STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195443	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation of Tallulah	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)
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. Based on record review and interviews the facility failed to ensure competent nursing staff provided nursing and related services to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident by failing to administer insulin as ordered for 1 (#56) of 5 residents whose medication regimens were reviewed.Findings:Review of the medical record revealed Resident #56 had an admit date of 11/20/2025 with a diagnosis which included diabetes. Review of the 2026 physician orders revealed the resident was to receive insulin as needed by a sliding scale. The sliding scale indicated the resident was to receive 2 units when her blood sugar ranged from 150 to 199. Review of the April 2026 Medication Administration Record revealed the following blood sugars were obtained and no insulin was given as ordered:04/07/2026 at 9:00 a.m. - 18204/13/2026 at 9:00 a.m. - 15204/18/2026 at 9:00 a.m. - 17004/05/2026 at 5:00 p.m. - 16204/06/2026 at 5:00 p.m. - 16904/07/2026 at 5:00 p.m. - 17204/14/2026 at 5:00 p.m. - 18604/16/2026 at 5:00 p.m. - 197 On 04/22/2026 at 8:50 a.m., interview with S4Nurse Practitioner confirmed the ordered sliding scale insulin injections began at 150 and for blood sugars between 150 to 199 Resident #56 should have received 2 units of insulin.On 04/22/2026 at 9:00 a.m., interview with S2DON confirmed Resident #56 should have received 2 units of insulin on the days where her blood sugars ranged from 150 to 199.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure residents that had an order for psychotropic medication as needed were not subjected to chemical restraints for 1 (#2) of 5 residents reviewed for unnecessary medications. The facility failed to ensure a prn order for a psychotropic medication was limited to 14 days for Resident #2.Findings:Review of Resident #2's record revealed an admission date of 08/08/2025 with a readmission date of 12/03/2025. Further review revealed diagnoses that included major depressive disorder, anxiety disorder, vascular dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and metabolic encephalopathy.Review of Resident #2's April 2026 Physician's Orders revealed an order dated 12/15/2025 for Lorazepam/Ativan (psychotropic medication) oral tablet 1 mg give 1 tablet via peg tube q 4 hours prn for agitation related to anxiety disorder.Review of the Pharmaceutical Consultant Report (Psychoactive Gradual Dose Reduction) dated 01/19/2026 for Resident #2 revealed the following recommendation for Ativan 1 mg q 4 hours prn: prn psychotropic is limited to 14 days and required the prescriber to evaluate the resident prior to extending the order. If extending the order, document the rationale for the extended time period in the medical record and indicate a specific duration. Further review of the report revealed S4NP failed to document the rationale for an extended time period and failed to indicate a specific duration as per the pharmacist's recommendation.An interview on 04/22/2026 at 9:45 a.m. with S2DON confirmed there was no documented evidence of a rationale for the use of Lorazepam/Ativan prn for Resident #2 and failed to indicate the specific duration for the medication.

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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. Based on record review and interview, the facility failed to ensure the pharmacist identified irregularities related to adequate monitoring of a prescribed medication for 1 (#14) of 5 residents reviewed for unnecessary medications.Findings:Review of the medical record for Resident #14 revealed an admission date of 07/02/2024 with diagnoses that included cerebral palsy, anxiety, and vitamin deficiency.Review of the care plan revealed Resident #14 had a diagnosis of vitamin deficiency and the interventions included to administer medications as ordered and to draw labs as ordered by the physician. Review of the April 2026 physician orders for Resident #14 revealed an order dated 07/05/2025 for Ergocalciferol (Vitamin D2) oral capsule 1.25 mg, give one capsule by mouth every Friday related to vitamin deficiency. Further review revealed an order dated 08/08/2025 to obtain a Vitamin D level every six months.Review of the medical record for Resident #14 revealed no documented evidence of a Vitamin D level obtained every six months as ordered by the physician.Review of the monthly Drug Regimen Review dated 03/18/2026 revealed the pharmacist failed to identify Resident #14's Vitamin D level was not obtained in February 2026 as ordered.On 04/21/2026 at 3:10 p.m. interview with S2DON confirmed the pharmacist failed to identify the Vitamin D level was not obtained every six months as ordered for Resident #14 on the March 2026 monthly Drug Regimen Review.

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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. Based on record review and interview, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs by failing to obtain a Vitamin D level as ordered for 1 (#14) of 5 residents reviewed for unnecessary medications.Findings:Review of the medical record for Resident #14 revealed an admission date of 07/02/2024 with diagnoses that included cerebral palsy, anxiety, and vitamin deficiency.Review of the care plan revealed Resident #14 had a diagnosis of vitamin deficiency and the interventions included to administer medications as ordered and to draw labs as ordered by the physician. Review of the April 2026 physician orders for Resident #14 revealed an order dated 07/05/2025 for Ergocalciferol (Vitamin D2) oral capsule 1.25 mg, give one capsule by mouth every Friday related to vitamin deficiency. Further review revealed an order dated 08/08/2025 to obtain a Vitamin D level every six months.Review of the record revealed there was no documented evidence a Vitamin D level was obtained in February 2026 as ordered. On 04/21/2026 at 12:00 p.m. interview with S2DON confirmed a Vitamin D level was not obtained for Resident #14 in February 2026 as ordered.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure it did not have a medication error rate of greater than 5% by having a medication error rate of 7%.Findings:On 04/21/2026 at 7:50 a.m., a medication pass was observed for Resident #4. During the medication pass, S3LPN used a teaspoon to scoop a dosage of Miralax. Review of the April 2026 physician orders revealed an order for Miralax 17 grams, 1 scoop. Review of the manufacturer's recommendation revealed it instructed to fill the bottle cap to the top of the white section, which is marked to indicate the 17 gram dose. After the completion of the medication pass, review of the April 2026 physician orders revealed Resident #4 should have received Senna 8.6mg by mouth. On 04/21/2026 at 9:15 a.m., interview with S3LPN confirmed she did not administer Senna 8.6mg during the morning medication pass as prescribed and she confirmed she administered only a teaspoon of Miralax. On 04/21/2026 at 9:20 a.m., S2DON was notified of the 2 medication errors resulting in a medication error rate of 7%.