| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195599 | A. Building<br>B. Wing | 06/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Legacy Nursing and Rehabilitation of Port Allen | 403 15th Street<br>Port Allen, LA 70767 |

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 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47500<br><br>Based on interviews and record reviews, the facility failed to ensure nursing staff communicated a significant change in status to the resident's physician for 2 (#3 and #R4) of 8 (#1, #2, #3, #R1, #R2, #R3, #R4, and #R5) residents reviewed for notification of change.<br><br>This deficient practice resulted in an Immediate Jeopardy situation on 05/31/2024 at 4:00 a.m. when S4LPN failed to notify Resident #3's physician when the resident had no urine output. On 05/30/2024 at 2:56 p.m., Resident #3 was observed to be lethargic and weak, which resulted in S6NP ordering 500 cc normal saline via intravenous infusion and lab work in the morning. On 05/31/2024 at 4:00 a.m., S4LPN attempted to collect urine from Resident #3 with an in and out catheter which resulted in no urine. The resident's brief was also observed to be dry at that time. S4LPN did not notify the resident's physician or nurse practitioner that Resident #3 had no urine output. On 05/31/2024 at 7:00 a.m., Resident #3 was lethargic, his body was rigid, and extremities were twitching. On 05/31/2024 at 8:30 a.m., Resident #3 was transferred to the hospital. Resident #3 was diagnosed with Acute Metabolic Encephalopathy, Hypernatremia, and Acute Cystitis with Hematuria. Resident #3 was admitted to the hospital on 05/31/2024 and discharged back to the facility on [DATE].<br><br>S1ADM and S2DON were notified of the Immediate Jeopardy situation on 06/21/2024 at 2:41 p.m.<br><br>The Immediate Jeopardy was removed on 06/23/2024 at 2:53 p.m., as confirmed by onsite verification through observations, interviews, and record reviews. The facility implemented an acceptable Plan of Removal (POR) prior to the survey exit.<br><br>The deficient practice continued at more than minimal harm for any resident residing in the facility.<br><br>Findings:<br><br>Review of the facility's undated Resident Rights and Quality of Life Policy and Procedure revealed, in part:<br><br>Policy:<br><br>A resident has the right:<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195599 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/24/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Legacy Nursing and Rehabilitation of Port Allen | | STREET ADDRESS, CITY, STATE, ZIP CODE 403 15th Street Port Allen, LA 70767 | |

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 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 11. To be notified, and his or her physician notified of significant changes in condition, of a need to significantly alter treatment, or of a decision to be transferred.<br><br>Resident #3<br><br>Review of Resident #3's medical record revealed Resident #3 was admitted to the facility on [DATE] with the following diagnoses, in part, Unspecified Dementia, Schizophrenia, Benign Prostatic Hyperplasia with lower urinary tract symptoms, Metabolic Encephalopathy, Sepsis, Acute Embolism and Thrombosis of left Peroneal Vein.<br><br>Review of Resident #3's Progress Note dated 05/30/2024 by S6NP revealed, in part, vital signs: P 99, BP 178/91, T 98, R 18, O2 sat 95% RA. Staff reports that resident stayed in bed most of the day yesterday; today he is weak and required help with eating. BP elevated prior to medications, looks comfortable. Staff reports Resident #3 was weak, requiring assistance with feeding, not talking but tracks people and follows command, poor intake yesterday. Give IV bolus 500cc NS today, check CBC, CMP, UA.<br><br>Review of Resident #3's Physician Orders dated May 2024 revealed, in part, the following:<br><br>An order dated 05/30/2024 CBC, CMP, and UA in the morning for diagnoses: lethargy;<br><br>An order dated 05/30/2024 for 500 cc Normal Saline IV one time only for dehydration for 1 day;<br><br>An order dated 05/31/2024 for send to emergency room for evaluation.<br><br>Review of Resident #3's Administration Note dated 05/31/2024 at 4:00 a.m. by S4LPN revealed, in part, Resident #3 was in bed and alert to nurse's voice. Resident #3's adult brief was dry. In and Out catheter attempted, no urine output, abdomen soft and non-tender, resident weak and fatigued more than normal. Report given to oncoming nurse of resident status. Further review revealed the NP and/or physician were not notified that the resident had no urine output.<br><br>Review of Resident #3's Nurse's Note dated 05/31/2024 at 7:00 a.m. by S3LPN revealed, in part, Resident #3 was in bed with eyes closed, lethargic, body rigid, extremities twitching, refusing any oral fluids, 0.9% sodium chloride infusing at 20 ml/hr in IV noted to right arm. Night shift reported he had no urine output during the night shift and was unable to obtain urine when attempted to catheterize him this a.m. S6NP was informed of resident's condition. Received orders to send to hospital.<br><br>Review of Resident #3's emergency provider note dated 05/31/2024 revealed, in part, Resident #3's chief complaint was weakness, increased weakness for 2 days, normally walking. Further review revealed, apparently on 05/28/2024 Resident #3 began to become more weak and less talkative, resident is non-communicative, so history was provided through EMS. Further review revealed, diagnoses included encephalopathy, weakness, and acute cystitis with hematuria.<br><br>Review of Resident #3's hospital history and physical dated 05/31/2024 revealed, in part, acute metabolic encephalopathy-suspect from volume depletion and acute cystitis; hypernatremia- sodium elevated at 148, suspect volume depletion; acute cystitis with hematuria-UA consistent with acute cystitis and patient grossly encephalopathic.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195599 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/24/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Legacy Nursing and Rehabilitation of Port Allen | | STREET ADDRESS, CITY, STATE, ZIP CODE: 403 15th Street Port Allen, LA 70767 | |

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 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #3's hospital discharge summary dated 06/04/2024 revealed, in part, Resident #3 was admitted to the hospital on 05/31/2024 and discharged back to the facility on [DATE].<br><br>On 06/20/2024 at 8:10 a.m., an interview was conducted with S6NP. She stated on 05/30/2024 the nurse notified her Resident #3 was weak and lethargic, so she ordered a normal saline bolus via IV with labs to be completed in the morning. She stated she instructed the staff to notify her if there was no improvement or any decline. She stated she was not notified Resident #3 had no urine output, on 05/31/2024 at 4:00 a.m., when the nurse attempted to collect urine for the urinalysis. She stated she should have been notified of no urine output immediately.<br><br>On 06/20/2024 at 9:20 p.m., an interview was conducted with S4LPN. She stated the provider should be notified of any changes in a resident's status. She stated on 05/31/2024 at 4:00 a.m. Resident #3's brief was dry, and there was no urine output noted when an In and Out catheter was used to collect the urine specimen. She stated she didn't notify the NP of no urine output at 4:00 a.m. on 05/31/2024, and should have.<br><br>On 06/20/2024 at 11:25 a.m., an interview was conducted with S3LPN. She stated when she arrived to work on 05/31/2024 for the 6:00 a.m. to 6:00 p.m. shift, S4LPN asked her to assess Resident #3 during report since he had no urine output during the night shift. She stated Resident #3 was walking on Tuesday, 05/28/2024 and on 05/31/2024 he was lethargic. She stated Resident #3's blood pressure and heart rate were elevated so she called the S6NP and received orders to send him out.<br><br>Resident #R4<br><br>Review of Resident #R4's medical record revealed Resident #R4 was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes Mellitus with Diabetic Nephropathy, Morbid Obesity, and Chronic Obstructive Pulmonary Disease.<br><br>Review of Resident #R4's MAR dated May 2024 revealed, in part, the following:<br><br>Normal Saline Intravenous Solution 1000 ml/hr with a note to see progress note dated 05/02/2024.<br><br>Review of Resident #R4's Progress Note dated 05/02/2024 by S6NP revealed, in part, Resident #R4 was confused and lethargic. Further review revealed, start IV NS; infuse 1 liter over 4 hours and encourage fluid intake.<br><br>Review of Resident #R4's Nurse's Note dated 05/02/2024 at 7:03 p.m. by S7LPN revealed, in part, unable to start IV, could not access vein, attempted three times.<br><br>On 06/21/2024 at 6:00 p.m., an interview was conducted with S7LPN. She stated she confirmed she was not able to obtain IV access on 05/02/2024 and she did not administer the IV fluids as ordered on 05/02/2024. She also stated she did not notify the NP and should have.<br><br>On 06/21/2024 at 6:15 p.m., an interview was conducted with S6NP. She stated she ordered IV fluids for Resident #R4 on 05/02/2024. She confirmed was not notified of the IV not being able to be obtained and she should have been.<br><br>(continued on next page) |

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195599 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/24/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Legacy Nursing and Rehabilitation of Port Allen | 403 15th Street<br>Port Allen, LA 70767 |

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 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 06/24/2024 at 10:30 a.m., an interview was conducted with S2DON. She confirmed providers should be notified immediately when orders are not able to be followed or for any significant change in a resident's condition. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195599 | A. Building<br>B. Wing | 06/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Legacy Nursing and Rehabilitation of Port Allen | 403 15th Street<br>Port Allen, LA 70767 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46225<br><br>Based on record reviews and interviews the facility failed to ensure a plan of care was developed and implemented for 5 (#3, #R1 #R2, #R3, and #R4) of 8 (#1, #2, #3, #R1 #R2, #R3, #R4, and #R5) residents who had intravenous fluids ordered for hydration purposes.<br><br>Findings:<br><br>Resident #3<br><br>Review of Resident #3's Clinical Record revealed Resident #3 was admitted to the facility on [DATE] with the following diagnoses, in part: Unspecified Dementia, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Metabolic Encephalopathy, and Sepsis.<br><br>Review of Resident #3's Physician's Orders revealed an order dated 05/30/2024 for Normal Saline 500 cc IV one time only for 1 day for Dehydration.<br><br>Review of Resident #3's Comprehensive Plan of Care failed to reveal a problem or approach related to Resident #3's diagnosis of Dehydration.<br><br>Resident #R1<br><br>Review of Resident Clinical Record revealed Resident #R1 was admitted to the facility on [DATE] with the following diagnoses, in part: Type 2 Diabetes Mellitus with Diabetic Neuropathy, and Aphasia.<br><br>Review of Resident #R1's Physician's Orders revealed an order dated 06/17/2024 for Sodium Chloride Solution 0.9%- Use 100 ml/hr intravenously x 24 hours for poor intake related to Dehydration for 1 day.<br><br>Review of resident #R1's Comprehensive Plan of Care failed to reveal a problem or approach related to Resident #R1's diagnosis of Dehydration.<br><br>Resident #R2<br><br>Review of Resident #R2's Clinical Record revealed Resident #R2 was admitted to the facility on [DATE] with the following diagnosis, in part: Dysphagia.<br><br>Review of Resident #R2's Physician's Orders revealed an order dated 05/02/2024 for Sodium Chloride Solution 0.9%- Use 500cc intravenously one time only for Dehydration for 1 day.<br><br>Review of resident #R2's Comprehensive Plan of Care failed to reveal a problem or approach related to Resident #R2's diagnosis of Dehydration.<br><br>Resident #R3<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195599 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/24/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Legacy Nursing and Rehabilitation of Port Allen | 403 15th Street Port Allen, LA 70767 |

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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #R3's Clinical Record revealed Resident #R3 was admitted to the facility on [DATE] with the following diagnoses, in part: Type 2 Diabetes Mellitus with Hyperglycemia and Unspecified Protein-Calorie Malnutrition.<br><br>Review of Resident #R3's Physician's Orders revealed an order dated 05/20/2024 for Dextrose -NaCl Solution 5-0.45%- Use 100 ml/hr intravenously continuous for diagnoses of Hypotension and fluid depletion for 2 days.<br><br>Review of resident #R3's Comprehensive Plan of Care failed to reveal a problem or approach related to Resident #R3's diagnosis of fluid depletion.<br><br>Resident #R4<br><br>Review of Resident #R4's Clinical Record revealed, in part, resident was admitted to the facility on [DATE] with diagnosis of Type 2 Diabetes Mellitus with Diabetic Nephropathy.<br><br>Review of Resident #R4's Physician's Orders revealed an order dated 05/02/2024 for Normal Saline- Use 1000 ml/hr intravenously one time only for infection; urinary for 4 hours.<br><br>Review of resident #R4's Comprehensive Plan of Care failed to reveal a problem or approach related to Resident #R4's need for hydration related to a urinary infection.<br><br>On 06/24/2024 at 9:20 a.m., an interview was conducted with S12MDS. S12MDS stated care plans should be updated as needed with any new diagnoses or changes in condition. She stated residents who had IV fluids ordered for hydration should have a dehydration care plan developed. She confirmed Residents #3, #R1 #R2, #R3, and #R4 did not have dehydration care plans, and should have.<br><br>On 06/24/2024 at 10:30 a.m., an interview was conducted with S2DON. S2DON confirmed residents who had IV fluids ordered for hydration should have a dehydration care plan developed. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195599 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/24/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Legacy Nursing and Rehabilitation of Port Allen | 403 15th Street Port Allen, LA 70767 |

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 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47500<br><br>Based on interviews and record reviews, the facility failed to a resident received treatment and care in accordance with professional standards of practice and each resident's physical needs including assess, monitor, and record accurate intake/output for a resident receiving IV therapy for 1 (#3) of 5 (#3, #R1, #R2, #R3, and #R5) residents reviewed for IV therapy.<br><br>This deficient practice resulted in an Immediate Jeopardy situation on 05/30/2024 at 2:56 p.m., when Resident #3 began receiving IV fluids as ordered for lethargy and weakness. On 05/31/2024 at 4:00 a.m., S4LPN attempted to collect urine from Resident #3 with an in and out catheter which resulted in no urine. The resident's brief was also observed to be dry at that time. There was no documentation of each shift's total intake and output. On 05/31/2024 at 7:00 a.m., Resident #3 was lethargic, his body was rigid, and extremities were twitching. On 05/31/2024 at 8:30 a.m., Resident #3 was transferred to the hospital. Resident #3 was diagnosed with Acute Metabolic Encephalopathy, Hypernatremia, and Acute Cystitis with Hematuria. Resident #3 was admitted to the hospital on 05/31/2024 and discharged back to the facility on [DATE].<br><br>S1ADM and S2DON were notified of the Immediate Jeopardy situation on 06/21/2024 at 2:39 p.m.<br><br>The Immediate Jeopardy was removed on 06/23/2024 at 2:53 p.m., as confirmed by onsite verification through observations, interviews, and record reviews. The facility implemented an acceptable Plan of Removal (POR) prior to the survey exit.<br><br>The deficient practice continued at more than minimal harm for any resident residing in the facility requiring IV therapy residing in the facility.<br><br>Findings:<br><br>Review of the facility's undated Documentation and Charting Guidelines Policy revealed, in part,<br><br>Purpose:<br><br>The purpose of charting and documentation is to provide the following:<br><br>A complete account to the resident's care, treatment, response to the care, signs, symptoms, and progress of resident care. Guidance to the physician in prescribing appropriate medication and treatment, assistance in the development of a plan of care for the resident.<br><br>Procedure:<br><br>6. Intake and Output:<br><br>a. consistent and accurate documentation and measurement of the resident's intake/output.<br><br>b. each shift's total intake<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195599 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/24/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Legacy Nursing and Rehabilitation of Port Allen | | STREET ADDRESS, CITY, STATE, ZIP CODE 403 15th Street Port Allen, LA 70767 | |

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 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | c. each shift's total output<br><br>d. The 24-hour total intake/output for all shifts.<br><br>e. Intake/output documentation shall be recorded when a resident has an IV.<br><br>7. IV therapy:<br><br>d. 24-hour intake/output record.<br><br>Review of Resident #3's medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses, in part, Unspecified Dementia, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Metabolic Encephalopathy, and Sepsis.<br><br>Review of Resident #3's Physician Orders dated May 2024 revealed, in part, the following:<br><br>An order dated 05/30/2024 for labs: CBC, CMP, and UA in the morning for diagnosis: Lethargy;<br><br>An order dated 05/30/2024 for 500 cc Normal Saline IV one time only for Dehydration for 1 day;<br><br>An order dated 05/31/2024 to send emergency room for evaluation.<br><br>Review of Resident #3's MAR dated May 2024 revealed, in part, 500 cc normal saline IV one time only for dehydration for 1 day administered on 05/30/2024 at 10:13 a.m.<br><br>Review of Resident #3's Nurse's Note dated 05/30/2024 by S6NP revealed, in part, Staff reports Resident #3 was weak, requiring assistance with feeding, not talking but tracks people and follows command, poor intake yesterday. Give IV bolus 500cc NS today, check CBC, CMP, UA.<br><br>Review of Resident #3's Administration Note dated 05/31/2024 at 4:00 a.m. by S4LPN revealed, in part, adult brief dry, In an Out catheter attempted, no urine output, resident weak and fatigued more than normal. Report given to oncoming nurse of resident status. Further review revealed the NP was not notified.<br><br>Review of Resident #3's medical record failed to reveal documentation of each shift's total intake and output on 05/30/2024 and the facility failed to provide any documentation of each shift's total intake and output.<br><br>On 06/20/2024 at 9:20 p.m., an interview was conducted with S4LPN. She stated on 05/31/2024 at 4:00 a.m. Resident #3's brief was dry, and there was no urine output noted when an In and Out catheter was used to collect the urine specimen. She stated she was not monitoring intake/output of Resident #3 and should have been.<br><br>On 06/20/2024 at 11:25 a.m., an interview was conducted with S3LPN. She stated when she arrived to work on 05/31/2024 for the 6:00 a.m. to 6:00 p.m. shift, S4LPN asked her to assess Resident #3 during report since he had no urine output during the night shift. She stated Resident #3 was walking on 05/28/2024 and on 05/31/2024 he was lethargic and not walking. She stated Resident #3's blood pressure and heart rate were elevated, so she called the S6NP and received orders to send him out.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195599 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/24/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Legacy Nursing and Rehabilitation of Port Allen | | STREET ADDRESS, CITY, STATE, ZIP CODE: 403 15th Street Port Allen, LA 70767 | |

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 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #3's Nurse's Note dated 05/31/2024 at 7:00 a.m. by S3LPN revealed, in part, Resident #3 was in bed with eyes closed, lethargic, body rigid, extremities twitching, refusing any oral fluids, 0.9% sodium chloride infusing at 20 ml/hr in IV noted to right arm. Night shift reported he had no urine output during the night shift and was unable to obtain urine when attempted to catheterize him this a.m. S6NP was informed of resident's condition. Received orders to send to hospital.<br><br>Review of Resident #3's emergency provider note dated 05/31/2024 revealed, in part, Resident #3's chief complaint was weakness, increased weakness for 2 days. Further review revealed, on 05/28/2024 Resident #3 began to become more weak and less talkative, resident was non-communicative.<br><br>Review of Resident #3's history and physical dated 05/31/2024 revealed, in part, Acute Metabolic Encephalopathy-suspect from volume depletion and Acute Cystitis; Hypernatremia- sodium elevated at 148, suspect volume depletion; Acute Cystitis with Hematuria-UA consistent with Acute Cystitis and patient grossly Encephalopathic.<br><br>On 06/21/2024 at 10:20 a.m., an interview was conducted with S10CNA. She stated she did not monitor or document intake & output amounts. She stated she did not document how many times a resident had gone to the bathroom. She was only required to document incontinence once a shift. She stated she was not instructed to monitor intake/output for any residents.<br><br>On 06/21/2024 at 10:35 a.m., an interview was conducted with S8LPN. She stated supplemental fluid with meals was not tracked. She stated the CNAs monitored how many times the resident urinated and was unsure if that was documented.<br><br>On 06/21/2024 at 10:37 a.m., an interview was conducted with S9LPN. She stated she was not tracking intake/output for residents who may have been dehydrated. She stated she didn't know how urine output was measured for incontinent residents.<br><br>On 06/21/2024 at 10:50 a.m., an interview was conducted with S5LPN. She stated she did not monitor intake or output for residents receiving IV fluids.<br><br>On 06/20/2024 at 8:10 a.m., an interview was conducted with S6NP. She stated on 05/30/2024 the nurse notified her Resident #3 was weak and lethargic; she ordered a normal saline bolus via IV with labs to be completed on 05/31/2024 in the morning. She stated she instructed the staff to notify her if there was no improvement or any decline. She stated she expected nursing staff to document and assess a resident's fluid intake and output if she ordered IV fluids for dehydration or if the resident had decreased intake.<br><br>On 06/21/2024 at 11:40 a.m., an interview was conducted with S2DON. She confirmed the documenting and charting policy indicated to track intake and output for residents receiving IV therapy.<br><br>On 06/24/2024 at 10:30 a.m., an interview was conducted with S2DON. She stated Resident #3 should have had accurate intake and output monitoring while receiving IV fluids. She also stated the nurse practitioner should have been notified immediately when Resident #3 had no urine output from the in an out catheter attempt. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | 195599 | A. Building<br>B. Wing | 06/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
| --- | --- |
| Legacy Nursing and Rehabilitation of Port Allen | 403 15th Street<br>Port Allen, LA 70767 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
| --- | --- |
| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>46225<br><br>Based on observations and interviews, the facility failed to ensure nurse staffing data, including resident census, and total number and actual hours worked for licensed and unlicensed nursing staff, was posted on a daily basis in a prominent location readily accessible to residents and visitors. This deficient practice had the potential to affect any of the 118 residents residing in the facility.<br><br>Findings:<br><br>On 06/18/2024 at 8:00 a.m., an observation revealed there was no nurse staffing data posted.<br><br>On 06/20/2024 at 8:10 a.m., an observation revealed there was no nurse staffing data posted.<br><br>On 06/22/2024 at 10:15 a.m., an observation revealed the nurse staffing data posted was dated 06/21/2024.<br><br>On 06/23/2024 at 8:45 a.m., an observation revealed the nurse staffing data posted was dated 06/21/2024.<br><br>On 06/24/2024 at 10:30 a.m., an interview was conducted with S2DON. S2DON confirmed the daily nurse staffing sheet should be updated and posted daily.<br><br>On 06/24/2024 at 10:41 a.m. an interview was conducted with S1ADM. S1ADM confirmed the staffing data should have been updated and posted daily. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195599 | A. Building<br>B. Wing | 06/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Legacy Nursing and Rehabilitation of Port Allen | 403 15th Street<br>Port Allen, LA 70767 |

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 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47500<br><br>Based on interviews and record review the facility failed to be administered in a manner that enabled it use its resources effectively and efficiently by failing to implement a system to provide quality care to meet the needs of each resident by failing to:<br><br>1. Ensure nursing staff communicated a resident's significant change in condition to the physician after having no urine output while receiving IV therapy for 1 (#3) of 5 (#3, #R1, #R2, #R3, and #R5) residents reviewed for receiving IV therapy; and<br><br>2. Ensure a resident received treatment and care in accordance with professional standards of practice and each resident's physical needs including assess, monitor, and record accurate intake/output for a resident receiving IV therapy for 1 (#3) of 5 (#3, #R1, #R2, #R3, and #R5) residents reviewed for IV therapy.<br><br>This deficient practice resulted in an Immediate Jeopardy situation on 05/30/2024 at 2:56 p.m., Resident #3 was observed to be lethargic and weak, which resulted in S6NP ordering 500 cc normal saline via intravenous infusion and lab work in the morning. On 05/31/2024 at 4:00 a.m., S4LPN attempted to collect urine from Resident #3 with an in and out catheter which resulted in no urine. The resident's brief was also observed to be dry at that time. S4LPN did not notify the physician of this significant change in status for Resident #3. There was no documentation of each shift's total intake and output. On 05/31/2024 at 7:00 a.m. , Resident #3 was lethargic, his body was rigid, and extremities were twitching. On 05/31/2024 at 8:30 a.m., Resident #3 was transferred to the hospital. Resident #3 was diagnosed with Acute Metabolic Encephalopathy, Hypernatremia, and Acute Cystitis with Hematuria. Resident #3 was admitted to the hospital on 05/31/2024 and discharged back to the facility on [DATE].<br><br>S1ADM and S2DON were notified of the Immediate Jeopardy situation on 06/21/2024 at 2:42 p.m.<br><br>The Immediate Jeopardy was removed on 06/23/2024 at 2:53 p.m., as confirmed by onsite verification through observations, interviews, and record reviews. The facility implemented an acceptable Plan of Removal (POR) prior to the survey exit.<br><br>The deficient practice continued at more than minimal harm for any resident residing in the facility.<br><br>Findings:<br><br>Cross Reference F580 and F684<br><br>Review of the facility's In-service Training Record Documentation revealed, in part, the following:<br><br>Names of Person giving the training: S2DON<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195599 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/24/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Legacy Nursing and Rehabilitation of Port Allen | | STREET ADDRESS, CITY, STATE, ZIP CODE 403 15th Street Port Allen, LA 70767 | |

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 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Date of Training: 01/01/2024<br><br>Purpose of Training: Educating nursing staff on notifying physician/nurse practitioner of incident.<br><br>Attachment: Documentation and Charting Guidelines<br><br>Name of Person giving the training: S3ADON<br><br>Date of Training: 04/09/2024<br><br>Purpose of Training: Hydration<br><br>Attachment: Hydration Policy and Procedure<br><br>Review of the facility's undated Documentation and Charting Guidelines Policy revealed, in part, the following:<br><br>Purpose:<br><br>The purpose of charting and documentation is to provide the following:<br><br>A complete account to the resident's care, treatment, response to the care, signs, symptoms, and progress of resident care. Guidance to the physician in prescribing appropriate medication and treatment, assistance in the development of a plan of care for the resident.<br><br>Procedure:<br><br>6. Intake and Output:<br><br>a. consistent and accurate documentation and measurement of the resident's intake/output.<br><br>b. each shift's total intake<br><br>c. each shift's total output<br><br>d. The 24-hour total intake/output for all shifts.<br><br>e. Intake/output documentation shall be recorded when a resident has an IV.<br><br>7. IV therapy:<br><br>d. 24-hour intake/output record.<br><br>Review of the facility's undated Hydration Policy and Procedure revealed, in part, the following:<br><br>Purpose:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195599 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/24/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Legacy Nursing and Rehabilitation of Port Allen | | STREET ADDRESS, CITY, STATE, ZIP CODE 403 15th Street Port Allen, LA 70767 | |

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 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | To assure that the resident receives sufficient amount of fluid based on individual needs to prevent dehydration.<br><br>Procedure:<br><br>3. Intake and Output will be done every shift on residents that have:<br><br>e. Any other condition that warrant possible dehydration or as ordered by the physician.<br><br>Review of Resident #3's medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses, in part, Unspecified Dementia, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Metabolic Encephalopathy, and Sepsis.<br><br>Review of Resident #3's Physician Orders dated May 2024 revealed, in part, the following:<br><br>An order dated 05/30/2024 for labs: CBC, CMP, and UA in the morning for diagnosis: Lethargy;<br><br>An order dated 05/30/2024 for 500 cc Normal Saline IV one time only for Dehydration for one day;<br><br>An order dated 05/31/2024 to send emergency room for evaluation.<br><br>Review of Resident #3's Nurse's Note dated 05/30/2024 by S6NP revealed, in part, Staff reports Resident #3 was weak, requiring assistance with feeding, not talking but tracks people and follows command, poor intake yesterday. Give IV bolus 500cc NS today, check CBC, CMP, UA.<br><br>Review of Resident #3's Administration Note dated 05/31/2024 at 4:00 a.m. by S4LPN revealed, in part, adult brief dry, In and Out catheter attempted, no urine output, resident weak and fatigue more than normal. Report given to oncoming nurse of resident status.<br><br>Review of Resident #3's Nurse's Note dated 05/31/2024 at 7:00 a.m. by S3LPN revealed, in part, Resident #3 was in bed with eyes closed, lethargic, body rigid, extremities twitching, refusing any oral fluids, 0.9% sodium chloride infusing at 20 ml/hr in IV noted to right arm. Night shift reported he had no urine output during the night shift and was unable to obtain urine when attempted to catheterize him this a.m. S6NP was informed of resident's condition. Received orders to send to hospital.<br><br>Review of Resident #3's emergency provider note dated 05/31/2024 revealed, in part, Resident #3's chief complaint was weakness, increased weakness for 2 days. Further review revealed, on 05/28/2024 Resident #3 began to become more weak and less talkative, resident was non-communicative.<br><br>Review of Resident #3's history and physical dated 05/31/2024 revealed, in part, Acute Metabolic Encephalopathy-suspect from volume depletion and Acute Cystitis; Hypernatremia- sodium elevated at 148, suspect volume depletion; Acute Cystitis with Hematuria-UA consistent with Acute Cystitis and patient grossly encephalopathic.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195599 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/24/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Legacy Nursing and Rehabilitation of Port Allen | | STREET ADDRESS, CITY, STATE, ZIP CODE: 403 15th Street Port Allen, LA 70767 | |

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 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 06/20/2024 at 9:20 p.m., an interview was conducted with S4LPN. She stated the provider should be notified of any changes in a resident's status. She stated on 05/31/2024 at 4:00 a.m. Resident #3's brief was dry, and there was no urine output noted when an In and Out catheter was used to collect the urine specimen. She stated she didn't notify the NP of no urine output at 4:00 a.m. on 05/31/2024, and should have.<br><br>On 06/20/2024 at 8:10 a.m., an interview was conducted with S6NP. She stated on 05/30/2024 the nurse notified her Resident #3 was weak and lethargic; she ordered a normal saline bolus via IV with labs to be completed on 05/31/2024 in the morning. She stated she instructed the staff to notify her if there was no improvement or any decline. She stated she expected nursing staff to document and assess a resident's fluid intake and output if she ordered IV fluids for dehydration or if the resident had decreased intake. She stated she was not notified Resident #3 had no urine output, on 05/31/2024 at 4:00 a.m., when the nurse attempted to collect urine for the urinalysis. She stated she should have been notified of no urine output immediately.<br><br>On 06/21/2024 at 11:40 a.m., an interview was conducted with S2DON. She stated intake and output was only tracked if there was an order from the provider. She confirmed the facility's documenting and charting policy indicated to track intake and output for all residents receiving IV therapy. She stated she expected nursing staff to contact the provider for any change in condition. She confirmed she conducted an in-service for nursing staff to notify the physician/nurse practitioner of any resident incidents which included the Documentation and Charting Guidelines Policy on 01/01/2024 and ADON conducted an in-service on the Hydration Policy on 04/09/2024. She stated she was not monitoring compliance of the in-services conducted on 01/01/2024 and 04/09/2024.<br><br>On 06/24/2024 at 10:30 a.m., an interview was conducted with S2DON. She stated Resident #3 should have had accurate intake and output monitoring while receiving IV fluids. She also stated the nurse practitioner should have been notified immediately when Resident #3 had no urine output from the in an out catheter attempt. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195599 | A. Building<br>B. Wing | 06/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Legacy Nursing and Rehabilitation of Port Allen | 403 15th Street<br>Port Allen, LA 70767 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47500<br><br>Based on interviews and record reviews, the facility failed to ensure completed care was documented correctly in resident's records for 3 (#3, #R1, and #R2) of 8 (#1, #2, #3, #R1, #R2, #R3, #R4, and #R5) sampled residents.<br><br>Findings:<br><br>Resident #3<br><br>Review of Resident #3's Medical Record revealed, in part, Resident #3 was admitted to the facility on [DATE] with diagnoses which included Unspecified Dementia, Schizophrenia, Benign Prostatic Hyperplasia, Metabolic Encephalopathy, Sepsis, and Acute Embolism and Thrombosis of Left peroneal vein.<br><br>Review of Resident #3's MDS with an ARD of 05/07/2024 revealed, in part, Resident #3 was dependent with toileting hygiene.<br><br>Review of Resident #3's Late Loss ADL document dated 04/30/2024 through 05/31/2024 revealed, in part, only one shift documented toileting on 04/30/2024, 05/03/2024, 05/04/2024, 05/05/2024, 05/08/2024, 05/11/2024, 05/15/2024, 05/16/2024, 05/17/2024, 05/18/2024, 05/21/2024, 05/23/2024, 05/24/2024, 05/26/2024, 05/27/2024, and 05/29/2024.<br><br>Resident #R1<br><br>Review of Resident #R1's Medical Record revealed, in part, Resident #R1 was admitted to the facility on [DATE] with diagnoses which included Cerebral Infarction, Type 2 Diabetes Mellitus with Diabetic Neuropathy, and Aphasia.<br><br>Review of Resident #R1's MDS with an ARD of 04/02/2024 revealed, in part, Resident #R1 was dependent with toileting hygiene.<br><br>Review of Resident #R1's Late Loss ADL documentation dated 06/06/2024 through 06/20/2024 revealed, in part, only 1 shift documented toileting on 06/08/2024, 06/11/2024, and 06/17/2024.<br><br>Resident #R2<br><br>Review of Resident #R2's Medical Record revealed, in part, Resident #R2 was admitted to the facility on [DATE] with diagnoses which included Unspecified Psychosis, Schizoaffective disorder, Hyperlipidemia, Major Depressive Disorder, and Dysphagia.<br><br>Review of Resident #R2's MDS with an ARD of 05/02/2024 revealed, in part, Resident #R2 required partial/moderate assistance with toileting hygiene.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195599 | A. Building<br>B. Wing | 06/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Legacy Nursing and Rehabilitation of Port Allen | 403 15th Street<br>Port Allen, LA 70767 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #R2's Late Loss ADL Documentation dated 05/01/2024 through 06/16/2024 revealed, in part, one shift documented toileting on 05/06/2024, 05/10/2024, 05/15/2024, 05/20/2024, 05/24/2024, 05/25/2024, 05/29/2024, 06/03/2024, 06/07/2024, 06/12/2024, and 06/13/2024.<br><br>On 06/21/2024 at 7:39 p.m., an interview was conducted with S12MDS. She stated the staff was required to document ADLs every shift. She stated the days where toileting was documented once meant the staff did not document on each shift, and the documentation was missing.<br><br>On 06/21/2024 at 8:37 p.m., an interview was conducted with S11ADON. She stated CNAs were required to document toileting once a shift and each day included two shifts. S11ADON confirmed the above days were missing documentation.<br><br>On 06/21/2024 at 8:40 p.m., an interview was conducted with S2DON. She stated CNAs were required to document toileting on each shift and each day included two shifts. S2DON confirmed there was missing documentation on the toileting documentation for Resident #3, Resident #R1, and Resident #R2. |