STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195392	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation of Winnsboro	804 Polk Street Winnsboro, LA 71295

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17835 Based on record reviews, observations and interviews, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming and personal hygiene for 3 (#51, #55, & #57) of 5 (#4, #38, #51, #55, & #57) sampled residents reviewed for activities of daily living (ADLs). Findings: Resident #51 Review of the record for resident #51 revealed diagnoses of weight loss, dehydration, recent falls and vascular dementia and urinary tract infection. Review of the Minimal Data Set (MDS) assessment dated [DATE] revealed the resident scored a 1 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognitive skills for daily decision making. Further review revealed resident #51 required total assistance with activities of daily living (ADLs). Review of the plan of care for resident #51 revealed the resident required assistance for all ADLs with the following interventions: assist resident with hygiene and grooming and assist me with my clothing. Observation on 05/13/2024 at 8:20 a.m. of resident #51 revealed the resident was in the dining room of the locked unit eating breakfast. Further observation revealed food debris and liquid on her blouse and pants after her meal was consumed. Observation of resident #51 revealed she was barefooted. Observation on 05/13/2024 at 12:29 p.m. of resident #51 revealed resident #51 was eating her lunch meal. Resident #51 was observed with food debris and liquid debris on her clothing after the meal and was wearing the same clothing from the morning meal. Observation on 05/13/2024 at 3:10 p.m. revealed resident #51 had the same blouse on and was observed to have food debris and liquid spilled on blouse after eating snack food. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/14/2024 at 8:18 a.m. revealed resident #51 in the dining room eating breakfast. Resident was observed to have same blouse on from the previous day. Further observation revealed that resident spilled orange juice on self and S8Certified Nursing Assistant (CNA) was observed to wipe off access juice with paper towel and did not change the resident. Resident #51 was observed to be barefooted. Observation on 05/15/2024 at 7:46 a.m. revealed resident #51 was observed to have emesis on her clothing. An interview with S10CNA confirmed that resident #51 vomited during breakfast meal. An interview on 05/15/2024 at 3:00 p.m. with S2Director of Nursing (DON) confirmed that staff are to assist residents with all meals and beverages and are to change the residents' clothes when needed. Further interview with S2DON revealed that staff are to ensure residents have on proper footwear/non-slip socks. 19256 Resident #55 Review of the medical record for resident #55 revealed the resident was admitted on [DATE] with diagnoses including bilateral osteoarthritis of knee, anxiety disorder, agoraphobia with panic disorder, severe obesity, bipolar disorder with psychotic features, hypertension, depression, and malignant neoplasm of left breast. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored a 15 on the Brief Interview for Mental Status (BIMS) which indicated her cognition was intact. The resident required set up assistance with personal hygiene. Review of the record revealed the following care plan: I require staff assistance for all activities of daily living (ADLs). Further review of the care plan revealed the following intervention: assist me with hygiene and grooming tasks. An interview on 05/13/2024 at 12:00 p.m. revealed resident #55 stated, My toenails need to be trimmed. Observation of the resident's toenails at this time revealed they were long and needed to be trimmed. An interview on 05/14/2024 at 9:00 a.m. with resident #55 revealed her toenails were still in need of trimming. During an observation of resident #55's toenails with S2Director of Nursing (DON) on 05/15/2024 at 9:30 a.m. , S2DON confirmed that resident #55's toenails were in need of trimming and staff should assist resident #55 with personal hygiene. Resident #57 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record for resident #57 revealed the resident was admitted on [DATE] with diagnoses of cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebellar artery, Alzheimer's, schizoaffective disorder, bipolar type, hemiplegia and hemiparesis following cerebral infarction, dysarthria following cerebral infarction, chronic pain, peripheral vascular disease, and muscle weakness. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored a 6 on the Brief Interview of Mental Status (BIMS) which indicated the resident had severely impaired cognitive skills for daily decision making skills. The resident had range of motion impairment on both side of the upper extremities and lower extremities. The resident required substantial/maximal assistance with toileting/hygiene and shower/bathe self. The resident required partial/moderate assistance with personal hygiene. Review of the record revealed the following care plan: I require staff assistance for all activities of daily living. Further review of the care plan revealed the following intervention: assist me with hygiene and grooming. Observations on 05/13/2024 at 10:15 a.m. and on 05/14/2024 at 9:40 a.m. revealed resident #57 had long, jagged fingernails. During an observation of resident #57's fingernails with S3Wound Care Nurse on 05/15/2024 at 8:50 a.m., S3Wound Care Nurse confirmed resident #57's fingernails were long and needed to be trimmed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17835 Based on record review, observations, and interviews, the facility failed to ensure the resident environment remained as free of accident hazards as possible and failed to ensure that each resident received adequate supervision to prevent accidents for 1 (#51) of 3 (#51, #61 & #62) sampled residents reviewed for falls. Findings: Review of the record for resident #51 revealed diagnoses of closed head injury, dehydration, falls and urinary tract infection. Resident #51 was admitted to the local hospital on 05/09/2024 and discharged back to facility on 05/11/2024 after sustaining a fall on the secured unit. Review of the Fall Risk assessment dated [DATE] revealed resident #51 scored a 65, high risk for falling. Review of the Minimal Data Set (MDS) assessment dated [DATE] revealed the resident scored a 1 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognitive skills for daily decision making. Review of the plan of care for resident #51 revealed the resident was at risk for falls related to weakness and balance - fall with injury - hematoma to scalp/forehead. Interventions include Certified Nursing Assistant (CNA) to stand by assist when resident #51 is ambulating, nonskid socks and supervision at all times. Review of the record for resident #51 revealed the following incident (no date and time noted): while administering medication in the dementia unit, resident #51 was sitting in a chair in the day room with other residents. CNA on duty called for me stating that resident #51 had fallen face first onto the floor. Resident #51 was examined for injuries. Resident#51 had a hematoma to her forehead that had blood present. Resident #51 was sent to local emergency department for evaluation - mental status is impairment with medical diagnoses, injury type: hematoma to top of scalp. Observation on 05/13/2024 at 8:15 a.m. of the lock unit day room revealed resident #51 attempting to ambulate without assistance with an unsteady gait. Resident #51 was also observed to be barefooted. Observation on 05/14/2024 at 8:14 a.m. of the locked unit day room revealed S8CNA stepped out of the room away from 6 residents in the day room. No staff were present to assist and monitor resident #51 or the other 5 residents in the locked unit day room. Resident #51 was sedated in appearance and was again barefooted. Observation on 05/14/2024 at 3:30 p.m. revealed resident #51 was ambulating with an unsteady gait and walking behind her walker. Staff were not observed to be in close proximity of resident #51. Interview on 05/15/2024 at 9:45 a.m. with S7CNASupervisor confirmed that resident #51 required assistance with ambulation at all times and that staff must be present with resident #51 while ambulating or attempting to ambulate. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/15/2024 at 11:06 a.m. with S4Assistant Director of Nurses (ADON) confirmed that staff are to assist resident #51 with ambulation. Further interview with S4ADON confirmed that staff are not to ever leave residents unattended. S4ADON confirmed that staff are responsible to ensure that each resident has proper foot wear in place.

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F 0690 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405 Based on interviews, observations, and record reviews, the facility failed to ensure a resident admitted with a urinary catheter received necessary treatment and services, consistent with professional standards to promote healing and prevent infections for 1 (#9) of 3 (#9, #40, and #231) sampled residents reviewed for urinary catheters. This failed practice resulted in actual harm for resident #9 on 04/16/2024 due to the facility failing to: 1. Ensure resident #9 was free of urinary tract infections as evidenced by resident #9 having a urinary tract infection on 04/16/2024 and again on 05/13/2024, and was treated with antibiotic therapy on both occasions for 5 days, beginning respectively on 04/17/2024 and 05/13/2024. 2. Assess the medical justification for the indication for use of a urinary catheter for resident #9 upon admission on 03/18/2024. 3. Ensure the facility documented the color, clarity and character of resident #9's urine as per resident #9's current care plan. Findings: Review of the facility's current policy and procedure for Catheter Indwelling, Insertion and Removal (updated 06/30/2021) and Catheter Care, Indwelling Competency (02/22/2024) revealed no pertinent guidance on documentation of the appearance of urine when a catheter is used nor the need for medical justification of urinary catheters being assessed upon admission to the facility. Review of the record for resident #9 revealed an admitted to the facility of 03/18/2024 from a hospitalization . Diagnoses included chronic kidney disease stage 3, dehydration, diabetic ulcer of right foot, hypertension, type 2 diabetes mellitus with ketoacidosis without coma, and non-pressure chronic ulcer of other part of right foot with unspecified severity. Review of the Nursing Admission/Readmission Form dated 03/18/2024 revealed resident #9 required 2 person physical assist with toileting, urinary incontinence - always continent, bowel continence- always continent, and indwelling catheter was marked. Review of the Medicare 5 day Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating cognitively intact. Further review of the MDS revealed the resident required substantial/maximal assistance with toileting hygiene. Further review of the MDS revealed resident #9 had an indwelling urinary catheter on admission. Review of the May 2024 Physician's Orders for resident #9 revealed an order dated 03/19/2024 to maintain urinary catheter 16 French (10) cubic centimeters (cc) balloon, monitor catheter care every shift and as needed. The medical record had no other orders for the care of the urinary catheter. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Some	Review of the current care plan dated 03/18/2024 revealed resident #9 had a 16 French catheter. Interventions included to assess for symptoms of urinary tract infection as needed, change catheter tubing/bag as appropriate, evaluate for removal of catheter as appropriate, ongoing assessment of color, clarity, and character of urine, provide catheter care every shift, and watch for acute behavioral changes that may indicate a urinary tract infection. An observation and interview with resident #9 on 05/13/2024 at 10:45 a.m. revealed the resident was up in her gerichair and was noted to have a urinary catheter bag with dark amber urine, and catheter tubing that was very cloudy. Resident #9 reported at this time she should have had her catheter changed already. An observation on 05/14/2024 at 3:15 p.m. of resident #9 revealed amber urine still noted in catheter bag, but catheter tubing was clear. An interview on 05/14/2024 at 3:15 p.m. with resident #9 revealed that a nurse changed her catheter on 05/13/2024 and the nurse got a urine sample due to cloudy urine and her complaint of lower back pain. Review of the March 2024, April 2024, and May 2024 Medication Administration Record (MAR) revealed no documentation of color, clarity, and character of urine since resident #9 was admitted on [DATE]. Review of the April 2024 and May 2024 nurses' progress notes revealed there were only 6 entries (04/21/2024, 04/22/2024, 04/29/2024, 05/03/2024, 05/13/2024, and 05/14/2024) that documented color and clarity of the urine, but had no character of the urine noted. An interview on 05/14/2024 at 3:20 p.m. with S11Licensed Practical Nurse (LPN) revealed S11LPN reported resident #9 was crying and complaining of lower back pain on 05/13/2024, noted that resident's catheter was cloudy with dark urine in the catheter bag. S11LPN notified S13Nurse Practitioner (NP) and received an order to obtain a urinalysis on resident #9. S11LPN reported that she changed the resident's catheter bag and catheter tubing before she obtained a urine sample for urinalysis. S11LPN reported that resident #9 had 4+ bacteria noted on urinalysis, and was started on Macrobid (antibiotic) 100 milligrams (mg) 1 capsule by mouth twice a day beginning on 05/13/2024. S11LPN reported that urinary catheters are changed as needed for obstruction. S11LPN confirmed that March, April, and May 2024 MARs for resident #9 did not have documentation of color, consistency, and character of urine documented. S11LPN confirmed that resident #9 had a urinary catheter upon admission to the facility on [DATE]. Review of resident #9's urinalysis results dated 05/13/2024 revealed the following results: cloudy urine, 3+ blood in urine, 1+ protein, white blood cells too numerous to count, and 4+ bacteria. An interview on 05/14/2024 at 3:30 p.m. with S2Director of Nursing (DON) revealed that resident #9 has had a catheter since she was admitted to the facility on [DATE]. S2DON confirmed resident #9 had a urinary tract infection (UTI) currently and was started on Macrobid 100 mg 1 capsule by mouth twice a day for 5 days beginning 05/13/2024. S2DON confirmed there was no documentation of color, clarity, and character of the urine for resident #9 on March, April, and May 2024 MARs. Review of the April MAR for resident #9 revealed a urinalysis was obtained on 04/16/2024. Further review of the MAR revealed resident #9 was administered Macrobid 100 mg 1 capsule by mouth twice a day for 5 days beginning on 04/17/2024. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Some	Review of resident #9's urinalysis results dated 04/16/2024 revealed the following: 3+ bacteria, 2+ blood, cloudy urine, and white blood cells 20-30. Review of the urine culture results dated 04/16/2024 for resident #9 revealed Escherichia coli identified. An interview on 05/15/2024 at 8:05 a.m. with S2DON confirmed resident #9 did not have orders related to changing the resident's urinary catheter. S2DON confirmed that resident #9 had a urinary tract infection on 04/16/2024 and was started on Macrobid 100 mg 1 capsule by mouth twice a day on 04/17/2024. Review of resident #9's hospital discharge summary dated 03/18/2024 revealed resident #9 will be continued on ciprofloxacin for 10-14 days for Proteus infection of her foot wound. No diagnoses in hospital discharge record revealed a diagnosis that would medically justify the need for resident #9 to have a urinary catheter. An interview on 05/15/2024 at 8:45 a.m. with S12LPN/Minimum Data Set (MDS) Coordinator revealed the facility did not have a catheter use justification for resident #9, and was not aware that a justification was needed. She further reported resident was admitted with the urinary catheter, and the resident was unable to walk due to the wound to her right heel, so they left the catheter in place. An interview on 05/15/2024 at 8:55 a.m. with S2DON confirmed the facility did not have (indication for use of urinary catheter) a catheter justification, and that resident #9 did not have a diagnosis that would justify having a urinary catheter. An interview on 05/15/2024 at 1:48 p.m. with S13Nurse Practitioner (NP) revealed she was aware that resident #9 was admitted with a urinary catheter and confirmed there was no medical justification to indicate that resident #9 should have had a urinary catheter. S13NP confirmed resident #9 has had 2 urinary tract infections since she was admitted to the facility. S13NP confirmed that she spoke with S11LPN on 05/15/2024 and gave an order to discontinue resident #9's urinary catheter. S13NP confirmed resident #9 should not have been admitted to the facility with a urinary catheter without having a medical diagnosis to justify the use of a urinary catheter. An interview on 05/15/2024 at 2:30 p.m. with resident #9 revealed that staff removed her catheter today. Resident #9 reported she was able to urinate on her own before the catheter was put into place while in the hospital. An interview on 05/15/2024 at 2:35 p.m. with S12LPN/MDS Coordinator confirmed she should have identified resident #9 was admitted to the facility with a urinary catheter and did not have a medical diagnosis to justify use of the catheter. S12LPN/MDS Coordinator reported she should have made sure resident #9 had a medical justification for the indication of a urinary catheter. S12LPN/MDS Coordinator confirmed resident #9 has had 2 UTIs since she was admitted to the facility on [DATE]. S12LPN/MDS Coordinator confirmed the discharge documentation from the hospital for resident #9 did not include a medical justification for the use of a urinary catheter. An interview on 05/15/2024 at 2:45 p.m. with S2DON confirmed the following: -resident #9 had a urinary catheter on admission on 03/18/2024 but was not assessed for medical justification for indication of use of a urinary catheter, (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Some	-resident #9 did not have a diagnoses that justified the need for use of a urinary catheter, -no documentation of color, clarity, and character of resident #9's urine on March, April, and May 2024 MAR, and -resident #9 had a UTI on 04/16/2024 and 05/13/2024 and was ordered Macrobid 100 mg 1 capsule by mouth twice a day for 5 days.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17835 Based on record review, observations, and interviews, the facility failed to ensure that a resident maintains acceptable parameters of nutritional status for 1 (#51) of 1 (#51) resident reviewed for nutrition. The facility failed to provide the required assistance with meals to prevent significant weight loss. Findings: Review of the record for resident #51 revealed diagnoses including weight loss, dehydration, recent falls, vascular dementia and urinary tract infection. Review of the weights for resident #51 revealed 124 pounds recorded on 05/09/2024. Resident #51 admit weight was 141 pounds recorded on 01/25/2024 which was an 11.66% weight loss since admit. Review of the Minimal Data Set (MDS) assessment dated [DATE] revealed the resident scored a 1 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognitive skills for daily decision making. Further review of MDS revealed that meals are to be supervised and set up with assistance. Review of the May 2024 physician orders revealed the following diet order for resident #51: No added salt, pureed texture, nectar thick fluid consistency, house supplement three times a day, and pudding twice daily. No straws, no ice related to dysphagia, oropharyngeal phase. Observation on 05/13/2024 at 8:20 a.m. of resident #51 revealed she was on the locked unit dining room eating breakfast which consisted of thickened dairy beverage, glass of thickened orange juice, thickened water, and pureed eggs and sausage. Resident #51 was observed to eat less than 20% of this meal. Further observation revealed staff set up tray only for resident #51 and did not prompt resident to consume meal. Observation on 05/13/2024 at 12:29 p.m. resident #51 was observed eating lunch meal. The meal consisted of pureed red beans and rice, mashed potatoes and gravy, pureed green beans, pudding and a glass of thickened tea. Resident #51 was observed to eat less than 20% of this meal. Further observation revealed staff set up meal tray only for resident #51. Observation on 05/14/2024 at 8:18 a.m. revealed resident #51 in locked unit day room eating breakfast. The meal consisted of thickened dairy beverage, thickened orange juice, thickened water, pureed sausage and eggs. Further observation revealed that S8Certified Nursing Assistant (CNA) was standing over resident #51 and prompting resident #51 to eat meal. Further observation revealed S8CNA left the day room and went outside leaving 6 residents including resident #51 unattended. During this time, resident #51 spilled the glass of orange juice on self and did not eat any of the meal. Observation on 05/14/2024 at 3:30 p.m. revealed resident #51 was eating a bag of BBQ potato chips without staff monitoring. Observation on 05/15/2024 at 7:46 a.m. revealed resident #51 was observed to have emesis on clothing. S10CNA confirmed that she vomited during the breakfast meal this morning. Further interview with S10CNA revealed resident #51 did not eat any breakfast. S10CNA stated that resident #51 had a decline and that staff have to feed her all meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/15/2024 at 9:45 a.m. with S7CNA Supervisor confirmed that resident #51 required total assistance with meals and set up. Further interview with S7CNA Supervisor confirmed that staff should never leave residents unattended during the meal process. Interview with S4Assistant Director of Nursing (ADON) on 05/15/2024 at 11:06 a.m. confirmed that staff are to be present to assist residents with meals and beverages at all times. S4ADON confirmed weight loss for resident #51. S4ADON stated that CNAs are to notify floor nurses of any change of status and when residents are not eating. S4ADON further stated that resident#51 should not have been given BBQ chips.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19256 Based on record review, observations, and interviews, the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice for 1 (#10) of 1 sampled residents reviewed for respiratory care. The facility failed to ensure the oxygen tubing and cannula were stored properly when not in use for resident #10. Findings: Review of the Oxygen Concentrator Cleaning Policy and Procedure dated 04/08/2022 revealed in part: Procedure: 2. Store oxygen tubing, cannula, and mask in plastic bag when not in use. Review of the medical record for resident #10 revealed the resident was admitted on [DATE] with diagnoses including: chronic obstructive pulmonary disease (COPD), hypertensive heart disease with heart failure, severe obesity, schizoaffective disorder/depressive type, insomnia, depression, peripheral venous insufficiency, hypertension, edema, and heart failure. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored a 10 on the Brief Interview of Mental Status (BIMS) which indicated the resident had moderately impaired cognitive skills for daily decision making skills. Review of the physician orders revealed an order dated 03/26/2024 - oxygen to run at 2-3 Liters per minute (LPM) via nasal cannula as needed to keep oxygen saturations > 90% with shortness of breath (SOB), SOB when lying flat. Review of the Medication Administration Record for May 2024 revealed: oxygen at 2 LPM per nasal cannula at bedtime (hs) due to SOB while lying flat at bedtime related to COPD. Review of the record revealed the following care plan: I require oxygen therapy at hs and as needed due to SOB r/t COPD and congestive heart failure (CHF). Further review revealed an intervention to administer my oxygen as ordered. Observation on 05/13/2024 at 11:51 a.m. revealed the resident's nasal cannula was not in use and it was observed directly on the mattress. Interview with resident #10 at this time revealed he wears the nasal cannula at night. Observation on 05/14/2024 at 9:43 a.m. and 3:15 p.m. revealed the resident's nasal cannula was not in use and it was observed uncovered and hanging on the side rail on the bed. Observation on 05/15/2024 at 9:15 a.m. revealed the resident's nasal cannula was not in use and it was observed uncovered and hanging on the side rail on the bed. An interview with S14Licensed Practical Nurse (LPN) on 05/15/2024 at 9:15 a.m. confirmed resident #10's nasal cannula should be stored in a bag when not in use. During an observation with S2Director of Nursing (DON) on 05/15/2024 at 9:25 a.m., S2DON confirmed resident #10 required oxygen per nasal cannula at night and the nasal cannula should be stored in a bag while not in use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195392	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation of Winnsboro	804 Polk Street Winnsboro, LA 71295

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405 Based on record reviews and interviews, the facility failed to assure that nursing staff possessed the competency to provide nursing related services as evidenced by S2Director of Nursing (DON), S12Licensed Practical Nurse (LPN)/Minimum Data Set (MDS) Coordinator, and S13Nurse Practitioner (NP) failing to ensure a resident admitted with a urinary catheter had a medical justification for the indication/use of a urinary catheter for 1 (#9) of 3 (#9, #40 and #231) sampled residents reviewed for urinary catheters. Findings: Review of the facility's current policy and procedure for Catheter Indwelling, Insertion and Removal (updated 06/30/2021) and Catheter Care, Indwelling Competency (02/22/2024) revealed no guidance for the need of an admission assessment to determine a medical justification for the use of a urinary catheter. Review of the record for resident #9 revealed an admitted [DATE] with diagnoses including chronic kidney disease stage 3, dehydration, diabetic ulcer of right foot, diabetic ketoacidosis, hypertension, and non-pressure chronic ulcer of other part of right foot with unspecified severity. Review of the Medicare 5 day Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating mild cognitive impairment. Further review of the MDS revealed resident #9 had an indwelling urinary catheter. Review of the current care plan dated 03/18/2024 revealed resident #9 had a 16 French catheter. Interventions included to assess for symptoms of urinary tract infection as needed, change catheter tubing/bag as appropriate, evaluate for removal of catheter as appropriate, ongoing assessment of color, clarity, and character of urine, provide catheter care every shift, and watch for acute behavioral changes that may indicate a urinary tract infection. Review of resident #9's hospital Discharge Summary dated 03/18/2024 revealed resident #9 did not have a diagnosis that would medically justify the need for resident #9 to have a urinary catheter. An interview on 05/15/2024 at 8:05 a.m. with S2Director of Nursing (DON) confirmed resident #9 had a urinary catheter since she was admitted to the facility on [DATE]. S2DON further confirmed resident #9 had 2 urinary tract infections since she was admitted on [DATE]. An interview on 05/15/2024 at 8:45 a.m. with S12LPN/Minimum Data Set (MDS) Coordinator revealed the facility did not have a catheter justification for resident #9 and S12LPN/MDS Coordinator was not aware that a justification was needed. An interview on 05/15/2024 at 1:48 p.m. with S13Nurse Practitioner (NP) revealed she was aware that resident #9 was admitted with a urinary catheter on 03/18/2024 and confirmed there was no medical justification to indicate that resident #9 should have had a urinary catheter. S13NP confirmed that she spoke with S11LPN on 05/15/2024 and ordered to discontinue resident #9's urinary catheter. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 05/15/2024 at 2:45 p.m. with S2DON confirmed she was aware that resident #9 had a urinary catheter upon admission. Further interview with S2DON confirmed resident #9 was not assessed for a medical justification for the urinary catheter.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19256 Based on record reviews and interview, the pharmacist failed to report any irregularities to the attending physician and the facility's medical director and director of nursing for 1 (#30) of 1 sampled resident who received an anticoagulant medication. The pharmacist failed to identify that the facility had not monitored resident #30 for bleeding while the resident was receiving an anticoagulant medication. Findings: Review of the medical record for resident #30 revealed the resident was admitted on [DATE] with diagnoses of hypertensive heart disease with heart failure, edema, Alzheimer's, anxiety disorder, hyperlipidemia, and cervical disc degeneration. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed the resident scored a 9 on the Brief Interview for Mental Status (BIMS) which indicated the resident had moderately impaired cognitive skills for daily decision making skills. The resident required supervision for toileting/hygiene and partial/moderate assistance for shower/bathe self and dressing. Review of the physician orders revealed an order dated 02/27/2024 for Eliquis (anticoagulant or blood thinner) 5 milligrams (mg) give 1 tablet by mouth two times a day related to hypertensive heart disease with heart failure. Review of the record revealed the following care plan: I have been prescribed multiple medications. Further review revealed the following intervention: I need monitoring for adverse reactions. Review of the Medication Administration Record and Treatment Administration Record for May 2024 revealed there was no documented evidence that the staff were monitoring the resident for bleeding. Review of the Drug Regimen Review for 03/01/2024, 04/03/2024, and 05/01/2024 revealed there was no documented evidence the pharmacist identified that the staff were not monitoring the resident for bleeding while receiving Eliquis. An interview on 05/15/2024 at 2:50 p.m. with S2Director of Nursing (DON) confirmed there was no documented evidence the pharmacist identified that the staff were not monitoring the resident for bleeding while receiving Eliquis.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19256 Based on record reviews and interview, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for 1 (#30) of 1 sampled resident who received an anticoagulant medication. The facility failed to monitor resident #30 for bleeding when administered an anticoagulant medication. Findings: Review of the medical record for resident #30 revealed the resident was admitted on [DATE] with diagnoses of hypertensive heart disease with heart failure, edema, Alzheimer's, anxiety disorder, hyperlipidemia, and cervical disc degeneration. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed the resident scored a 9 on the Brief Interview for Mental Status (BIMS) which indicated the resident had moderately impaired cognitive skills for daily decision making skills. The resident required supervision for toileting/hygiene and partial/moderate assistance for shower/bathe self and dressing. Review of the physician orders revealed an order dated 02/27/2024 for Eliquis (anticoagulant or blood thinner) 5 milligrams (mg) give 1 tablet by mouth two times a day related to hypertensive heart disease with heart failure. Review of the record revealed the following care plan: I have been prescribed multiple medications. Further review revealed the following intervention: I need monitoring for adverse reactions. Review of the Medication Administration Record and Treatment Administration Record for May 2024 revealed there was no documentation that the staff were monitoring the resident for bleeding. An interview on 05/15/2024 at 2:50 p.m. with S2Director of Nursing (DON) confirmed there was no documented evidence that the facility was monitoring resident #30 for bleeding while she was receiving Eliquis.