STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195449	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation of Lafourche	1002 Tiger Drive Thibodaux, LA 70301

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record review, the facility failed to ensure the kitchen's walk-in cooler was maintained in a sanitary manner. Findings: Review of the facility's undated Food Safety and Sanitization policy and procedure revealed, in part, stored food was to have been protected from contamination and growth of any pathogenic organisms. Review of the facility's undated Dietary Manager job description revealed, in part, the duties and responsibilities of the Dietary Manager included ensuring the kitchen was maintained as required by state and federal governing agencies regulations and standards, keeping the kitchen clean and organized, and keeping the work areas clean. Review of the facility's February 2026 Dietary Cleaning Schedule revealed, in part, floors of the cooler should be checked for food and/or spills, and mopped. Observation of the kitchen's walk-in cooler on 02/23/2026 at 8:45AM revealed 3 decomposing tomatoes, one brown decomposing lemon like fruit, a discolored milk carton laying on its side sitting in an unknown white curdled substance, and an unknown brown liquid on the floor underneath the raised storage racks. Observation of the kitchen's walk-in cooler on 02/24/2026 at 11:10AM with S4Dietary Manager revealed 3 decomposing tomatoes, one brown decomposing lemon like fruit, a discolored milk carton laying on its side sitting in an unknown white curdled substance, and an unknown brown liquid on the floor underneath the raised storage racks. In an interview on 02/24/2026 at 11:15AM, S4Dietary Manager indicated the above mentioned lemon on the ground in the walk in cooler was brown and decomposing, the above mentioned tomatoes were rotten with mold growth, and the above mentioned milk carton was leaking and disintegrating. S4Dietary Manager further indicated the floors in the cooler were not kept in a sanitary manner and should have been.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interviews and record reviews, the facility failed to ensure staff immediately consulted a physician regarding a resident's change of condition for 1 (Resident #52) of 1 sampled residents reviewed for notification of change. Findings:Review of the facility's undated Incident and Accident policy and procedure revealed, in part, the nurse will conduct an immediate investigation of any incident and accident. Further review revealed all incidents that occurred in the building required an incident report regardless of how minor the incident may have been. Review of the facility's undated Certified Nursing Assistant (CNA) job description revealed, in part, CNA duties and responsibilities included informing the assigned nurse and/or nursing management of a change in the resident's condition. On 02/24/2026 at 1:00PM, S2Director of Nursing (DON) was presented with a request for any and all documents related to the incident on 02/18/2026 involving Resident #52. Review of the facility's incident report, dated 02/18/2026 at 4:00PM, revealed, in part, Resident #52's right 4th and 5th digit were bruised. Further review revealed Resident #52 indicated his pinky finger was bruised and the incident occurred this morning (02/18/2026) during a transfer from the bed to the wheelchair. Review of Resident #52's right hand x-ray results, dated 02/19/2026 at 4:38PM, revealed, in part, Resident #52 had an a diagnosis of an acute appearing fracture of the base of the fifth proximal phalanx (bone in a finger). Further review revealed there was a mild displacement of the distal fragment (the broken piece of bone located further away from the bodies center.) Review of Resident #52's record revealed, in part, no documentation Resident #52's physician was consulted the morning of 02/18/2026 when the above mentioned incident occurred. In an interview on 02/24/2026 at 9:49AM, S5Licensed Practical Nurse (LPN) indicated she was the nurse assigned to Resident #52 during the 6:00AM to 2:00PM shift on 02/18/2026. S5LPN further indicated Resident #52's right hand had gotten caught in his wheelchair during a mechanical lift transfer on the morning shift (6:00AM to 2:00PM) of 02/18/2026. S5LPN further indicated S7Certified Nursing Assistant (CNA) did not report the above mentioned incident to her until the following day, 02/19/2026. In an interview on 02/24/2026 at 1:32PM, S7CNA indicated she was the CNA assigned to Resident #52 during the 6:00AM to 2:00PM shift on 02/18/2026. S7CNA further indicated when she lowered Resident #52 down into his wheelchair using the mechanical lift, Resident #52's right hand had gotten caught in the wheelchair. S7CNA indicated she did not report the above mentioned incident to S5LPN until 02/19/2026. S7CNA further indicated she did not report the above mentioned incident to S5LPN or the facility's administration when it occurred on 02/18/2026 and should have. In an interview on 02/26/2026 at 10:45AM, S2DON confirmed Resident #52's incident occurred at 9:00AM on 02/18/2026 and was not reported by S7CNA until the following day, 02/19/2026. S2DON further indicated she was unaware S7CNA knew that Resident #52's hand was caught in the wheelchair at the time of the above mentioned incident on 02/18/2026. In an interview on 02/26/2026 at 12:10AM, S1Administrator was presented with the above mentioned findings. S1Administrator indicated she was unaware S7CNA had not notified the nurse and/or completed an incident report on 02/18/2026 but should have.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a resident's catheter was maintained in a sanitary condition for 1 (Resident #8) of 2 residents investigated for urinary catheter usage.Review of Resident #8's medical record revealed, in part, Resident #8 was admitted to the facility on [DATE] with diagnoses, which included, obstructive uropathy (a blockage that restricts the flow of urine), and benign prostatic hyperplasia (a condition where to prostate grows larger and restricts the flow of urine). Review of Resident #8's Minimum Data Set with an Assessment Reference Date of 01/08/2026 revealed, in part, Resident #8 had a Brief Interview for Mental Status score of 15, which indicated Resident #8 was cognitively intact. Review of Resident #8's care plan with a goal date of 04/14/2026 revealed, in part, Resident #8 had a suprapubic catheter, and staff were to ensure Resident #8's catheter was secured appropriately. Review of Resident #8's February 2026's physician's orders revealed, in part, an order to ensure Resident #8's suprapubic catheter was hanging freely off of the floor. Observation on 02/24/2026 at 1:36PM revealed Resident #8's catheter bag, which was inside a privacy bag, was hanging on the back of Resident #8's wheelchair and was touching the floor. Further observation revealed the bottom of Resident #8's privacy bag was soiled with an unknown black/gray substance. Observation on 02/25/2026 at 10:55AM revealed Resident #8's catheter bag, which was inside a privacy bag, was hanging on the back of Resident #8's wheelchair and was touching the floor. Further observation revealed the bottom of Resident #8's privacy bag was soiled with an unknown black/gray substance. In an interview on 02/26/2026 at 9:18AM, S5Licensed Practical Nurse indicated Resident #8's catheter bag should hang freely off of the floor, and confirmed Resident #8's catheter bag should not be touching the floor. In an interview on 02/26/2026 at 10:10AM, S2Director of Nursing indicated Resident #8's urinary catheter bag was touching the floor, and it should have been freely hanging off the floor as ordered. In an interview on 02/26/2026 at 10:43AM, S1Administrator confirmed the above deficient practice.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to ensure:1. Staff followed enhanced barrier precautions when providing care to residents with an indwelling catheter (Resident #8, Resident #65); and,2. Staff performed hand hygiene between glove changes (Resident #65).This deficient practice was identified for 2 (Resident #8, Resident #65) of 2 sampled residents observed for catheter care. Findings:1. Review of the facility's undated Enhanced Barrier Precautions (EBP) Policy and Procedure revealed, in part, EBP to have been used during high-contact care activities for residents with indwelling medical devices, regardless of their multidrug resistance status. Further review revealed EBP should be used when the staff was performing high-contact resident care activities, such as, when providing hygiene, and when caring for a urinary catheter device. Further review revealed personal protective equipment (PPE) of a gown and gloves were to be applied prior to performing the high-contact resident activity. Resident #8 Review of Resident #8's Minimum Data Set (MDS) with an Assessment Reference Data (ARD) of 01/08/2026 revealed, in part, Resident #8 had an indwelling catheter. Review of Resident #8's care plan revealed, in part, Resident #8 required EBP related to a suprapubic catheter with a target date of 04/14/2026. Further review revealed, in part, staff would wear PPE during care of an indwelling medical device. Review of Resident #8's February 2026 physician orders revealed, in part, staff were to implement EBP related to Resident #8's suprapubic catheter. Observation on 02/24/2026 at 1:40PM revealed S7Certified Nursing Assistant (CNA) provided catheter care to Resident #8 without wearing a gown. In an interview on 02/24/2026 at 1:44PM, S7CNA indicated Resident #8 was on EBP, and she did not wear a gown while providing catheter care for Resident #8 and should have. In an interview on 02/25/2026 at 9:23AM, S2Director of Nursing (DON) indicated S7CNA should have worn a gown while providing catheter care to Resident #8 who was on EBP, and S7CNA did not. In an interview on 02/25/2026 at 9:25AM, S1Administrator confirmed S7CNA should have worn a gown while providing catheter care for Resident #8 who was on EBP, and S7CNA did not. Resident #65 Review of Resident #65's MDS with an ARD of 12/24/2025 revealed, in part, Resident #65 had an indwelling catheter. Review of Resident #65's care plan with a target date of 03/30/2026 revealed, in part, Resident #65 required EBP related to an indwelling catheter. Further review revealed staff would wear PPE during care of an indwelling medical device. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #65's February 2026 physician orders revealed, in part, staff were to implement EBP related to Resident #65's indwelling catheter. Observation on 02/24/2026 at 2:09PM revealed S10Certified Nursing Assistant (CNA) provided incontinence care and catheter care to Resident #65 without wearing a gown. In an interview on 02/24/2026 at 2:09PM, S10CNA indicated Resident #65 was on EBP; therefore, she should have worn a gown and gloves per the requirements. In an interview on 02/24/2026 at 3:08PM, S2Director of Nursing (DON) was notified of the above findings. S2DON indicated S10CNA should have worn a gown while performing incontinence care and catheter care on a resident who required EBP. 2. Review of the facility's undated Hand Hygiene Policy and Procedure revealed, in part, hand hygiene would be performed by staff involved in direct resident contact consistent with accepted standards of practice, to reduce the spread of infections and prevent cross contamination. Further review revealed hand hygiene would be performed via hand sanitizer or hand washing before and after direct resident contact and after removing gloves. Resident #65 Observation on 02/24/2026 at 2:09PM revealed S10CNA applied gloves, opened Resident #65's incontinence brief, and then cleaned feces from Resident #65's perineal area. Further observation revealed, S10CNA then moved Resident #65's blanket removed her gloves and applied a new gloves without performing hand hygiene. Further observation revealed S10CNA then continued to finish wiping Resident #65's perineal area, removed her gloves, applied new gloves, and touched Resident #65's blanket without performing hand hygiene. Further observation revealed S10CNA again removed her gloves, applied new glove, turned Resident #65 to her side, and finished cleaning Resident #65's perineal area without performing hand hygiene. Observation revealed S10CNA did not perform hand hygiene between any glove changes or before touching items in Resident #65's environment during the above mentioned perineal care. In an interview on 02/24/2026 at 2:09PM, S10CNA indicated she should have performed hand hygiene between each glove change, and after any contact with items in Resident #65's environment. In an interview on 02/24/2026 at 3:08PM, S2DON was notified of the above findings. S2DON indicated S10CNA should have performed hand hygiene between all the glove changes and before any contact with items in Resident #65's environment.