STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195386	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation of Morgan City	740 Justa Street Morgan City, LA 70380

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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 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** Based on observations, interviews, and record reviews, the facility failed to protect a resident's right to be free from verbal and mental abuse by another resident for 1 (Resident #30) of 3 (Resident #15, Resident #30, Resident #33) sampled residents investigated for abuse. This deficient practice resulted in an actual harm on 07/06/2025 at approximately 9:30PM, when Resident #15, a resident with known aggressive behaviors towards staff and other residents, was overheard by her roommate, Resident #30, during a telephone conversation where Resident #15 used racial slurs so loudly that Resident #30 overheard the conversation. On 07/07/2025 at approximately 2:30PM, Resident #30 was observed by staff crying. Resident #30 informed S9Certified Nursing Assistant (CNA) of the conversation that was overheard on 07/06/2025 when Resident #15 used racial slurs. Resident #15 who was in the room during the conversation reacted to S9CNA and Resident #30 by using racial slurs, cursing, and kicking the trash can. Resident #30 indicated this aggressive behavior caused her to be anxious, nervous, and unable to avoid Resident #15 because she was bed bound. Resident #30 further indicated she kept her grabber within reach and planned to use it to defend herself against any physical attacks from Resident #15. Resident #30 indicated she notified S3Social Services, S4Infection Preventionist, S5CNA, S6CNA, S7CNA, S8CNA, S9CNA, and S11Licensed Practical Nurse (LPN) that she was upset, felt anxious and depressed having to room with Resident #15. The facility failed to intervene on behalf of Resident #30. Findings:Review of the facility's undated Abuse Prevention and Prohibition policy revealed, in part, each resident had the right to be free from abuse and should not be subjected to abuse by anyone, including other residents; abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish; verbal abuse was defined as the use of oral, written, or gestured language that willfully included disparaging and derogatory terms to residents or their families within their hearing distance or sight, regardless of their age, ability to comprehend, or disability. Further review revealed the safety of other residents and employees of the facility was the primary concern. Resident #30Review of Resident #30's MDS with an ARD of 05/07/2025 revealed, in part, Resident #30 was admitted to the facility on [DATE] and was African American. Further review revealed Resident #30 had a BIMS score of 13, which indicated Resident #30 was cognitively intact. Review revealed Resident #30 was dependent on staff for all activities of daily living. Resident #15Review of Resident #15's electronic medical record (EMR) revealed, in part, Resident #15 was admitted to the facility on [DATE] with diagnoses of generalized anxiety disorder and depression. Review of Resident #15's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/28/2025 revealed, in part, Resident #15 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated Resident #15 had moderate cognitive impairment. Further review revealed Resident #15 was capable of propelling herself in her manual wheelchair.Review of Resident #15's admission packet from Resident #15's previous facility revealed, in part, a nurse's note dated 09/27/2024 which indicated Resident #15 became upset at another resident and stated that black mother f*cker. Review of Resident #15's Follow-Up Question Report documentation by Certified Nursing Assistants (CNA) dated 05/15/2025 (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	through 07/07/2025 revealed, in part, Resident #15 had documented behaviors including screaming at others, agitation, cursing at others, expressing frustration and anger at others, spitting, and physical aggression towards others. Review of Resident #15's Social Service Progress Note dated 07/07/2025 at 5:41PM revealed, in part, S3Social Services documented the CNA reported that on 07/06/2025, Resident #15 was talking on the phone and stated her roommate was the devil. Further review revealed Resident #15 made derogatory comments about African Americans due to the way she was raised. Further review revealed Resident #15 would have a psychiatric evaluation. Review of Resident #15's Psychiatric Evaluation dated 07/08/2025 revealed, in part, Resident #15 was seen due to displaying verbal aggression. Further review revealed Resident #15 was started on buspirone hydrochloride (a medication used to treat anxiety) 5 milligrams by mouth every 12 hours. Further review revealed the Psychiatric Evaluation did not address the incidents from 07/06/2025 and 07/07/2025. Review of Resident #15's Follow-Up Question Report documentation by CNAs dated 07/08/2025 through 08/06/2025 revealed, in part, Resident #15 continued to have behaviors following Resident #15's psychiatric evaluation and medication initiation. Further review revealed Resident #15's documented behaviors included cursing at others, expressing frustration and anger at others, disruptive sounds, agitation, screaming at others, threatening others, pushing others, and entering other residents' personal space. Review of Resident #15's record revealed, in part, Resident #15 did not have any additional documented incidents of verbally or mentally abusing Resident #30 following the 07/06/2025 and 07/07/2025 incidents. There was no documented evidence, and the facility failed to present any documented evidence, additional interventions were implemented to protect Resident #30 from additional mental and verbal abuse and ensure Resident #30 was assessed and provided services following the verbal and mental abuse by Resident #15. In an tearful interview on 08/05/2025 at 8:57AM, Resident #30 indicated on 07/06/2025 at approximately 9:30PM, she overheard her roommate, Resident #15, informing someone on the phone that Resident #15's niece brought home a n*gger. Resident #30 further indicated Resident #15 then stated if Resident #15's mother was aware, Resident #15's mother would beat the sh*t out of her because we do not like n*ggers. Resident #30 further indicated that on the same phone conversation, Resident #15 called Resident #30 evil and the devil. Resident #30 reported that on 07/07/2025 at approximately 2:30PM, S9CNA found Resident #30 crying and asked Resident #30 what was wrong. Resident #30 indicated she reported to S9CNA that Resident #30 overheard Resident #15's telephone conversation the night before. Resident #30 further indicated Resident #15 overheard Resident #30 and S9CNA speaking about the incident, and Resident #15 became violent and screamed racial slurs towards both Resident #30 and S9CNA. Resident #30 indicated this aggressive behavior caused her to be anxious, nervous, and unable to avoid Resident #15 because she was bed bound. Resident #30 further indicated she kept her grabber within reach and planned to use it to defend herself against any physical attacks from Resident #15. Resident #30 indicated she reported the incident to S3Social Services and several staff, but Resident #30 felt like the facility did not care because nothing was done. Resident #30 was not asked by the surveyor if S1Administrator offered her a room change. In an interview at 08/05/2025 at 10:35AM, S11LPN indicated Resident #15 stated she did not like black people because that was the way she was raised. S11LPN further indicated Resident #15 would often say racial slurs to Resident #30. S11LPN further indicated this would be considered bulling or verbal abuse due to Resident #30's reaction to the behavior by being tearful and visibly upset. In an interview on 08/05/2025 at 12:06PM, S11LPN indicated S3Social Services and S1Administrator were aware of the behavior from Resident #15 towards Resident #30. In an interview on 08/05/2025 at 1:21PM, S9CNA indicated on 07/07/2025 at about 2:30PM she was going into Resident #15 and Resident #30's room for rounds and upon entering she observed Resident #30 crying. Resident #30 explained to S9CNA that she overheard a phone conversation by Resident #15 in which Resident #15 used racial slurs of the n word and called Resident #30 the devil. S9CNA indicated during the conversation, Resident #15 overheard Resident #30 speaking to S9CNA and propelled her wheelchair over to Resident #30's side of the room and (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	exclaimed, I was raised that way, I don't give a f*ck. S9CNA indicated Resident #15 continued to curse and yell at her and Resident #30. S9CNA further indicated she reported the above mentioned incident to S10CNA Supervisor. In an interview on 08/05/2025 at 1:46PM, S10CNA Supervisor indicated S9CNA reported that Resident #30 was upset because Resident #15 was used racial slurs and profanity towards S9CNA and Resident #30. S10CNA Supervisor further indicated she informed the S2DON, S3Social Worker, and S1Administer, and they came up with a plan to document all of Resident #15's aggressive behaviors. S10CNA Supervisor further indicated she was not made aware of any interventions implemented for Resident #30. In an interview on 08/05/2025 at 2:01PM, S3Social Services indicated she was aware Resident #15 was vulgar, aggressive and used racial slurs. S3Social Services further indicated she was aware of the incidents between Resident #15 and Resident #30 on 07/06/2025 and 07/07/2025 and was aware Resident #30 was upset as a result. S3Social Services further indicated the facility did not have another room available to separate the residents. In an interview on 08/05/2025 at 3:59PM, S8CNA confirmed worked with Resident #15 and 30 on 07/06/2025 from 6:00PM to 6:00AM. S8CNA indicated she was told by Resident #30 that Resident #15 was on a phone call with a friend when Resident #15 called Resident #30 derogatory names and stated that Resident #15 hated black people. S8CNA further indicated that Resident #15 often had behaviors and was very aggressive towards anyone around her. S8CNA confirmed that Resident #15 often cursed and said derogatory comments to Resident #30. S8CNA further indicated she did feel like Resident #15 was verbally abusive to Resident #30. In an interview on 08/05/2025 at 4:22PM, S5CNA, indicated she had witnessed Resident #15 use racial slurs to staff and Resident #30. S5CNA further indicated Resident #30 was negatively affected by Resident #15's derogatory racial slurs because she became upset and had nonverbal indicators of being upset. S5CNA further indicated Resident #15's racial slurs were considered verbal abuse to staff and Resident #30. S5CNA confirmed she was never made aware of any changes to Resident #30's care due to Resident #15's behaviors. In an interview on 08/05/2025 at 4:30PM, S7CNA indicated Resident #30 had informed her about the incident between Resident #15 and Resident #30 after the incident happened. S7CNA indicated Resident #30 was very upset about it. S7CNA further indicated that Resident #15 acted out and cursed everyone around her when Resident #15 was upset. S7CNA further indicated she could see how Resident #30 would take this behavior from Resident #15 as verbal abuse. In an interview on 08/05/2025 at 4:32PM, S6CNA confirmed she worked with Resident #15 and Resident #30. S6CNA confirmed Resident #15 cursed out staff and was very hostile and impatient. S6CNA confirmed on 07/07/2025, Resident #30 was crying and informed her that Resident #15 made racially inappropriate remarks on the telephone. S6CNA indicated Resident #30 was very upset and offended by what Resident #15 said on 07/06/2025. S6CNA further indicated the administration was aware of Resident #15's behaviors and never implemented anything new to divert Resident #15's behaviors. S6CNA confirmed Resident #15 verbally abused Resident #30 and staff. In an interview on 08/06/2025 at 10:33AM, S15CNO indicated she was not aware of Resident #15's aggressive behaviors or the incidents between Resident #15 and Resident #30 prior to the surveyor bringing the information to her attention. S15CNO further indicated that Resident #15 should have been removed from Resident #30's room immediately and interventions should have been in place for both residents following the discovery of the incidents on 07/06/2025 and 07/07/2025. S15CNO further indicated, per the Abuse and Neglect policy, Resident #30 was verbally and mentally abused by Resident #15. In an interview on 08/06/2025 at 10:48AM, S1Administrator indicated he was aware of the incidents between Resident #15 and Resident #30 prior to the survey because Resident #30 informed him of the telephone conversation where Resident #15 directed racial slurs towards Resident #30. S1Administrator further indicated he was aware that Resident #30 was upset, but was not aware that Resident #30 was crying or tearful. S1Administrator further indicated that Resident #15 was verbally aggressive, cursed, used racial slurs and based on the interviews and documentation the staff presented, S1Administrator would consider that Resident #15 verbally and emotionally abused (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #30. S1Administrator indicated he offered Resident #30 a room change, but Resident #30 declined.

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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, interviews, and record reviews, the facility failed to:1. Ensure expired medications were not available for resident use (Medication Cart A);2. Ensure the facility's shift verification of controlled substances count sheet was completed every shift (Medication Cart A); and,3. Ensure medications were documented as administered on the electronic Medication Administration Record (eMAR) when administered (Resident #83).This deficient practice was identified for 1 (Medication Cart A) of 2 (Medication Cart A, Medication Cart B) sampled medication carts observed during medication storage observations and 1 (Resident #83) of 1 (Resident #83) sampled residents investigated for hospice. Findings:1. Review of the facility's undated Storage of Medications policy and procedure revealed, in part, no discontinued, outdated, or deteriorated medications were available for use in the facility. Further review revealed all discontinued, outdated, or deteriorated medications were to be destroyed. Observation of Medication Cart A on 08/06/2025 at 3:30PM revealed, in part: -Advair diskus (medication used to treat inflammatory lung issues) with an expiration date of 10/11/2024 prescribed to Resident #36; - Famotidine (medication used to treat excessive stomach acid) 10 milligram tablets for general resident use with an expiration date of 07/2025; and, - Four Hydrocortisone Acetate (medication used to treat inflammation) 25 mg suppositories (medication inserted into the rectum) for general resident use with an expiration date of 07/2025. In an interview on 08/06/2025 at 3:35PM, S16Licensed Practical Nurse (LPN) confirmed the above mentioned medications' expiration dates and confirmed the above mentioned medications were expired and should not have been on the medication cart available for resident use. In an interview on 08/07/2025 at 9:55AM, S2Director of Nursing (DON) confirmed the above mentioned expired medications should not have been available for resident use. 2. Review of facility's undated Narcotics policy and procedure revealed one licensed nurse from the off-going shift and one licensed nurse from the oncoming shift must count and sign the narcotic count sheet in front of the narcotic box. Review of Medication Cart A's Shift Verification of Controlled Substances Count document revealed, in part: -no documented evidence of the nurse from the off-going 6:00PM-6:00AM shift having verified the narcotic count on: 06/04/2025 and 07/04/2025; -no documented evidence of the off-going 10:00PM-6:00AM shift having verified the narcotic count on: 6/12/2025; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-no documented evidence of the nurse from the off-going 6:00AM-10:00PM shift having verified the narcotic count on: 6/28/2025; -no documented evidence of the nurse from the off-going 6:00AM-6:00PM shift having verified the narcotic count on: 07/08/2025; -no documented evidence of the nurse from the on-coming 6:00AM-6:00PM shift having verified the narcotic count on: 07/04/2025 and 7/21/2025; and, -no documented evidence of the nurse from the on-coming unidentified shift having verified the narcotic count on: 06/27/2025 In an interview on 08/06/2025 at 3:35PM, S16LPN confirmed the above mentioned shifts did not have documentation of the off-going and on-coming shift verified the narcotic count, as required. In an interview on 08/07/2025 at 1:38PM, S2DON indicated the facility had no further documentation to present and had no further explanation for the omission of signatures on the above mentioned dates. 3. Review of the facility's undated Medication Administration policy and procedure revealed, in part, each dose of medication administered shall be properly recorded in the resident's medical record. In an interview on 08/04/2025 at 4:05PM, S13LPN indicated Resident #83 was administered Ativan 0.5milligrams/mg (a medication used to treat anxiety) earlier during the shift. The surveyor asked S13LPN what time she administered Resident #83's Ativan. S13LPN indicated Resident #83's Ativan 0.5mg was administered at approximately 12:30PM; however, S13LPN failed to document the administration of Ativan 0.5mg on Resident #83's eMAR. There was no documented evidence, and the facility was unable to present any documented evidence, Resident #83's Ativan 0.5mg was documented as administered on 08/04/2025. In an interview on 08/06/2025 at 1:26PM, S2DON indicated when a medication was administered the nurse should document the administration on the eMAR. S2DON confirmed S13LPN did not document the administration of Resident #83's on 08/04/2025 on Resident #83's eMAR, and should have.

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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 observations, interviews, and record reviews, the facility failed to:1. Ensure the scoop used to serve ice did not have the handle submerged in the residents' ice (Ice Chest A); 2. Ensure staff properly handled soiled linen (S12Certified Nursing Assistant); and, 3. Ensure staff implemented Enhanced Barrier Precautions (EBP) for a resident (Resident #76). This deficient practice was identified for 1 (Ice Chest A) of 2 (Ice Chest A, Ice Chest B) ice chests used to provide ice to residents; 1 (S12CNA) of 1 (S12CNA) CNAs observed during random linen handling observations; and, 1 (Resident #76) of 12 (Resident #5, Resident #9, Resident #10, Resident #17, Resident #32, Resident #70, Resident #76, Resident #77, Resident #81, Resident #85, Resident #90, Resident #91) sampled residents observed on EBP. Findings: 1.Observation on 08/04/2025 at 8:46AM revealed a blue and white ice chest located in the dining room with the ice scoop handle submerged in water and ice. In an interview on 08/04/2025 at 8:55AM, S2Director of Nursing (DON) confirmed the ice scoop handle was inside the ice chest submerged in the residents' water and ice. S2DON indicated the ice scoop should be stored in the ice scoop holder on outside of ice chest and should have not been in the ice chest submerged in residents' water and ice. 2. Review of the facility's undated Linen Handling policy revealed, in part, soiled linen should be bagged, in or near the resident's room, and securely closed prior to transport. Observation on 08/04/2025 at 8:40AM revealed S12Certified Nursing Assistant (CNA) walked in the hallway with unbagged soiled linen.In an interview on 08/04/2025 at 8:42AM, S10Certified Nursing Assistant Supervisor indicated S12CNA should not have walked in the hall with unbagged soiled linen.In an interview on 08/04/2025 at 8:55AM, S2DON indicated S12CNA should not have walked in the hallway with unbagged soiled linen. In an interview on 08/04/2025 at 10:11AM, S12CNA indicated she should not have walked in the hallway with unbagged soiled linen. 3. Review of the facility's undated (EBP) policy and procedure revealed, in part, EBP referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms, where employees wear gowns and gloves during high contact resident care activities. Further review of the policy revealed EBP was to be used for residents with indwelling medical devices which included central lines. Review of the policy also revealed EBP should be used when performing care of or accessing a central line. Review of Resident #76's record revealed, in part, Resident #76 had a peripherally inserted central catheter (PICC) for the administration of intravenous (administered directly into the vein) medication due to a diagnosis of osteomyelitis (infection of the bone). Observation on 08/05/2025 at 7:40AM revealed an EBP signage was present on Resident #76's door indicating personal protective equipment of gloves and gowns were required. Observation on 08/05/2025 at 8:00AM revealed S11Licensed Practical Nurse (LPN) prepared an IV medication for administration and entered Resident #76's room without wearing a surgical gown. In an interview on 08/05/2025 at 8:05AM, S11LPN indicated Resident #76 required EBP and she administered an IV antibiotic via Resident #76's PICC line. S11LPN further indicated she did not wear a gown when accessing Resident #76's PICC line for medication administration. In an interview on 08/05/2025 at 8:15AM, S4Infection Preventionist (IP) indicated EBP required staff to wear gloves and gowns when administering medications via a PICC line. S4IP further indicated S11LPN should have worn a gown when she accessed Resident #76's PICC line for medication administration. In an interview on 08/05/2025 at 9:59AM, S2DON confirmed S11LPN should have worn a gown when she accessed Resident #76's PICC line for medication administration.

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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. Based on interviews and record reviews, the facility failed to report an allegation of verbal and mental abuse to the state agency for 1 (Resident #30) of 3 (Resident #15, Resident #30, Resident #33) sampled residents reviewed for abuse.Findings:Cross Reference F600Review of the facility's undated Abuse Prevention and Prohibition policy revealed, in part, each resident had the right to be free from abuse and should not be subjected to abuse by anyone, including other residents. Further review revealed verbal abuse was defined as the use of oral, written, or gestured language that willfully included disparaging and derogatory terms to residents or their families, or within their hearing distance or sight, regardless of their age, ability to comprehend, or disability. Further review revealed staff should immediately report their knowledge related to abuse allegations to the Administrator or DON without fear of reprisal. Further review revealed an alleged violation of abuse will be reported immediately, but not later than 2 hours if the alleged violation involved abuse or had resulted in serious bodily injury. Review revealed the facility administrator, or designee shall report or ensure a report was submitted to the mandated state agency per reporting criteria within guidelines of notification of an alleged abuse. Review revealed the administrator would have 5 working days from the initial report of abuse to complete the Statewide Incident Management System (SIMS) report according to the Department of Health and Hospitals (DHH) guidelines.Review of Resident #15's social services progress note dated 07/07/2025 revealed, in part, staff reported Resident #15 was talking on the phone on 07/06/2025 and stated Resident #30 was the devil. Further review revealed Resident #15 and Resident #30 began to argue, and then Resident #15 made derogatory comments about African Americans. Review further revealed Resident #15 was asked to refrain from derogatory remarks.In an interview on 08/05/2025 at 8:57AM, Resident #30 indicated Resident #15 called one of her friends on speaker phone on 07/06/2025 at approximately 9:30PM and Resident #15 told her friend very loudly that Resident #15 did not like n****rs. Resident #30 further stated in Resident #15's same phone conversation, Resident #15 called Resident #30 evil and the devil. Resident #30 further indicated on 07/07/2025 at approximately 2:30PM she informed S9Certified Nursing Assistant (CNA) of the Resident #15's phone conversation from 07/06/2025. Resident #30 indicated during her conversation with S9CNA Resident #15 became violent and screamed profanities and racial slurs toward Resident #30 and S9CNA. Resident #30 further indicated Resident #30 spoke to the social worker and several staff about the incidents which occurred on 07/06/2025 and 07/07/2025.In an interview on 08/05/2025 at 9:04AM, S1Administrator reported the facility did not report any Statewide Incident Management Systems (SIMS) to the state agency for Resident #15 and Resident #30.In an interview on 08/05/2025 at 12:06PM, S11Licensed Practical Nurse indicated she was aware of the continued conflict between Resident #15 and Resident #30. S11LPN further indicated S3Social Services and S1Administrator were aware of the behavior from Resident #15 towards Resident #30.In an interview on 08/05/2025 at 1:21PM, S9CNA indicated on 07/07/2025 at approximately 2:30PM, Resident #30 was crying and informed her of the above mentioned incident from 07/06/2025. S9CNA further indicated while Resident #30 explained the incident to S9CNA, Resident #15 propelled herself over to Resident #30's side of the room and started to curse and yell at S9CNA and Resident #30. S9CNA further indicated she reported this incident to S10CNA Supervisor.In an interview on 08/05/2025 at 1:46PM, S10CNA Supervisor indicated S9CNA reported the above mentioned incidents to her immediately after it happened. S10CNA Supervisor further indicated she notified S1Administrator, S2Director of Nursing (DON), and S3Social Services of the above mentioned incidents on 07/07/2025.In an interview on 08/05/2025 at 2:01PM, S3Social Services indicated she was aware of the incidents between Resident #15 and Resident #30 on 07/06/2025 and 07/07/2025.In an interview on 08/06/2025 at 10:48AM, S1Administrator, indicated he was aware of the incidents on 07/06/2025 and 07/07/2025 between Resident #15 and Resident #30 prior to the (continued on next page)

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Legacy Nursing and Rehabilitation of Morgan City	740 Justa Street Morgan City, LA 70380

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	survey. There was no documented evidence, and the facility did not present any documented evidence, the incidents between Resident #15 and Resident #30 on 07/06/2025 and 07/07/2025 had been reported to the state agency.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews and record reviews, the facility failed to have documented evidence a thorough investigation was completed following allegations of verbal and mental abuse for 1 (Resident #30) of 3 (Resident #15, Resident #30, Resident #33) sampled residents investigated for abuse. Findings:Cross Reference F600 Review of the facility's undated Abuse Prevention and Prohibition policy revealed, in part, each resident had the right to be free from abuse and should not be subjected to abuse by anyone, including other residents. Further review revealed abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Further review revealed verbal abuse was defined as the use of oral, written, or gestured language that willfully included disparaging and derogatory terms to residents or their families, or within their hearing distance or sight, regardless of their age, ability to comprehend, or disability. Review revealed an abuse investigation included interviewing employees who worked in the resident's room and signed statements should be obtained from the employees. Further review revealed the investigation included interviewing the resident if they were cognitive. Review revealed the facility employee or agent, who became, aware of abuse or neglect, including injuries of unknown source or alleged misappropriation of resident property, shall immediately report the matter to the facility administrator or director of nurses. Further review revealed the administrator or designee would notify the regional director and corporate nurse. Review of Resident #15's social services progress note dated 07/07/2025 revealed, in part, staff reported that on 07/06/2025, Resident #30 had overheard Resident #15's phone conversation in which Resident #15 stated Resident #30 was the devil, and the residents argued. Further review revealed Resident #15 then made derogatory remarks about African Americans. In an interview on 08/05/2025 at 12:06PM, S11Licensed Practical Nurse (LPN) indicated she was aware of the continued conflict between Resident #15 and Resident #30. S11LPN further indicated S3Social Services and the S1Administrator were aware of Resident #15's behaviors toward Resident #30. In an interview on 08/05/2025 at 1:21PM, S9Certified Nursing Assistant (CNA) indicated on 07/07/2025 at approximately 2:30PM, S9CNA observed Resident #30 crying. S9CNA further indicated Resident #30 informed her about Resident #15's phone conversation Resident #30 overheard on 07/06/2025 where Resident #15 called Resident #30 the devil and used racial slurs. S9CNA further indicated while Resident #30 explained the incident to S9CNA, Resident #15 propelled herself over to Resident #30's side of the room and started to curse and yell at S9CNA and Resident #30. S9CNA indicated she reported this incident to S10CNA Supervisor on 07/07/2025. In an interview on 08/05/2025 at 1:46PM, S10CNA Supervisor indicated S9CNA made her aware of the above mentioned incidents from 7/06/2025 and 07/07/2025. S10CNA Supervisor indicated she reported the incidents to S1Administrator, S2DON, and S3Social Services on 07/07/2025. In an interview on 08/05/2025 at 2:01PM, S3Social Services indicated she was aware of the incidents between Resident #15 and Resident #30 on 07/06/2025 and 07/07/2025 and she was aware Resident #30 was upset. In an interview on 08/06/2025 at 10:33AM, S15Chief Nursing Officer (CNO) indicated she was not aware of the incidents between Resident #15 and Resident #30 that occurred on 07/06/2025 and 07/07/2025 prior to the survey; therefore, S15CNO did not have any documented evidence of an investigation was completed following the incidents. In an interview on 08/06/2025 at 10:48AM, S1Administrator indicated he was aware of the incident on 07/06/2025 and 07/07/2025 between Resident #15 and Resident #30 prior to the survey. S1Administrator further indicated based on the surveyor's presented findings, Resident #30 was verbally and mentally abused by Resident #15. In an interview on 08/06/2025 at 1:49PM, S2Director of Nursing (DON) was asked for the facility's investigation of the incidents between Resident #15 and Resident #30 that occurred on 07/06/2025 and 07/07/2025. S2DON indicated she would try to find the facility's investigation to provide to the surveyor.In an interview on 08/06/2025 at 11:25AM, S1Administrator was asked for the facility's investigation of the incidents between Resident #15 and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #30 that occurred on 07/06/2025 and 07/07/2025. S1Administrator indicated he would not present any further investigation regarding the incident between Resident #15 and Resident #30.In an interview on 08/06/2025 at 1:36PM, S3Social Services was asked for the facility's investigation of the incidents between Resident #15 and Resident #30 that occurred on 07/06/2025 and 07/07/2025. S3Social Services indicated the only investigation she completed regarding incidents between Resident #15 and Resident #30 that occurred on 07/06/2025 and 07/07/2025 was the Social Services note she documented on 07/07/2025. In an interview on 08/06/2025 at 1:54PM, S1Administrator was asked for the facility's investigation of the incidents between Resident #15 and Resident #30 that occurred on 07/06/2025 and 07/07/2025. S1Administrator indicated the facility was refusing to present any documentation of an investigation following the 07/06/2025 and 07/07/2025 incidents between Resident #15 and Resident #30. There was no documented evidence, and the facility failed and/or refused to present any documented evidence, the facility had completed a thorough investigation following the 07/06/2025 and 07/07/2025 incidents between Resident #15 and Resident #30.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to implement interventions for residents who were identified at risk for falls for 2 (Resident #3, Resident #7) of 8 (Resident #3, Resident #7, Resident #8, Resident #12, Resident #16, Resident #17, Resident #30, Resident #73) sampled residents investigated for accidents.Findings:Resident #3: Review of Resident #3's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/30/2025 revealed, in part, a Brief Interview for Mental Status score of 4. A score of 4 which indicated Resident #3 had severe cognitive impairment. Review of Resident #3's electronic medical record (EMR) chart revealed, in part, a special instruction for Resident #3 to have an auto lock brakes feature. (An auto lock brake feature engages the wheelchair's brakes when the user's weight is removed from the seat, preventing the chair from rolling away unintentionally). Review of Resident #3's Fall Risk assessment dated [DATE] revealed, in part, a score of 55 (A score of 45 or higher indicated high risk of falls). Review of Resident #3's care plan revealed, in part, Resident #3 was identified at risk for falls related to an unsteady gait. Further review revealed Resident #3's Care Plan included a documented intervention, dated 12/13/2024, for the auto lock brake feature. Review of Resident #3's social service progress note dated 07/24/2025 revealed, in part, Resident #3 was up daily in his wheelchair with confusion, impulsivity, and attempted to transfer without assistance. Further review revealed redirection was unsuccessful. Observation on 08/06/2025 at 1:45PM revealed Resident #3 was in his wheelchair and the wheelchair did not have the auto lock brake feature. In an interview on 08/06/2025 at 2:25PM, S2Director of Nursing (DON) confirmed Resident #3 was in a wheelchair which did not have the auto lock brake feature. Resident #7 Review of Resident #7's EMR revealed Resident #7 was admitted to the facility on [DATE] with a diagnosis of, in part, dementia (a loss of brain function that occurs with certain diseases) and a history of falls. Review of Resident #7's MDS with an ARD of 07/16/2025 revealed, in part, Resident #7 had a history of falls with two or more falls since admit. Review of Resident #7's care plan with the latest revision revealed, in part, Resident #7 was at risk for falls and injury related to a history of falls prior to admission, psychoactive medication use, impaired safety awareness, unsteady gait (how a person walks), dementia, and left sided weakness with a revised date of 07/28/2025. Further review revealed an intervention to provide Resident #7 with a wheelchair pocket attachment to facilitate the storage of snacks to be easily accessible to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	avoid dropping items on the floor. Observation on 08/05/2025 at 8:35AM revealed Resident # 7 was in her wheelchair at the nursing station. Further observation revealed no evidence Resident #7's wheelchair had a pocket attachment. Observation on 08/06/2025 at 8:40AM revealed Resident #7 was in her wheelchair at the nursing station. Further observation revealed no evidence Resident #7's wheelchair had a pocket attachment. In an interview on 08/05/2025 at 12:35PM, S13Licensed Practical Nurse (LPN) indicated the staff put Resident #7's snacks close to Resident #7 to prevent Resident #7 from falls. S13LPN further indicated Resident #7 often forget she could not walk and attempted to get snacks which resulted in falls. In an interview on 08/06/2025 at 8:45AM, S16LPN indicated Resident #7 had a history of attempting to retrieve items that were out of her reach; therefore, staff placed everything within her reach to prevent falls. In an interview on 08/06/2025 at 9:00AM, S2DON indicated Resident #7's care plan implementation for the wheelchair pocket attachment was to facilitate storage of snacks. In an interview on 08/06/2025 at 9:10AM, S17MDS Coordinator indicated all interventions on the current care plan should have implemented. In an interview on 08/06/2025 at 9:30AM, S2DON indicated Resident #7 did not have a wheelchair pocket attachment as per Resident #7's care plan and should have.

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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 observations, interviews, and record reviews, the facility failed to:1. Follow a physician's order for oxygen administration (Resident #33, Resident #63); and, 2. Ensure oxygen tubing was changed and dated weekly (Resident #33, Resident #63). This deficient practice was identified for 2 (Resident #33, Resident #63) of 2 (Resident #33, Resident #63) sampled residents investigated for respiratory care. Findings:1.Review of the facility's undated Oxygen Administration policy and procedure revealed, in part, staff should check the physician's order for liter flow rate of oxygen and method of administration. Further review revealed staff should adjust the liter flow rate of oxygen to the rate ordered by the physician. Resident #33Review of Resident #33's August 2025 Physician Orders revealed, in part, an order dated 09/29/2023 for oxygen to be administered at 2 liters per minute (LPM) via nasal cannula continuously related to chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). Review of Resident #33's care plan dated 09/14/2023 revealed, in part, staff were to administer Resident #33's oxygen as ordered by the physician. Observation on 08/04/2025 at 4:57PM with S2Director of Nursing (DON) present, revealed Resident #33 received oxygen at 3.5LPM per nasal cannula. In an interview on 08/04/2025 at 4:57PM, S2DON confirmed Resident #33 received oxygen at 3.5LPM per nasal cannula. In an interview on 08/04/2025 at 4:59PM, S13Licensed Practical Nurse (LPN) indicated Resident #33 had an order for oxygen to be administered continuously at 2LPM via nasal cannula, and should not have received oxygen at 3.5LPM. Resident #63Review of Resident #63's August 2025 Physician Orders revealed, in part, an order for oxygen to be administered at 2LPM via nasal cannula as needed. Observation on 08/04/2025 at 9:23AM revealed Resident #63 received oxygen via nasal cannula between 2.5LPM and 3LPM. Observation on 08/04/2025 at 4:50PM with S13LPN present, Resident #63 received oxygen between 2.5LPM and 3LPM via nasal cannula. In an interview on 08/04/2025 at 4:50PM, S13LPN indicated Resident #63 had an order for oxygen to be administered at 2LPM as needed, and should not have received oxygen between 2.5LPM and 3LPM. In an interview on 08/06/2025 at 2:37PM, S2DON indicated Resident #33 and Resident #63 should have received oxygen according to their physician orders, as mentioned above. 2.Review of the facility's undated Oxygen Concentration Cleaning policy and procedure revealed, in part, oxygen tubing/cannula should be changed weekly and as needed. Resident #33Review of Resident #33's August 2025 Physician Orders revealed, in part, an order dated 09/29/2023 for oxygen to be administered at 2 liters per minute (LPM) via nasal cannula. Observation on 08/04/2025 at 4:57PM with S2DON present, revealed Resident #33 received oxygen via nasal cannula and Resident #33's oxygen tubing was not dated. In an interview on 08/04/2025 at 4:57PM, S2DON indicated Resident #33's oxygen tubing should have been dated on the day it was changed, and was not. Observation on 08/05/2025 at 12:22PM with S4Infection Preventionist present, revealed Resident #33's oxygen tubing was not dated. In an interview on 08/05/2025 at 12:22PM, S4Infection Preventionist indicated Resident #33's oxygen tubing was not dated, and should have been. Resident #63Review of Resident #63's Quarterly Minimum Data Set with an Assessment Reference Date of 06/18/2025 revealed, in part, Resident #63 had a BIMS score of 13, which indicated Resident #63's cognition was intact. Review of Resident #63's August 2025 Physician Orders revealed, in part, an order dated 12/26/2023 for oxygen to be administered at 2LPM via nasal cannula as needed. Observation on 08/04/2025 at 9:23AM revealed Resident #63 received oxygen via nasal cannula and Resident #63's oxygen tubing was not dated. In an interview on 08/04/2025 at 9:23AM, Resident #63 indicated her oxygen tubing had not been changed for approximately 2 weeks. Observation on 08/04/2025 at 4:45PM revealed Resident #63 received oxygen via nasal cannula and Resident #63's oxygen tubing was not dated. In an interview on 08/04/2025 at 4:50PM, S13LPN confirmed Resident #63 received oxygen via nasal cannula, and Resident #63's oxygen tubing was not dated. S13LP confirmed Resident #63's oxygen tubing should have been dated to indicate when it was last changed and was not. There was no documented (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evidence, and the facility was unable to provide any documented evidence, Resident #33's and Resident #63's oxygen tubing was changed weekly, as required. In an interview on 08/06/2025 at 2:37PM, S2DON indicated Resident #33's and Resident #63's oxygen tubing should have been dated to indicate the date it had been changed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to: 1. ensure food stored in the facility's refrigerator was labeled with an opened date and/or discarded prior to the item's expiration date; and,2. ensure scoops were not stored inside the dry goods storage bins. Findings:1.Review of the facility's undated Food Safety and Sanitation policy and procedure revealed, in part, leftovers were to be dated when stored, and foods with expiration dates were to be used prior to the use by date on the package. Observation on 08/04/2025 at 8:30AM of the facility's kitchen with S14Dietary Manager revealed an opened gallon size container of ranch dressing stored in the facility's refrigerator. Further review revealed the container of ranch dressing had not been labeled with an opened date and had an expiration date of 07/24/2025. In an interview on 08/04/2025 at 8:39AM, S14Dietary Manager confirmed the container of ranch dressing, as mentioned above, was not labeled with an opened date and had an expiration date of 07/24/2025. S14Dietary Manager indicated the opened container of ranch dressing should have been discarded and should not have been available for resident consumption. 2. Observation on 08/04/2025 at 8:30AM of the facility's kitchen with S14Dietary Manager revealed the sugar and flour dry storage bins had scoops stored inside of the bins, with the handle of the scoop in direct contact with the flour and sugar. In an interview on 08/04/2025 at 8:30AM, S14Dietary Manager confirmed scoops were stored inside of the sugar and flour dry storage bins, and should not have been. In an interview on 08/06/2025 at 2:37PM, S2Director of Nursing (DON) confirmed the opened gallon sized container of ranch dressing, with an expiration date of 07/24/2025, should have been discarded and should not have been available for resident consumption. S2DON confirmed scoops should not have been stored inside the flour and sugar storage bins.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to post the most recent survey results in a place readily accessible to residents.Findings: Review of the facility's survey history revealed the last survey conducted was a complaint survey with an exit date of 04/03/2025. Observation on 08/05/2025 at 2:27PM of the facility's past survey results binder posted in the hallway next to the dining room revealed the last survey results available for review were dated 08/22/2024 for the recertification survey. There was no documented evidence, and the facility was unable to provide any documented evidence, the last survey results were posted in a place readily accessible to residents as required. In an interview on 08/05/2025 at 3:59PM, S1Administrator confirmed the complaint survey with an exit date of 04/03/2025 was not in the survey results binder.