed to address signs of pain in a nonverbal resident for 1 (Resident #1) of 5 (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) reviewed for pain. Findings: Review of Resident #1's care plan revealed the problem of left should fracture which was initiated on 04/02/2024. Further review revealed a goal for Resident #1 was to have minimal to no discomfort. Further review revealed interventions included for Resident #1 to have medications as prescribed by the physician and report any pain not relieved by pain medication to the physician. Review of Resident #1's March 2024 and April 2024 Electronic Medication Administration Record (EMAR) revealed the following , in part: pain level of 4 on the am shift on 03/29/2024, pain level of 8 on the am shift on 03/30/2024, pain level of 7 on the pm shift on 03/30/2024, pain level of 8 on the am shift on 03/31/2024, a pain level of 8 on the am shift on 04/03/2024 (for the pain scale 0 indicated no pain and 10 indicated the worst pain). Further review of Resident #1's March 2024 and April 2024 EMARs revealed no documented evidence and the facility was unable to provide any documented evidence that Resident #1received any pain medication. Review of the facility's standing physician orders revealed, in part, an order for mild-moderate pain to administer 650 milligrams of acetaminophen (a medication for pain) by mouth or percutaneous endoscopic gastrostomy tube (a tube to give food or medications when a person is unable to swallow) every 6 hours as needed for 4 doses. Further review of Resident #1's March 2024 and April 2024 MARs revealed no documented evidence and the facility was unable to provide any documented evidence of Resident #1 had his pain addressed. Observation on 04/02/2024 at 11:50 a.m., revealed S7Certified Nursing Assistant (CNA) and S5CNA provided Resident #1 with incontinence care. Observation further revealed Resident #1 had facial grimacing when he was being turned. In an interview on 04/04/2024 at 11:48 a.m., S8Licensed Practical Nurse (LPN) stated she measured pain for nonverbal residents by looking for signs of pain such as facial grimacing. Observation on 04/04/2024 at 11:58 a.m., revealed S6CNA and S4CNA provided Resident #1 with incontinent care. Observation further revealed Resident #1 had facial grimacing while they turned him. In an interview on 04/04/2024 at 12:06 p.m., S4CNA confirmed Resident #1 had facial grimacing during incontinence care. In an interview on 04/04/2024 at 12:21 p.m., S3Licensed Practical Nurse (LPN) stated pain medication should have been ordered per standing orders and given for the pain ratings of 7 and 8. S3LPN confirmed Resident #1 had no documented evidence of pain medication administered in EMAR. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/04/2024 at 12:32 p.m., S2Director of Nursing (DON) confirmed Resident #1 had pain scale ratings of 7 and 8 documented in his March 2024 and April 2024 EMAR. S2DON indicated Resident #1 did not receive pain medication. In an interview on 04/04/2024 at 2:15 p.m., Resident #1's Nurse Practitioner indicated a fracture can be painful and Resident #1 had standing orders to give acetaminophen for pain.