

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Legacy Nursing and Rehabilitation of Plaquemine		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on interviews and record reviews, the facility failed to ensure residents received specialized rehabilitative services as ordered for 1 (Resident #2) of 4 sampled residents reviewed for rehabilitation services. Findings: Review of Resident #2's record revealed, in part, an admission date of 06/22/2026. Further review revealed Resident #2 had diagnoses of, in part, hemiplegia (a complete loss of strength and movement on one side) and hemiparesis (partial weakness, allowing some movement but reduced strength and coordination) following a cerebral infarction (a stroke) which affected the right dominant side, aphasia (a language disorder affecting communication), and dysphagia (difficulty swallowing). Review of Resident #2's hospital discharge instructions for admission to the facility dated 06/22/2026 revealed, in part, for Resident #2 to continue the therapy program. Review of Resident #2's progress notes revealed, in part, Resident #2 had an encounter visit with Resident #2's Family Nurse Practitioner on 06/23/2026. Further review revealed Resident #2 was admitted to the facility for continued physical therapy, occupational therapy, and speech therapy. Review of Resident #2's admission therapy screening dated 06/22/2026 revealed, in part, therapy was not indicated at the time of screening. In an interview on 07/15/2026 at 9:50AM, S3Director of Rehabilitation indicated when a resident was admitted to the facility and needed therapy, nursing staff was to let the therapy department know. S3Director of Rehabilitation further indicated she was not aware Resident #2 had orders for therapy; therefore, S3Director of Rehabilitation marked Resident #2's screening for therapy as not indicated. S3Director of Rehabilitation further indicated Resident #2's daughter had emailed the therapy department that Resident #2 was supposed to receive therapy, but had not. In an interview on 07/15/2026 at 10:00AM, S2Director of Nursing indicated the hospital discharge orders for Resident #2 were reviewed upon admission, and Resident #2's order to continue therapy at the facility was missed. In an interview on 07/15/2026 at 1:00PM, S3Director of Rehab indicated Resident #2 was delayed starting therapy, because S3Director of Rehabilitation was unaware Resident #2 had an order to receive therapy upon admission.		

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, interview, and record review, the facility failed to ensure a resident's call light was within reach for 1 (Resident #2) of 4 sampled residents observed for access to their call light. Findings: Review of Resident #2's care plan initiated 06/23/2026 with a next review date of 09/21/2026, revealed, in part, Resident #2 had a cerebrovascular accident and had right sided hemiplegia with an intervention to place Resident #2's call light within reach. Observation on 07/14/2026 at 2:00PM revealed Resident #2 was lying in bed, and Resident #2's call light was hanging over the light on the wall, out of Resident #2's reach. Observation on 07/15/2026 at 8:50AM revealed Resident #2 was lying in bed, and Resident #2's call light was hanging over the light on the wall, out of Resident #2's reach. Observation on 07/15/2026 at 1:25PM revealed Resident #2 was sitting on his bed, and Resident #2's call light was hanging over the light on the wall, out of Resident #2's reach. In an interview on 07/15/2026 at 3:45PM, S1Administrator indicated Resident #2's call light should have been within Resident #2's reach and was not, as required.		