

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195554	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2025
NAME OF PROVIDER OR SUPPLIER Legrand Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 650 Holt Street Bastrop, LA 71220	

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. (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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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to ensure the nursing staff had appropriate competencies and skill sets to provide nursing care for 1 (#1) of 3 (#1, #2, #3) sampled residents reviewed. The nurse failed to: 1) review Resident #1 discharge orders when writing his admission orders to the facility and 2) clarify with the Physician if Resident #1 need to continue his home medications. Findings: Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses included encounter for surgical aftercare following surgery on the nervous system, type 2 diabetes mellitus with diabetic neuropathy, low back pain, hyperlipidemia, post-traumatic osteoarthritis, insomnia, constipation, depression, intervertebral disc disorders with myelopathy, thoracolumbar region, edema, and hypokalemia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated Resident #1 was cognitively intact for daily decision making. Review of the Resident #1's discharge orders from the hospital dated 07/31/2025 revealed an order to continue home medications; see attached list. Review of the attached medication list revealed Pioglitazone 45 milligrams (mg) daily. Further review revealed Riluzole 50 mg twice a day was not listed. Review of Resident #1's admission orders dated 08/01/2025 written by S3ADON revealed an order for Pioglitazone 30 mg by mouth (po) daily. Further review of the admission orders revealed there was no order for Riluzole 50 mg po twice a day. Review of the August 2025 Electronic Medication Administration Record (EMAR) revealed documentation Resident #1 received Pioglitazone 30 mg po daily. Further review revealed Resident #1 did not receive Riluzole 50 mg po twice a day. On 09/30/2025 at 8:32 a.m., an interview with Resident #1 revealed he was admitted to the facility on [DATE] to receive therapy after having back surgery on 07/29/2025. Resident #1 reported his step son and daughter-in law transported him to the facility and they brought all of his home medications. Resident #1 reported he specifically told the nurse that he needed to continue his home medication, Riluzole 50 (mg) tablet twice a day for 1 month. Resident #1 reported the nurse took all of his home medications with her. Resident #1 reported his daughter-in law was present when he told the nurse about needing to continue taking the Riluzole medication. Resident #1 reported on 08/27/2025 when he was being discharge from the facility S5Licensed Practical Nurse (LPN) went over his discharge instructions. Resident #1 revealed S5LPN went over his medication list with him. Resident #1 reported his home medication, Riluzole, was not on the discharge medication list. Resident #1 reported they also had Pioglitazone 30mg daily. Resident #1 reported normally took Pioglitazone 45 mg daily. Resident #1 reported S5LPN returned his home medications and that is when he notice that the bottle of Riluzole, was still full. Resident #1 reported he became upset when he found out he had not received the medication. Resident #1 reported S2Director of Nursing (DON) and S3Assistant Director of Nursing (ADON) informed he did not receive Riluzole because it was not on his discharge orders from the hospital. On 09/03/2025 at 1:20 p.m., an interview with S2DON revealed S3ADON wrote Resident #1 admission orders. Surveyor asked S2DON about the discrepancy between Pioglitazone 45 mg po daily that was on Resident #1's discharge orders dated 07/31/2025 and the admission orders dated 08/01/2025 which had Pioglitazone 30 mg po daily. S2DON reported she was not aware of the discrepancy. On 09/30/2025 at 3:25 p.m., a telephone interview with S4LPN revealed she admitted Resident #1 to the facility on [DATE] at 1:30 p.m. S4LPN revealed Resident #1 arrived via private auto with his step son and daughter-in law. S4LPN reported they brought his home medications with him. S4LPN reported they normally do not use the resident's home medication unless it is a medication that they are not able to obtain from the pharmacy. S4LPN revealed she was given a bag containing Resident #1's home medications and she stored them in the medication room. S4LPN revealed she did not recall Resident #1 telling her that he needed to continue taking his home medication, Riluzole. S4LPN reported Resident #1's daughter-in law told her not to reorder Riluzole from the pharmacy. On 09/30/2025 at 4:24 p.m. an interview with Resident #1's daughter-in law revealed she was present when Resident #1 told the nurse he needed to continue taking the Riluzole 50 mg tablet twice day for 1 month after his surgery. Resident #1's daughter-in law revealed Resident #1 brought all of his home medication with him in a bag and Resident #1 handed the bottle of Riluzole to the nurse and told her he need to continue it twice a day for 1 month. Resident #1's daughter-in law reported she instructed the nurse to use his home medication of Riluzole and not to reorder the medication because there was a month supply in the bottle. On 10/01/2025 at 1:55 p.m. an interview with S4LPN revealed she admitted Resident #1 on 08/01/2025 at 1:30 p.m. but she did not write his admission</p>		