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	01/29/2025

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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 45877 Based on observations, interviews, and record review the facility failed to maintain a resident's right to privacy while performing care for 1 (Resident #17) of 22 (Resident #14, Resident #15, Resident #17, Resident #23, Resident #32, Resident #35, Resident #36, Resident #42, Resident #48, Resident #51, Resident #52, Resident #55, Resident #64, Resident #73, Resident #76, Resident #82, Resident #84, Resident #89, Resident #93, Resident #105, Resident #106, Resident #357) sampled residents. Findings: Review of Resident #17's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/03/2024 revealed the following, in part, Resident #17 had a Brief Interview Mental Status score of 01 which indicated severe cognitive impairment. Further review revealed Resident #17 was dependent on staff for incontinence care, showering/bathing, upper body dressing, and lower body dressing. Observation on 01/28/2025 at 10:46AM revealed S14Certified Nursing Assistant (CNA) and S15CNA provided Resident #17 with a bed bath. Observation further revealed the privacy curtain to the room was not pulled and the blinds to the window, which faces a parking lot, was pulled halfway up, which exposed Resident #17's nude body to the outside. Observation on 01/28/2025 at 10:58AM revealed S14CNA and S15CNA changed Resident #17's bedsheets while he was in bed and his body nude. Observation further revealed the privacy curtain to the room was not pulled and the blinds to the window, which faces a parking lot, was pulled halfway up, which exposed Resident #17's nude body to the outside. In an interview on 01/28/2025 at 11:10AM, S6CNA Supervisor indicated the privacy curtain should have been pulled and the blinds pulled down to provide Resident #17 privacy during his bed bath. In an interview on 01/28/2025 at 11:24AM, S13Assistant Director of Nursing confirmed Resident #17's privacy should have been maintained during care. In an interview on 01/28/2025 at 11:50AM, S2Director of Nursing further indicated privacy should have been provided for Resident #17 during care.

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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46361 Based on observations and interviews, the facility failed to ensure resident rooms and equipment were cleanded and maintained in a sanitary manner for 2 (Resident #32, Resident #37) of 6 (Resident #2, Resident #14, Resident #32, Resident #37, Resident #55, Resident #95) sampled residents investigated for environment. Findings: Resident #32 Observation on 01/28/2025 at 10:08AM revealed a dried light brown unknown substance was present on Resident #32's enteral feeding (a method of providing nutrition through a tube inserted directly into the stomach) pump pole, and on Resident #32's floor. Observation on 01/28/2025 at 3:45PM revealed a dried light brown unknown substance was present on Resident #32's enteral feeding pump pole, and on Resident #32's floor. In an interview on 01/28/2025 at 3:45PM, S1Administrator confirmed there was a dried light brown unknown substance present on Resident #32's enteral feeding pump pole and on Resident #32's floor and it should have been cleaned by the staff. Resident #37 Observation on 01/27/2025 at 11:31AM revealed a dried light brown unknown substance was present on Resident #37's enteral feeding pump, enteral feeding pump pole, and on Resident #37's floor. Observation on 01/28/2025 at 10:06AM revealed a dried light brown unknown substance was present on Resident #37's enteral feeding pump, enteral feeding pump pole, and on Resident #37's floor. Observation on 01/28/2025 at 3:42PM revealed a dried light brown unknown substance was present on Resident #37's enteral feeding pump, enteral feeding pump pole, and on Resident #37's floor. In an interview on 01/28/2025 at 3:46PM, S1Administrator indicated Resident #37's enteral tube feeding pump, enteral feeding pump pole, and floor had large areas of dried tube feeding formula. S1Administrator stated, that is terrible, just terrible. S1Administrator indicated Resident #32 and Resident 37's enteral feeding equipment and floor should have been cleaned by staff, and had not been.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41461 Based on record reviews and interviews, the facility failed to ensure the Minimum Data Set (MDS) was completed accurately for 2 (Resident #42, Resident #51) of 22 (Resident #14, Resident #15, Resident #17, Resident #23, Resident #32, Resident #35, Resident #36, Resident #42, Resident #48, Resident #51, Resident #52, Resident #55, Resident #64, Resident #73, Resident #76, Resident #82, Resident #84, Resident #89, Resident #93, Resident #105, Resident #106, Resident #357) sampled residents reviewed for resident assessments. Findings: Resident #42 Review of Resident #42's record revealed, in part, Resident #42 was admitted to the facility on [DATE] with diagnoses, in part, of a right above the knee amputation (AKA) and a left AKA. Review of Resident #42's Quarterly MDS with an Assessment Reference Date (ARD) of 12/18/2024 revealed, in part, Section GG: Functional Abilities and Goals, he was dependent on staff for putting on or taking off footwear. Review of Resident #42's Quarterly MDS with an ARD of 09/25/2024 revealed, in part, Section GG: Functional Abilities and Goals, he was dependent on staff for putting on or taking off footwear. In an interview on 01/29/2025 at 2:54 PM, S11Director of Rehabilitation (DOR)/Physical Therapy Assistant (PTA) indicated she was responsible for completing Section GG of the MDS for residents. S11DOR/PTA indicated Resident #42 cannot put on or take off footwear due to him being a bilateral amputee. In an interview on 01/29/2025 at 3:38PM, S12MDS Nurse indicated Resident #42 could not be assessed for putting on or taking off footwear due to him being a bilateral amputee and him not having any feet. S12MDS Nurse further indicated Resident #42's MDS assessment dated [DATE] was incorrect. In an interview on 01/29/2025 at 3:48PM, S2Director of Nursing further indicated Resident #42's Section GG for his MDS was not completed accurately. Resident #51 Review of Resident #51's record revealed, in part, an admitted [DATE] with diagnoses which included Schizophrenia, Bipolar Disorder, and Post Traumatic Stress Disorder (serious mental illnesses that required medications). Review of a significant change Minimal Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 10/22/2024 revealed, in part, Section A1500 Preadmission Screening question which inquired if Resident #51 had a serious mental illness was answered as no. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	In an interview on 01/28/2025 at 2:30 PM, S16MDS nurse indicated the above mentioned MDS question was not marked correctly. 45877

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 51376 Based on observations, interviews, and record reviews, the facility failed to ensure care plan interventions were implemented to decrease risk of falls for 1 (Resident #84) of 3 (Resident #36, Resident #84, Resident #93) sampled residents investigated for falls. Findings: Review of Resident #84's current care plan revealed, in part, a care plan was initiated for Resident #84 being at risk for falls related to having an unsteady gait due to hemiplegia. Further review revealed an intervention start date of 10/19/2024 which included, in part, for staff to apply a self-release lap tray while up in his wheelchair. Observation on 1/27/2025 at 9:30AM revealed, in part, Resident #84 sitting up in his wheelchair without a self-release lap tray. Observation on 01/27/2025 at 10:10AM revealed, in part, Resident #84 up in his wheelchair by the nurse's station without a self-release lap tray on his wheelchair. Observation on 01/28/2025 at 9:27AM revealed, in part, Resident #84 was sitting up in his wheelchair with no self-release lap tray. Observation on 01/28/2025 at 11:45AM revealed Resident #84 was sitting up in his wheelchair in the dining room without a self-release lap tray on his wheelchair. In an interview on 01/28/2025 at 11:48AM, S10Licensed Practical Nurse (LPN) indicated Resident #84 should have a self-release lap tray on while up in his wheelchair. In an interview on 01/28/2025 at 11:50AM, S13Assistant Director of Nursing (ADON) indicated Resident #84 was supposed to have a self-release lap tray while up in his wheelchair.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46361 Based on observations, interviews, and record reviews the facility failed to ensure staff positioned a resident's urinary catheter bag below the level of the bladder for or 1 (Resident #64) of 4 (Resident #15, Resident #17, Resident #35, Resident #64) sampled residents investigated for urinary catheter and/or UTI. Findings: Review of the Centers for Disease Control's (CDC) Guideline for Prevention of Catheter-Associated Urinary Tract Infections, dated 2009 and revised on 06/06/2019, revealed, in part, to maintain unobstructed urine flow, the urine collection bag should be kept below the level of the bladder at all times. Review of Resident #64's clinical record revealed Resident #64 had a suprapubic catheter related to neuromuscular dysfunction of the bladder (a condition where the bladder does not empty properly). Review of Resident #64's care plan revealed, in part, Resident #64 had a suprapubic catheter and staff were to ensure the catheter bag was positioned below the bladder. Review of Resident #64's infection reports revealed, in part, Resident #64 was diagnosed with a UTI on 07/08/2024, 08/22/2024, and 12/31/2024. Further review revealed Resident #64 was diagnosed with cystitis (inflammation of the bladder) on 09/24/2024 and 11/13/2024. Observation on 01/28/2025 at 10:09AM revealed Resident #64 was lying flat in bed and Resident #64's catheter bag was positioned in her bed near her feet and not below the level of her bladder. Observation on 01/29/2025 at 9:38AM revealed Resident #64 was lying flat in bed and S5Certified Nursing Assistant (CNA) initiated catheter care for Resident #64. Further observation revealed S5CNA placed Resident #64's catheter bag in her bed and not below the level of her bladder. Further observation revealed the catheter bag remained in Resident #64's bed until catheter care was completed at 9:50AM. In an interview on 01/29/2025 at 9:55AM, S5CNA indicated Resident's #64's catheter bag should have been positioned below her bladder when she provided catheter care. In an interview on 01/29/2025 at 11:20AM, S4Licensed Practical Nurse (LPN) indicated Resident #64 had a history of UTI's. S4LPN further indicated Resident #64's catheter bag should have been maintained below the level of the bladder and should not have been placed in the bed with Resident #64. In an interview on 01/29/2025 at 3:59PM, S3Assistant Director of Nursing (ADON)/Infection Preventionist indicated Resident #64 was treated for UTI's and/or cystitis on 07/08/2024, 08/22/2024, 09/24/2024, 11/13/2024, and 12/31/2024. S3ADON/Infection Preventionist further indicated Resident #64's catheter bag should have been kept below the level of her bladder.

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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. 41461 Based on observations, interview, and record review, the facility failed to follow their policy and procedure for maintaining respiratory care equipment for 1 (Resident #23) of 3 (Resident #23, Resident #36, Resident #51) sampled residents investigated for respiratory care. Findings: Review of the facility's undated Nebulizer Continuous positive airway pressure (CPAP) Machine Cleaning Policy and Procedure revealed, in part, store respiratory tubing, mouthpiece, and mask in a plastic bag when not in use. Observation on 01/27/2025 at 10:37AM revealed Resident #23's nasal cannula, nebulizer mask, and oxygen tubing was uncontained and lying on the floor. Observation on 1/28/2025 at 3:30PM revealed Resident #23's nebulizer mask was uncontained and lying on Resident #23's chest. Observation on 01/29/2025 at 10:00AM revealed Resident #23's nebulizer mask was uncontained and lying on the bedside table. In an interview on 01/29/25 at 10:09AM, S2Director of Nursing (DON) indicated Resident #23's nebulizer mask was uncontained and lying on his bedside table. She further indicated Resident #23's nebulizer mask should have been contained in a clean labeled plastic bag and was not

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34608 Based on observations, interviews, and record review, the facility failed to ensure: 1. Staff had all hair restrained when in the food preparation areas (S8Dietary Helper and S9Dietary Helper); 2. Food items were labeled with an open date and/or labeled with the contents of the container/bag; 3. Prepared food items was covered and refrigerated until time to serve; 4. Staff did not store their personal food items with residents' food items; and, 5. Expired foods were not available for use. This deficient practice was identified for the facility kitchen observed during the kitchen task. Findings: Review of the facility's undated policy titled, Dietary Cook, revealed, in part: Dietary staff were to ensure the kitchen was maintained as required by state and federal governing agencies' regulations and standards; food items were to be immediately labeled and stored after opening; and all staff entering the kitchen were to wear hairnets according to regulations and facility dress code. Observation on [DATE] at 8:49AM revealed, in part, S8Dietary Helper and S9Dietary Helper hair was not fully contained in a hairnet. Further observation revealed uncovered individual cups of vanilla pudding were sitting on the preparation table. Observation on [DATE] at 8:55AM of the facility's refrigerator revealed, in part, an unlabeled and undated 1.5 gallon zip lock bag three fourth full of cooked cubed chicken; an 8 ounce Styrofoam cup containing a pudding like substance with no label and undated; one-half cream cheese Danish which had no label and was undated; and a 1.5 gallon unlabeled zip lock bag of chopped cabbage dated [DATE], which had a grayish black unknown substance on the cabbage. Observation on [DATE] at 9:00AM of the facility's freezer revealed, in part, an undated 16 ounce half full bag frozen fries, and an unlabeled and undated opened package of [NAME] which had 4 [NAME] remaining in the package. In an interview on [DATE] at 9:05AM, S8Dietary Helper indicated the opened cream cheese Danish in the facility's refrigerator was her personal food item and should have not been stored in the facility's food storage refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 9:10AM, S7Dietary Manager indicated hairnets should be worn by all kitchen staff and all hair should be fully contained in the hairnet, the individual pudding cups should have been covered and stored in the refrigerator, the above listed items with no labels or dates should have been labeled and dated when opened, and the cabbage should have been discarded [DATE] and should have not been available for use. S7Diretary Manager further indicated staff should not store their personal food in the facility's food storage refrigerator.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 34608 Based on observations and interviews the facility failed to ensure a resident's call bell was within reach and available for use for 2 (Resident #2, Resident #95) of 2 (Resident #2, Resident #95) sampled residents investigated for call bells being within reach. Findings: Resident #2 In an interview on 01/27/2025 at 12:36PM, Resident #2 indicated he could not reach his call bell. Observation on 01/28/2025 at 9:50AM revealed Resident #2's call bell was tangled and located under Resident's #2's bed. Observation on 01/28/2025 at 1:22PM revealed, in part, Resident #2 was sitting in his room in a wheelchair next to the television. Further observation revealed Resident #2's call bell was tangled and located under Resident #2's bed. In an interview on 01/28/2025 at 1:22PM Resident #2 indicated he could not reach the call bell because it was under the bed. In an interview on 01/28/2025 at 1:25PM, S10Licensed Practical Nurse (S10LPN) indicated Resident #2 was capable of using a call bell and confirmed Resident #2's call bell was not in reach. Resident #95 Observation on 01/27/2025 at 9:50AM revealed, in part, Resident #95 was lying in bed. Resident #95's call bell was located on top of a dorm size refrigerator which was placed on a nightstand, and Resident #95 was unable to reach the call bell. Observation on 01/27/2025 at 10:10AM revealed, in part, Resident #95 was lying in bed. Resident #95's call bell was located on top of a dorm size refrigerator which was placed on a nightstand, and Resident #95 was not able to reach the call bell. Observation on 01/27/2025 at 1:15PM revealed, in part, Resident #95 was lying in bed. Resident #95's call bell was located on top of a dorm size refrigerator which was placed on a nightstand, and, Resident #95 was not able to reach the call bell. Observation on 01/28/2025 at 9:45AM revealed, in part, Resident #95 was lying in bed. Resident #95's call bell was located on top of a dorm size refrigerator which was placed on a nightstand, and Resident #95 was not able to reach the call bell. In an interview on 01/28/2025 at 9:45AM, Resident #95 indicated he wanted ice water but was not able to call the staff because Resident #95's call bell was not within reach. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/28/2025 at 1:20PM revealed, in part, Resident #95 was lying in bed. Resident #95's call bell was located on top of a dorm size refrigerator which was placed on a nightstand, and Resident #95 was not able to reach the call bell. In an interview on 01/28/2025 at 1:20PM S10Licensed Practical Nurse (LPN) indicated Resident #95 was capable of using the call bell. S10LPN confirmed Resident #95's call bell was not within reach and should have been. In an interview on 01/28/2025 at 1:30PM, S1Administrator indicated call bells should be within reach for residents to use.