| 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 | 06/18/2025 |

| 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 |

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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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure services were provided by the facility to meet quality professional standards for 1 (#R2) of 3 (#1, #2, and #R2) sampled residents reviewed with oxygen therapy. The facility failed to ensure Physician Orders for oxygen therapy were obtained for Resident #R2 prior to administration.<br><br>Findings:<br><br>Review of the facility's undated policy titled, Oxygen Administration Policy and Procedure revealed the following, in part:<br><br>Procedure:<br><br>1. Check Physician's Order for liter flow and method of administration.<br><br>Review of Resident #R2's Clinical Record revealed she admitted to the facility on [DATE] with diagnoses, which included Acute Respiratory Failure with Hypoxia, Emphysema, and Unspecified Heart Failure.<br><br>Review of Resident #R2's admission BIMS (Brief Interview for Mental Status) assessment dated [DATE] revealed a BIMS of 13, which indicated intact cognition.<br><br>Review of Resident #R2's Physician Orders dated June 2025 revealed no orders for oxygen therapy.<br><br>On 06/16/2025 at 8:13 a.m., an observation was made of Resident #R2's room. An oxygen concentrator with a humidifier bottle and nasal cannula tubing was observed on at 2 liters per minute next to Resident #R2's bed.<br><br>On 06/16/2025 at 9:10 a.m., an interview was conducted with S4LPN. She reviewed Resident #R2's Physician's Orders and confirmed there was no order for oxygen for Resident #R2. S4LPN observed the oxygen concentrator with humidifier bottle and nasal cannula tubing in Resident #R2's room and confirmed oxygen was not ordered for Resident #R2 and should not have been in the resident's room.<br><br>On 06/16/2025 at 11:15 a.m., an interview was conducted with Resident #R2. She stated used oxygen at night as needed. She stated she had oxygen in her room to use as needed since she admitted to the facility. She stated she used oxygen last night, on 06/15/2025.<br><br>(continued on next page) |



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

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/16/2025 at 12:00 p.m., an interview was conducted with S5LPN. She verified she worked on 06/15/2025, from 6:00 p.m. to 6:00 a.m. and was assigned to Resident #R2. She stated Resident #R2 wore oxygen as needed. She confirmed Resident #R2 wore oxygen last night, on 06/15/2025 during her shift.<br><br>On 06/16/2025 at 12:10 p.m., an interview was conducted with S2DON. He reviewed Resident #R2's clinical record and confirmed there were no Physician's Orders for oxygen. He confirmed a Physician's Order for oxygen was needed for it to be administered to Resident #R2. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure each resident received necessary respiratory care consistent with professional standards of practice for 3 of 3 (#1, #2, and #R2) residents reviewed for respiratory care. The facility failed to ensure:<br><br>1. A protocol was implemented for cleaning and/or replacing Resident #1's non-invasive ventilation tubing and mask; and<br><br>2. Oxygen tubing and humidification bottles were changed in a timely manner for 2 (#2 and #R2) of 3 (#1, #2, and #R2) residents reviewed for oxygen therapy.<br><br>Findings:<br><br>Review of the facility's undated policy titled, Nebulizer CPAP Machine Cleaning Policy and Procedure revealed the following, in part:<br><br>Purpose: To keep nebulizer or CPAP machine and equipment clean.<br><br>Policy: Resident's Nebulizer or CPAP will be kept clean when in resident room.<br><br>Procedure:<br><br>3. Tubing, mouthpiece, and mask to be changed out weekly and as needed.<br><br>Review of the Trilogy clinical manual revealed the following, in part:<br><br>Cleaning the Patient Circuit:<br><br>Cleaning the reusable circuit is important. Circuits infected with bacteria may infect the user's lungs. Clean the respiratory circuit on a regular basis. Follow your institution's protocol for cleaning the circuit. This company recommends that you perform the cleaning twice a week under normal conditions and more frequently as required.<br><br>Reusable circuit cleaning instructions:<br><br>Clean the patient circuit twice a week, or follow your institution's protocol.<br><br>Review of the facility's undated Policy titled, Oxygen Administration Policy and Procedure revealed the following, in part:<br><br>Procedure:<br><br>5. Prefilled, sealed, disposable humidifiers may be changed per facility policy.<br><br>g. Label humidifier with date and time opened. Change humidifier and tubing per facility procedure.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 9. At regular intervals, check and clean oxygen equipment, masks, tubing, and cannula.<br><br>1.<br><br>Resident #1<br><br>Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Morbid Obesity, Acute Pulmonary Edema, Chronic Congestive Heart Failure, Cardiomegaly, and Sleep Apnea.<br><br>Review of Resident #1's current Physician Orders revealed the following, in part:<br><br>Start Date: 05/05/2025 - Non-invasive ventilation support in use while lying in bed/asleep. Further review of Resident #1's Physician Orders revealed no orders to clean or replace the non-invasive ventilation support tubing and/or mask.<br><br>Review of Resident #1's current care plan revealed the following, in part:<br><br>Problem: I have Sleep Apnea<br><br>Interventions: Non-invasive ventilation support in use while lying in bed/asleep.<br><br>Further review of Resident #1's Care Plan revealed no indication to clean or replace the non-invasive ventilation support tubing and/or mask.<br><br>Review of Resident #1's MARs and TARs dated May through June 2025 revealed Resident #1 utilized his non-invasive ventilation support machine twenty days in the month of May 2025 and 16 days in the month of June 2025. Further review revealed no documentation the tubing and/or mask were cleaned or replaced.<br><br>Review of Resident #1's Nurses Notes dated May through June 2025 revealed no documentation his non-invasive ventilation support tubing and/or mask were cleaned or replaced.<br><br>A telephone interview was conducted with S9LPN on 06/17/2025 at 1:25 p.m. She stated she was regularly assigned to Resident #1. She stated Resident #1 utilized a non-invasive ventilation support machine. She stated there was no order or process to clean or replace Resident #1's non-invasive ventilation support mask or tubing. She stated she was unsure of the facility's protocol for cleaning the non-invasive ventilation support tubing and mask. She explained she cleaned the mask if it was visibly soiled but never cleaned or replaced the tubing.<br><br>An interview was conducted with S10LPN on 06/18/2025 at 9:30 a.m. She stated she was regularly assigned to Resident #1. She stated Resident #1 utilized a non-invasive ventilation support machine. She stated she was unable to recall if there were orders to clean or replace Resident #1's non-invasive ventilation support mask or tubing. She stated she would have cleaned the non-invasive ventilation support mask and tubing when visibly soiled.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview was conducted with S11LPN on 06/18/2025 at 10:56 a.m. She stated she was regularly assigned to Resident #1. She stated Resident #1 utilized a non-invasive ventilation support machine. She stated there was no order or process to clean or replace Resident #1's non-invasive ventilation support mask or tubing. She stated she would have cleaned the mask when visibly soiled. She stated she had never cleaned or replaced the tubing. She confirmed there was no documentation of cleaning or replacing Resident #1's non-invasive ventilation support mask or tubing.<br><br>An interview was conducted with S2DON on 06/18/2025 at 9:59 a.m. He reviewed Resident #1's Clinical Record. He confirmed there was no order to clean or replace the tubing and/or mask for Resident #1's non-invasive ventilation support machine and there should have been. He further confirmed there should have been documentation the tubing and mask were cleaned and/or replaced and there was not.<br><br>An interview was conducted with S1CNO on 06/18/2025 at 10:40 a.m. He stated he expected the nurses to follow the facility's policy and procedure titled, Nebulizer CPAP Machine Cleaning Policy and Procedure for cleaning non-invasive ventilation support masks and tubing.<br><br>A telephone interview was conducted with S8NP on 06/18/2025 at 9:15 a.m. She confirmed Resident #1 utilized a non-invasive ventilation support machine for breathing assistance. She confirmed the facility should have implemented a protocol to clean the tubing and mask.<br><br>2.<br><br>Resident #2<br><br>Review of Resident #2's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Congestive Heart Failure and Asthma.<br><br>Review of Resident #2's MDS with an ARD of 05/13/2025 revealed he had a BIMS of 15, which indicated he was cognitively intact.<br><br>Review of Resident #2's current Physician Orders revealed the following, in part:<br><br>Start Date: 05/13/2025- Oxygen at 2 to 3 Liters via Nasal Cannula as needed every shift.<br><br>An observation was made of Resident #2's oxygen concentrator on 06/16/2025 at 11:54 a.m. The oxygen humidifier bottle was observed dated 06/09/2025.<br><br>An interview was conducted with Resident #2 on 06/17/2025 at 10:35 a.m. The resident's oxygen humidifier bottle was observed dated 06/09/2025. He stated he wore his oxygen as needed, mostly at night.<br><br>An interview was conducted with S4LPN on 06/17/2025 at 1:40 p.m. She stated resident's oxygen tubing and humidifier bottles should be changed every week. She verified Resident #2 wore oxygen daily as needed. S4LPN observed Resident #2's oxygen humidifier bottle and confirmed it was dated 06/09/2025 and should have been changed prior to 06/17/2025.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview was conducted with S2DON on 06/18/2025 at 10:59 a.m. He reviewed Resident #2's Clinical Record and verified the oxygen humidifier bottle was ordered to be changed once weekly, on Wednesdays, during the night shift. He was made aware of the above observations. He confirmed Resident #2's oxygen humidifier bottle should have been changed prior to 06/17/2025.<br><br>Resident #R2<br><br>Review of Resident #R2's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Acute Respiratory Failure with Hypoxia, Emphysema, and Unspecified Heart Failure.<br><br>Review of Resident #R2's admission BIMS assessment dated [DATE] revealed a BIMS of 13, which indicated she was cognitively intact.<br><br>An observation was made of Resident #R2's oxygen concentrator on 06/16/2025 at 8:13 a.m. An empty humidifier bottle and nasal cannula tubing was observed with no date.<br><br>An interview was conducted with S4LPN on 06/16/2025 at 9:10 a.m. She observed and confirmed Resident #R2's oxygen humidifier bottle was empty and not dated, and the oxygen tubing was not dated and should have been. She stated oxygen tubing and humidifier bottles should be changed weekly.<br><br>An interview was conducted with Resident #R2 on 06/16/2025 at 11:15 a.m. She stated she used her oxygen at night as needed. She stated she wore her oxygen last night, on 06/15/2025.<br><br>An interview was conducted with S2DON on 06/16/2025 at 12:10 p.m. He stated resident's oxygen tubing and humidifier bottles should be changed weekly and labeled with the date. He was notified of the above observations. He confirmed Resident #R2's humidifier bottle and oxygen tubing should have been labeled with the date. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure correct installation, use, and maintenance of bed rails. The facility failed to ensure:<br><br>1. The risks and benefits were reviewed with the resident and/or resident representative, and informed consent was obtained prior to bed rail installation for 1 (#1) of 4 (#1, #3, #R1, and #R3) residents reviewed with bed rails; and<br><br>2. Each resident was assessed for risk for entrapment prior to bed rail installation for 4 of 4 (#1, #3, #R1, and #R3) residents reviewed with bed rails.<br><br>Findings:<br><br>1.<br><br>Resident #1<br><br>Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE] and had diagnoses, which included Polyneuropathy, Type 2 Diabetes Mellitus, Morbid Obesity, Acute Pulmonary Edema, Chronic Congestive Heart Failure, Cardiomegaly, Essential Hypertension, and Sleep Apnea. Further review of the Clinical Record revealed no documentation pertaining to bed rails, including an entrapment risk assessment, the risks and benefits of bed rails were reviewed with the resident and/or resident representative, and/or informed consent was obtained for bed rails.<br><br>An observation was made of Resident #1 on 06/16/2025 at 8:14 a.m. He was lying in his bed. He had bilateral one-quarter bed rails on the top of his bed.<br><br>An interview was conducted with S12CNA on 06/17/2025 at 10:30 a.m. She confirmed Resident #1 had bilateral bed rails on the top of his bed.<br><br>An observation was made of Resident #1's bed with S1CNO on 06/17/2025 at 2:15 p.m. S1CNO confirmed there were bilateral bed rails on Resident #1's bed.<br><br>An interview was conducted with S2DON on 06/17/2025 at 3:30 p.m. He confirmed Resident #1 had bilateral bed rails on his bed. He confirmed there was no documentation an entrapment risk assessment was completed, the risks and benefits of bed rails were reviewed with the resident and/or resident representative, or informed consent was obtained for Resident #1's bed rails.<br><br>2.<br><br>Resident #3<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #3's Clinical Record revealed she was admitted to the facility on [DATE] and had a diagnosis, which included Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Dominant Side. Further review revealed no documentation of an entrapment risk assessment for bed rails.<br><br>An observation was made of Resident #3 on 06/17/2025 from 11:10 a.m. She was lying in her bed. She had bilateral one-quarter bed rails raised on the top of her bed.<br><br>An interview was conducted with S14CNA on 06/18/2025 at 10:00 a.m. She observed and confirmed Resident #3 had bilateral bed rails raised on the top of her bed. She stated when Resident #3 was in bed, the bed rails were raised.<br><br>Resident #R1<br><br>Review of Resident #R1's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Paraplegia, Other Reduced Mobility, and Other Chronic Pain. Further review revealed no documentation of an entrapment risk assessment for bed rails.<br><br>An observation was made of Resident #R1 on 06/16/2025 at 8:40 a.m. He had a left one-quarter bed rail raised on top of his bed.<br><br>An interview was conducted with S15CNA on 06/18/2025 at 10:10 a.m. She observed and confirmed Resident #R1 had a left bed rail on the top of his bed. She stated when Resident #R1 was in bed, the bed rail was raised.<br><br>Resident #R3<br><br>Review of Resident #R3's Clinical Record revealed she was admitted to the facility on [DATE] and had a diagnosis, which included Cerebral Infarction. Further review revealed no documentation of an entrapment risk assessment for bed rails.<br><br>An observation was made of Resident #R3 on 06/17/2025 at 11:20 a.m. She was lying in her bed. She had a right one-quarter bed rail raised on the top of her bed.<br><br>An interview was conducted with S14CNA on 06/18/2025 at 10:02 a.m. She observed and confirmed Resident #R3 had a right bed rail on the top of her bed. She stated when Resident #R3 was in bed, the bed rail was raised.<br><br>An interview was conducted with S2DON on 06/18/2025 at 10:45 a.m. He confirmed Resident #3, #R1 and #R3 had bed rails on their beds. He confirmed there was no documentation an entrapment risk assessment was completed for Resident #3, #R1 and #R3's bed rails. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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** Based on interviews and record review, the facility failed to ensure a resident's medical record was complete and accurate by failing to ensure baths were documented as provided for 1 (#1) of 4 (#1, #2, #3, and #4) residents reviewed for activities of daily living.<br><br>Findings:<br><br>Review of the facility's undated policy titled, Documentation and Charting Guidelines revealed the following, in part:<br><br>Purpose: The purpose of charting and documentation is to provide the following: A complete account to the resident's care .<br><br>Review of Resident #1's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Polyneuropathy, Type 2 Diabetes Mellitus, Morbid Obesity, Chronic Congestive Heart Failure, and Cardiomegaly.<br><br>Review of Resident #1's Significant Change MDS with an ARD of 05/20/2025 revealed he was dependent on staff for bathing.<br><br>Review of Resident #1's Day Shift CNA Assignments dated 05/05/2025, 05/14/2025, 05/19/2025, and 05/23/2025 revealed S13CNA was assigned to Resident #1.<br><br>Review of Resident #1's Bath Documentation dated May 2025 revealed he was scheduled to receive a bath on Mondays, Wednesdays, and Fridays. Further review revealed no documented bath on 05/05/2025, 05/14/2025, 05/19/2025, and 05/23/2025, which indicated he did not receive a bath.<br><br>An interview was conducted with S13CNA on 06/17/2025 at 11:56 a.m. He stated Resident #1 was scheduled to receive bed baths every Monday, Wednesday, and Friday. He confirmed he was assigned to give Resident #1 baths on 05/05/2025, 05/14/2025, 05/19/2025, and 05/23/2025. He stated he provided baths to Resident #1 on 05/05/2025, 05/14/2025, 05/19/2025, and 05/23/2025. He reviewed Resident #1's Bath Documentation dated 05/05/2025, 05/14/2025, 05/19/2025, and 05/23/2025 and confirmed there was no bath documented. He confirmed the baths he provided to Resident #1 should have been documented.<br><br>An interview was conducted with S1CNO on 06/17/2025 at 1:48 p.m. He stated if a bath was provided, it should have been documented on the resident's Bath Documentation. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure there was a functioning call system to allow residents to call for staff assistance for 1 (#R1) of 7 (#1, #2, #3, #4, #R1, #R2 and #R3) residents reviewed for environment.<br><br>This deficient practice had the potential to affect any of the 122 residents residing in the facility.<br><br>Findings:<br><br>Review of the facility's undated policy titled, Call Light, Use of Policy and Procedure revealed the following, in part:<br><br>Policy:<br><br>2. To assure call system is in proper working order.<br><br>Procedure:<br><br>3. For bedside call lights, a light and a sound will appear and be heard over the door of the resident's room .<br><br>14. Notify the maintenance department and enter defective call light location(s) in the maintenance log.<br><br>Review of Resident #R1's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Paraplegia, Other Reduced Mobility, and Other Chronic Pain.<br><br>Review of Resident #R1's admission MDS with an ARD of 04/15/2025 revealed a BIMS of 15, which indicated he was cognitively intact.<br><br>Review of Resident #R1's current Care Plan revealed the following, in part:<br><br>Date Initiated: 07/01/2024<br><br>Problem: I am at risk for falls related to Paraplegia.<br><br>Intervention: Educate me on use of my call light.<br><br>Review of the facility's Maintenance Log dated 03/26/2025 to 06/15/2025 revealed no entries for Resident #R1's call light not functioning.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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) |
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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/16/2025 at 8:40 a.m., an interview was conducted with Resident #R1. He stated his call light had not worked since he moved into his current room in April 2025. He stated he told staff, could not recall who, when he first moved to his current room his call light did not work, but it was never fixed. He stated if he needed staff assistance he would self-transfer out of bed to his wheelchair, wheel down the hall and go find a staff member. Resident #R1 pressed his call light and it was observed not to function or illuminate outside of the room.<br><br>On 06/16/2025 at 8:43 a.m., an observation was made of Resident #R1's call light with S7CNA. She stated Resident #R1 was oriented and able to use his call light. She tested the call light and confirmed the call light did not function or illuminate outside of the room for Resident #R1 and should have.<br><br>On 06/16/2025 at 8:52 a.m., an observation was made of Resident #R1's call light with S4LPN. She stated Resident #R1 was oriented and could use the call light. She tested the call light and confirmed the call light did not function or illuminate outside of the room for Resident #R1 and should have.<br><br>On 06/16/2025 at 8:55 a.m., an observation was made of Resident #R1's call light with S3MS. He tested the call light and confirmed the call light did not function or illuminate outside of the room for Resident #R1 and should have. He stated no staff had notified him of Resident #R1's call light not functioning.<br><br>On 06/16/2025 at 12:20 p.m., an interview was conducted with S2DON. He stated when a resident's call light was not functioning, staff should document the issue in the maintenance log book and notify maintenance staff. He was made aware of the above findings. He stated Resident #R1 was cognitive and could use his call light. He confirmed Resident #R1 should have a functioning call light. |