

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195443	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Legacy Nursing and Rehabilitation of Tallulah		STREET ADDRESS, CITY, STATE, ZIP CODE 32 Crothers Drive Tallulah, LA 71282	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13974</p> <p>Based on observation, interview and record review, the facility failed to ensure each resident received services within a reasonable accommodations of their needs for 1 (#144) of 1 (#144) residents reviewed for accommodation of needs. The facility failed to ensure resident #144 was supplied with a call light that he could activate.</p> <p>Findings:</p> <p>Review of the medical record for resident #144 revealed he was admitted on [DATE] and had a diagnosis of wedge compression fracture of the T11-T12 vertebra.</p> <p>On 02/24/2025 at 12:50 p.m., interview with resident #144 revealed he was unable to activate his call light. Resident #144 demonstrated that he was unable to move his left arm and he was unable to move his right fingers to push the call light button.</p> <p>On 02/25/2025 at 12:45 p.m., S2Director of Nursing (DON) and the surveyor entered the room of resident #144. The resident demonstrated that he was unable to activate the call light due to physical disabilities. S2DON confirmed the resident was unable to activate the call light.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17835</p> <p>Based on record review and interview, the provider failed to ensure an incident involving an elopement was reported to the State Survey Agency for 1 (#294) of 1 sampled resident reviewed for elopement. Findings:</p> <p>Review of the facility's policy and procedure for resident elopement (no date) revealed in part the following: Purpose: to ensure that all residents are afforded adequate supervision to provide the safest environment possible. Policy: all residents will be assessed for behaviors or conditions that put them at risk for elopement and all residents so identified will have these issues addressed in their individual care plans. Definition: For the purpose of this policy, missing resident shall be defined to mean a resident who has left the facility grounds without signing him/herself out of the facility.</p> <p>Further review of the policy for resident elopement revealed to call or fax a report within 24 hours of the incident and prepare a complete report at the completion of the incident. Contact all the people/agencies previously notified that resident has been found.</p> <p>Review of the record for resident #294 revealed an admitted [DATE] with the following diagnoses: unspecified dementia with other behavioral disturbance and wandering.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed resident #294 had a brief interview for mental status of 3 which indicated that resident #294 had severe cognitive impairment with daily decision making. The assessment also indicated the resident was independent with transfers and did not require mobility devices.</p> <p>Review of elopement risk assessment completed on 11/07/2024 revealed resident was assessed as high risk for elopement with a score of 13.</p> <p>Review of an incident report 11/08/2024 at 1:08 p.m. revealed the following: S7Licensed Practical Nurse (LPN) notified this nurse (S10LPN) that resident #294 was out of facility unattended. Resident #294 was observed walking up Hall A when a sitter leaving out of emergency exit door, let resident #294 out believing that she was a visitor. S7LPN went out of the facility to get resident #294 whom was walking up a side road next to building. S7LPN requested assistance from a neighbor. S7LPN and neighbor transferred resident #294 back to facility in personal vehicle. Resident #294 then assisted to her room. Vitals 138/70; pulse 78, respirations 20, temperature 98 and oxygen saturation was 97% room air and resident #294 denies pain. No skin issues noted. Resident #294 stated that she was headed to her mom's room. Physician aware, no new orders. Daughter notified. Immediate Action taken: resident #294 assisted back to facility; vitals, no skin issues, resident #294 not taken to hospital. No injuries observed at time of incident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with S7LPN on 02/26/2025 at 9:15 a.m. revealed that on 11/08/2024 at approximately 1:00 p.m., S7LPN was working at her desk on Hall A when a sitter for another resident came to her door and stated she (sitter) let someone out of the building at the end of the hall while she was smoking. The sitter stated to S7LPN she thought she was a family member. S7LPN stated she immediately ran down to the door and saw resident #294 walking in the field off Hall A approximately 25 yards from the building. S7LPN stated she realized that she did not have her phone so she notified the sitter to go get staff. S7LPN then ran toward resident #294 and caught up with resident at the side road next to the facility. Further interview revealed that another staff member was driving up to the facility and saw S7LPN and resident #294. S7LPN and resident #294 got into her the car and returned to the front of the facility without incident. Resident #294 was pleasant, no agitation, but was confused. S7LPN stated she was able to return resident #294 into facility without incident. S7LPN stated resident #294 had a wander guard already on and the only way she got out was because the sitter opened the door for her when she (sitter) was smoking. S7LPN confirmed the facility's staff was not aware resident #294 exited the building until notified by sitter. S7LPN confirmed that she never lost visual sight of the resident. Further interview with S7LPN revealed the whole incident, including resident #294 being returned to her room, was less than 10 minutes. Observation at this time with S7LPN revealed the door at end of Hall A was locked. S7LPN opened the door and proceeded to demonstrate the incident. The place in which S7LPN first saw resident #294 was approximately 25 yards from Hall A's exit door. The side road (unpaved) was another 25 yards away and lead directly to the staff parking lot. This road was only for staff parking and there was no thru traffic. Further observation revealed there were no cars and the road was a single lane only leading into the parking lot.</p> <p>Interview with S1Administrator on 02/26/2025 at 10:15 a.m. confirmed that resident #294 was able to elope out of the facility without the staff aware of the incident until a sitter notified the nursing staff. Further interview with S1Administrator confirmed that he did not report resident #294's elopement in the Statewide Incident Management System (SIMS).</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51983</p> <p>Based on observation, interview, and record review the facility failed to accurately assess safety devices for effectiveness and elimination for 1 (#58) of 1 (#58) residents reviewed for restraints.</p> <p>Findings:</p> <p>Review of the facility's Safety and Supervision of Resident's policy and Procedure (undated) revealed the following, in part:</p> <p>4. Implementing interventions to reduce accident risks and hazards shall include the following:</p> <p>e. Documenting interventions</p> <p>5. Monitoring the effectiveness of interventions shall include the following:</p> <p>b. evaluating the effectiveness of interventions</p> <p>Review of medical records for resident # 58 revealed an admitted [DATE] with a diagnosis including muscle weakness (generalized), idiopathic orofacial dystonia, mood disorder due to known physiological condition, altered mental status, personal history of transient ischemic attack (TIA), and catatonic schizophrenia.</p> <p>Quarterly Minimal Data Set (MDS) assessment dated [DATE] revealed resident #58 had a Brief Interview for Mental Status (BIMS) score of 4 which indicates cognitive impairment for daily decision making and that the resident required two person assistance with transfers, toileting, and bed mobility.</p> <p>On 02/24/2025 at 08:40 a.m. resident #58 was observed lying in bed. Resident #58's mattress edges were observed to be raised approximately five inches on each side.</p> <p>On 02/25/2025 at 09:34 a.m. resident #58 was observed lying in bed on the mattress with raised edges.</p> <p>On 02/25/2025 at 03:40 p.m. interview with S2Director of Nursing (DON) and S5Licensed Practical Nurse (LPN) confirmed that the safety device assessment dated [DATE] did not include resident # 58's raised edge mattress.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13974</p> <p>Based on record review and interview, the facility failed to ensure it provided an ongoing program to support the residents in their choice of activities for 1 (#26) of 1 (#26) residents reviewed for activities. The facility failed to provide adequate activities for resident #26 who had a diagnosis of blindness.</p> <p>Findings:</p> <p>On 02/24/2025 at 10:45a.m., interview with resident #26 revealed he was blind and didn't receive any activities.</p> <p>Review of the medical record of resident #26 revealed he had a diagnosis of blindness in the right eye category 3 and blindness in the left eye category 3 indicating a significant degree of vision loss in both eyes. Review of the quarterly activity assessment dated [DATE] revealed resident #26 was provided with the monthly activity calendar. He attended parties/socials and special events and he enjoyed 1:1 conversation while drinking coffee.</p> <p>On 02/25/2025 at 11:00a.m., interview with resident #26 revealed staff do not inform him of when activities are going to take place.</p> <p>On 02/25/2025 at 1:15p.m., interview with S3Activity Director revealed resident #26 was not individually told of upcoming activities. Resident #26 was then interviewed in the presence of S3Activity Director. Resident #26 was asked to rate, from 1 to 10, his satisfaction with the activities he was provided. He rated his satisfaction level as a 2.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17835</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure each resident received adequate supervision to prevent elopement for 1 (#294) of 1 sampled resident reviewed for elopement. Findings:</p> <p>Review of the facility's policy and procedure for resident elopement (no date) revealed in part the following: Purpose: to ensure that all residents are afforded adequate supervision to provide the safest environment possible. Policy: all residents will be assessed for behaviors or conditions that put them at risk for elopement and all residents so identified will have these issues addressed in their individual care plans. Definition: For the purpose of this policy, missing resident shall be defined to mean a resident who has left the facility grounds without signing him/herself out of the facility.</p> <p>Review of the record for resident #294 revealed an admitted [DATE] with the following diagnoses: unspecified dementia with other behavioral disturbance and wandering.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed resident #294 had a brief interview for mental status of 3 which indicated resident #294 had severe cognitive impairment with daily decision making. The assessment also indicated the resident was independent with transfers and did not require mobility devices.</p> <p>Review of elopement risk assessment completed on 11/07/2024 revealed resident was assessed as high risk for elopement with a score of 13.</p> <p>Review of the care plan revealed resident #294 was an elopement risk related to wandering with the following interventions: alert staff to my wandering behavior; if I wander away from unit, instruct staff to stay with me, converse and gently persuade me to walk back to designated area with them; monitor and document my behavior; notify my (medical doctor) MD and family if I attempt elopement; and place wander guard bracelet on me that sounds alarms when I leave building.</p> <p>Review of an incident report dated 11/08/2024 at 1:08 p.m. revealed the following: S7Licensed Practical Nurse (LPN) notified this nurse (S10LPN) that resident #294 was out of facility unattended. Resident #294 was observed walking up Hall A when a sitter leaving out of emergency exit door, let resident #294 out believing that she was a visitor. S7LPN went out of the facility to get resident #294 whom was walking up a side road next to building. S7LPN requested assistance from a neighbor. S7LPN and neighbor transferred resident #294 back to facility in personal vehicle. Resident #294 then assisted to her room. Vitals 138/70; pulse 78, respirations 20, temperature 98 and oxygen saturation was 97% room air and resident #294 denied pain. No skin issues noted. Resident #294 stated that she was headed to her mom's room. Physician aware, no new orders. Daughter notified. Immediate Action taken: resident #294 assisted back to facility; vitals, no skin issues, resident #294 not taken to hospital. No injuries observed at time of incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a statement from S7LPN dated 11/08/2024 revealed the following: I was sitting in my office on Hall A, when another resident's private sitter came to my door and stated, This lady just followed me outside the exit door on Hall A, and I don't know if she is a visitor or a patient. I immediately ran to the Hall A exit door and looked and saw it was a patient. I exited the door and started running toward the resident #294. My phone was on my desk, so I told the sitter to call the front desk and tell them I needed help. I kept my eyes on the patient the entire time. A neighbor assisted me in getting resident #294 back to the facility unharmed, without any injury or distress. Resident #294 was assisted inside stable condition.</p> <p>Interview with S7LPN on 02/26/2025 at 9:15 a.m. revealed that on 11/08/2024 at approximately 1:00 p.m., S7LPN was working at her desk on Hall A when a sitter for another resident came to her door and stated she (sitter) let someone out of the building at the end of the hall while she was smoking. The sitter stated to S7LPN she thought she was a family member. S7LPN stated she immediately ran down to the door and saw resident #294 walking in the field off Hall A approximately 25 yards from the building. S7LPN stated she realized that she did not have her phone so she notified the sitter to go get staff. S7LPN then ran toward resident #294 and caught up with resident at the side road next to the facility. Further interview revealed that another staff member was driving up to the facility and saw S7LPN and resident #294. S7LPN and resident #294 got into her the car and returned to the front of the facility without incident. Resident #294 was pleasant, no agitation, but was confused. S7LPN stated she was able to return resident #294 into facility without incident. S7LPN stated resident #294 had a wander guard already on and the only way she got out was because the sitter opened the door for her when she (sitter) was smoking. S7LPN confirmed the facility's staff was not aware resident #294 exited the building until notified by sitter. S7LPN confirmed that she never lost visual sight of the resident. Further interview with S7LPN revealed the whole incident, including resident #294 being returned to her room, was less than 10 minutes. Observation at this time with S7LPN revealed the door at end of Hall A was locked. S7LPN opened the door and proceeded to demonstrate the incident. The place in which S7LPN first saw resident #294 was approximately 25 yards from Hall A's exit door. The side road (unpaved) was another 25 yards away and lead directly to the staff parking lot. This road was only for staff parking and there was no thru traffic. Further observation revealed there were no cars and the road was a single lane only leading into the parking lot.</p> <p>Interview with S5LPN on 02/26/2025 at 9:30 a.m. revealed she did assessments and the care plan for resident #294. S5LPN confirmed resident #294 was admitted to the facility for high risk for wandering and a wander guard was placed on resident #294 on the date of admission, 11/07/2024.</p> <p>Interview with S2Director of Nursing (DON) on 02/26/2025 at 9:45 a.m. confirmed resident #294 was able to elope out of the facility via the Hall A exit door as result of another resident's sitter who was smoking outside the exit door and accidentally let resident #294 exit the building. S2DON confirmed the nurse was immediately notified and resident #294 was quickly returned back to the facility. S2DON confirmed resident #294 was high risk for wandering and resident #294 was able to exit the facility without the staff being aware until reported by a sitter.</p> <p>Interview with S6Maintenance Supervisor on 02/26/2025 at 10:00 a.m. confirmed the exit door on Hall A does not have a code alert bracelet (wander guard) system to alert if a resident who was wearing a wander guard was in close proximity to the exit door. S6Maintenance Supervisor confirmed that resident #294 exited out of the facility and there was no alert due to the fact that there was no alert system on exit door of Hall A.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with S1Administrator on 02/26/2025 at 10:15 a.m. confirmed resident #294 was able to elope out of the facility without the staff aware of the incident until a sitter notified the nursing staff. Further interview with S1Administrator revealed that it was determined a sitter for another resident let resident #294 out of the facility by mistake as she thought resident #294 was a visitor. S1Administrator confirmed the Hall A exit door did not have a code alert bracelet system and as a result did not alert when resident #294 exited the facility through that door.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22575</p> <p>Based on observations, record reviews and interviews, the facility failed to: 1) ensure residents had a physician's order for bed rails, 2) obtain informed consent from the resident or resident's representative for bed rail use, and 3) assess residents for the risk of entrapment from bed rails prior to the installation of bed rails for 4 (#23, #30, #34, and #60) of 4 (#23, #30, #34, and #60) residents reviewed for bed rails.</p> <p>Findings:</p> <p>Review of the facility's policy (undated), Restraint Devices - Physical Policy and Procedure revealed the following in part:</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. Assess the resident's need for the safety device use. 2. Obtain informed consent for restraint device use. 3. Obtain physician's order for restraint device use. <p>Resident #30</p> <p>Review of the medical record revealed resident #30 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, hypertension, cerebrovascular disease, major depressive disorder, cerebral infarction, and osteoarthritis.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #30's Brief Interview for Mental Status (BIMS) score was 15 which indicated intact cognition for daily decision making. Resident #30 required extensive - total assistance with most activities of daily living.</p> <p>On 02/24/2025 at 8:52 a.m. and 02/25/2025 at 12:05 p.m., observations of resident #30 revealed she was in the bed with 1/2 bed rails raised on both sides of the bed and both bed rails were loose.</p> <p>On 02/25/2025 at 1:35 p.m., the surveyor and S6Maintenance Supervisor observed the resident's bilateral 1/2 bed rails, and both bed rails were loose. He confirmed the bed rails were loose and needed to be adjusted.</p> <p>Review of resident #30's record revealed no documented evidence of the following: a physician's order for bed rails, informed consent from the resident or resident's representative for bed rail use, and an assessment for the risk of entrapment prior to the installation of bed rails on resident #30's bed.</p> <p>(continued on next page)</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 02/26/2025 at 9:10 a.m., an interview with S2Director of Nursing (DON) confirmed they failed to obtain a physician's order for bilateral 1/2 bed rails, informed consent for bed rail use from the resident or resident's representative, and an assessment for the risk of entrapment before bed rails were installed on resident #30's bed.</p> <p>32231</p> <p>Resident #23</p> <p>Review of the medical record revealed resident #23 was admitted to the facility on [DATE] with diagnoses including in part, bipolar disorder, Alzheimer's disease, unspecified dementia with agitation, anxiety disorder, insomnia, Spondylolisthesis, muscle weakness (generalized), and personal history of transient ischemic attack.</p> <p>Review of the annual MDS assessment dated [DATE] revealed resident #23's BIMS was documented as severely impaired. Resident #23 required total dependence with 2+ person's physical assist with bed mobility.</p> <p>On 02/25/2025 at 10:06 a.m. and 02/25/2025 at approximately 3:20 p.m., observations revealed resident #23 was lying in bed. Further observation revealed that resident #23's bilateral 1/2 bed rails were raised on both side of the bed.</p> <p>On 02/26/2025 at 9:30 a.m., an observation revealed resident #23 was lying in bed with 1/2 bed raised on the right side of the bed and the other 1/2 side lowered to the left side of the bed, however, the bed rail remained attached to the bed.</p> <p>Review of resident #23's record revealed no documented evidence of the following: a physician's order for bed rails, informed consent from the resident or resident's representative for bed rail use, and an assessment for the risk of entrapment prior to installation of bed rails on resident #23's bed.</p> <p>On 02/26/2025 at 2:35 p.m., S2Director of Nursing was notified of the above findings. She confirmed that after record reviews, resident #23's record revealed no documented evidence of the following: a physician's order for bilateral 1/2 bed rails, informed consent for bed rail use from the resident or representative's representative, and an assessment for the risk of entrapment prior to the installation of bed rails on the resident's bed.</p> <p>Resident #34</p> <p>Review of the medical record revealed resident #34 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side, aphasia, cerebral palsy, lack of coordination, and difficulty in walking.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed resident #34's BIMS score was 04 which indicated the resident was severely impaired with his daily decision making skills. Resident #34 required total dependence with 2+ person's physical assist with bed mobility.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Legacy Nursing and Rehabilitation of Tallulah		STREET ADDRESS, CITY, STATE, ZIP CODE 32 Crothers Drive Tallulah, LA 71282	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 02/25/2025 at 10:00 a.m., 02/25/2025 at 4:06 p.m., and 02/26/2025 at 9:04 a.m., resident #34 was observed lying in bed with 1/2 bed rails raised to both sides of the bed.</p> <p>Review of resident #34's record revealed no documented evidence of the following: a physician's order for bed rails, informed consent from the resident or resident's representative for bed rail use, and an assessment for the risk of entrapment prior to installation of bed rails on resident #34's bed.</p> <p>On 02/26/2025 at 2:35 p.m., S2Director of Nursing was notified of the above findings. She confirmed that after record reviews, resident #34's record revealed no documented evidence of the following: a physician's order for bilateral 1/2 bed rails, informed consent for bed rail use from the resident or representative's representative, and an assessment for the risk of entrapment prior to the installation of bed rails on the resident's bed.</p> <p>Resident #60</p> <p>Review of the medical record revealed resident #60 was admitted to the facility on [DATE] with diagnoses including aphasia following cerebral infarction, hemiplegia, unspecified, affecting right dominant side.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed resident #60 had a BIMS score of 10 which indicated moderate cognitive impairment with daily decision making skills.</p> <p>On 02/25/2025 at 10:11 a.m., 02/25/2025 at 4:06 p.m., and 02/26/2025 at 3:35 p.m., observations revealed resident #60 was lying in his bed resting, in his room. Further observation revealed resident #60's 1/2 bed rails raised on both sides of the bed.</p> <p>Review of resident #60's record revealed no documented evidence of the following: a physician's order for bed rails, informed consent from the resident or resident's representative for bed rail use, and an assessment for the risk of entrapment prior to installation of bed rails on resident #60's bed.</p> <p>On 02/26/2025 at 2:35 p.m., S2Director of Nursing was notified of the above findings. She confirmed that after record reviews, resident #60's record revealed no documented evidence of the following: a physician's order for bilateral 1/2 bed rails, informed consent for bed rail use from the resident or representative's representative, and an assessment for the risk of entrapment prior to the installation of bed rails on the resident's bed.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51983</p> <p>Based on record reviews and interviews, the facility failed to ensure each resident's medication regimen was free from unnecessary medications by failing to monitor for bleeding for a resident who received anticoagulant medication for 1 (#15) of 1 (#15) residents reviewed for anticoagulants.</p> <p>Findings:</p> <p>Review of medical records for resident #15 revealed an admitted [DATE] with diagnosis including cerebral infarction, transient cerebral ischemic attack, atherosclerotic heart disease of native coronary artery without angina pectoris, old myocardial infarction, long term (current) use of anticoagulants, and chronic atrial fibrillation</p> <p>Review of the February 2025 physician orders revealed that resident #15 was ordered Eliquis (anticoagulant) 5 milligrams (mg) every 12 hours and Aspirin (anticoagulant) 81 mg daily.</p> <p>Review of the current care plan revealed resident #15 was at risk for bleeding due to anticoagulant therapy. Interventions included to watch orifices for signs and symptoms of bleeding and notifying the physician of any signs and symptoms of bleeding.</p> <p>Review of resident #15's medical record revealed no documented evidence of monitoring for bleeding.</p> <p>On 02/25/2025 at 1:00 p.m. interview with S2Director of Nursing (DON) confirmed that resident #15 received Eliquis and Aspirin and there was no documentation of monitoring for bleeding for resident #15.</p> <p>On 02/25/2025 02:25 p.m. an interview with S4Licensed Practical Nurse (LPN) confirmed that she does not document bleeding or bruising monitoring when she administers resident # 15's anticoagulants.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>32231</p> <p>Based on observations and interviews, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety by, 1) storing clean pots on a shelf with old food particles, 2) having a buildup of an unknown black substance on the inside of the ice machine and a buildup of dust on the filters of the ice machine, 3) foods items being stored in the freezer that were open and exposed to air, and 4) storing flats of bottled water directly on the storage room floor. According to the Diet Type Report, there was a total of 84 residents who currently received a meal tray from the kitchen.</p> <p>Findings:</p> <p>On 02/24/2025 at 8:25 a.m., an observation of the food preparation table revealed pots and pans that had been turned upside down and stored on the bottom shelf. Further observation revealed there were old food particles scattered on the shelf and in direct contact with the pots and pans.</p> <p>An observation of the ice machine revealed that upon opening the top lid of the ice machine, there was a large amount of an unknown black colored substance that was scattered throughout the lid. Further observation revealed the unknown substance was also observed on an area that was located on the upper inside of the machine. S8Dietary Manager confirmed the ice machine needed to be cleaned.</p> <p>An observation of the outside of the ice machine revealed two large filters. Further observation revealed the filters had a buildup of dust on the slats. S8Dietary Manager confirmed the filters needed to be cleaned.</p> <p>An observation of the walk-in freezer revealed one large box of beef patties and one large box of Churro Bites. Further observation revealed that both boxes were open and the beef patties and Churro Bites were exposed to air. S8Dietary Manager confirmed the food items were not properly sealed.</p> <p>Further observation revealed a storage room that was located in the back of the kitchen. An observation of the storage room revealed two flats of bottled water that was sitting directly on the floor. S8Dietary Manager confirmed the flats should not have been stored on the floor. S8Dietary Manager presented the survey team with a Diet Type Report. Review of the report revealed there was a total of 84 residents who currently received a meal tray from the kitchen.</p> <p>On 02/26/2025 at 11:45 a.m., S1Administrator was notified of the above findings.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>32231</p> <p>Based on observations and interviews, the facility failed to maintain a sanitary environment to help prevent the development and transmission of communicable diseases and infections by, failing to ensure employees did not store their personal belongings in the kitchen food preparation and storage room. According to the Diet Type Report, there was a total of 84 residents who currently received a meal tray from the kitchen.</p> <p>Findings:</p> <p>On 02/24/2025 at 8:25 a.m., an observation of the kitchen revealed one purse that was located on a top shelf next to a measuring cup and other food preparation items. There was a cart that had a large box of parchment paper stored on the bottom shelf. The end of the box was opened, the parchment paper was exposed and there was one large single sheet of the parchment paper lying on the outside of box. Further observation revealed a black colored jacket lying on top of and in direct contact with the exposed parchment paper.</p> <p>S9Dietary [NAME] was present in the kitchen during the observations. She revealed that she did not know who the jacket belonged to. S9Dietary [NAME] confirmed the purse belonged to herself. Further observation of the kitchen revealed a storage room that was located in the back of kitchen. An observation of the storage room revealed three jackets and one purse that were hanging on hooks. The jackets and purse was located next to a rolling cart that contained several cans of soups.</p> <p>S8Dietary Manager was present in the kitchen at the time of the observations. She confirmed that the kitchen staff were not supposed to have their personal belongings stored in the kitchen and storage room due to the possibility of cross contamination. S8Dietary Manager presented the survey team with a Diet Type Report. Review of the report revealed there was a total of 84 residents who currently received a meal tray from the kitchen.</p> <p>On 02/26/2025 at 11:45 a.m., S1Administrator was notified of the above findings.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>32231</p> <p>Based on observations and interviews, the facility failed to maintain all mechanical equipment in safe operating condition by having a buildup of metal shavings on the can opener and a grease buildup inside of the deep fryer. According to the Diet Type Report, there were a total of 84 residents who currently received a meal tray from the kitchen.</p> <p>Findings:</p> <p>On 02/24/2025 at 8:35 a.m., an observation of the kitchen revealed the commercial can opener contained a large buildup of metal shavings underneath the blade. Further observation revealed the large gas fryer had a buildup of grease on the internal components.</p> <p>S8Dietary Manager was present during the observations and confirmed that the can opener and the gas fryer were not in safe operating condition.</p> <p>S8Dietary Manager presented the survey team with a Diet Type Report. Review of the report revealed there was a total of 84 residents who currently received a meal tray from the kitchen.</p> <p>On 02/26/2025 at 11:45 a.m., S1Administrator was notified of the above findings.</p>