

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 03/18/2026
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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from neglect for 1 (#1) of 5 residents reviewed for transportation. This was evidenced by: 1. S3TD neglecting to appropriately secure Resident #1 into the facility van; and 2. S3TD neglecting to notify the facility when Resident #1 fell out of the moving van. This deficient practice resulted in an Immediate Jeopardy situation for Resident #1, a wheelchair dependent resident, on 02/17/2026 at 12:30 p.m. when S3TD failed to appropriately secure Resident #1 into the facility's transportation van. As S3TD was driving out of the facility's parking lot, the van hit a pothole, the van's back door opened, ramp fell, and Resident #1 rolled out of the van onto the gravel driveway. S3TD stopped the van, assisted Resident #1 back into the van, and drove away without notifying the facility. S3TD's neglect placed Resident #1 at a likelihood for serious injury, harm, impairment, or even death. The facility implemented corrective actions which were completed prior to the State Agency's investigation; thus, it was determined to be a Past Noncompliance citation. S1ADM was notified of the Past Noncompliance Immediate Jeopardy on 03/18/2026 at 11:47 a.m. Review of the facility's policy updated and titled Transportation Policy Acknowledgement Form revealed the following: Emergency occurrence's during transport: Always notify the Administrator and/or DON of any incident or accident that occurs while on the van or during the transportation process. Reporting Incidents and Accidents: All incidents and accidents, no matter how minor or major, must be reported immediately to the administrator- wrecks, resident injury, employee injury, falls. Review of the facility's policy undated and titled Abuse Reporting and Investigation Policy and Procedure revealed the following: E. Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect may include, but is not limited to: Failure to provide timely, consistent, safe, adequate, and appropriate care and services as needed. Review of Resident #1's clinical record revealed he was admitted to the facility on [DATE] with diagnoses which included Ataxia. Further review revealed the resident required use of a wheelchair for mobility. Review of Resident #1's Quarterly MDS with ARD of 12/09/2025 revealed Resident #1 had a BIMS of 9, which indicated the resident was moderately impaired. Further review revealed Resident #1 required the use of a wheelchair for mobility. Review of Resident #1's current care plan revealed he required staff assistance for all ADLs with use of a wheelchair due to unsteady ataxic gait. Review of the facility's incident report dated 02/17/2026 at 12:30 p.m. revealed the following: Resident: Resident #1 Incident Location: Outside Person Preparing Report: S2DON Incident Description: As S3TD was leaving the parking lot, the rear door of the van opened which led to Resident #1 rolling backwards into the parking lot. Injury: No injuries Review of S1ADM's written statement dated 02/17/2026 at 12:30 p.m. revealed the following: On 02/17/2026 at 12:30 p.m., S3TD was transporting Resident #1 when he fell out the van. Video footage was reviewed, incident occurred in gravel side of the parking lot. At 12:31 p.m. S3TD put Resident #1 back into the facility van, and at 12:32 p.m. the van left the facility's parking lot. S3TD was observed placing Resident #1 in a regular van seat versus the wheelchair area. S2DON and S8TD met S3TD at Resident (continued on next page)</p>

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>#1's appointment. S2DON assessed Resident #1 and no injuries were noted. S2DON brought S3TD back to the facility S3TD was sent home pending investigation. After investigation it was determined S3TD did not follow safety procedures and did not report the incident immediately and was terminated as a result. Review of S3TD's personnel record revealed a termination date of 02/18/2026. Review of the Facilities Vehicle Safety Checklist dated 02/04/2026 revealed the Facility Van was inspected by S11CM. All of the vehicles doors were working properly. All seat belts, including the wheelchair seat belts were working properly and available. Wheelchair straps were available in the vehicle. On 03/17/2026 at 2:54 p.m., a telephone interview was conducted with S11CM. He stated he inspected the Facility Transport Van on 02/04/2026 and completed the Vehicle Safety Checklist at that time. He stated all doors on the van were working properly, the back door latch was not loose, the ramp latches/locks were working properly, and all seat belts and safety straps were available and working appropriately. On 03/17/2026 at 9:03 a.m., a telephone interview was conducted with S3TD. He stated he was responsible for transporting residents in the facility van. He stated he received training on how to safely transport and safely secure wheelchair bound residents in the van. He stated he was driving the facility van on 02/17/2026 when Resident #1 fell out of the van. He stated he loaded Resident #1 in his wheelchair into the back of the van. He stated he did not have the appropriate wheelchair seat belt or safety straps to transport the resident, so he did the best he could. He denied reporting he did not have the appropriate belt or straps to administration prior to loading the resident into the van. He stated he placed the wheelchair between the two back seats. He stated he secured the seat belt from the van seat onto the side of the resident's wheelchair, then wrapped it around the resident. He stated he fastened it to the seatbelt buckle. He stated the seat belt went around Resident #1 but it did not properly secure and lock Resident #1 in place. He stated he knew this wasn't the right way but it was the only way he could secure Resident #1 without having the appropriate wheelchair seat belt and straps. He stated he secured the ramp and the back door. He stated Resident #1 told him he had no injuries or pain. He stated he did not tell Administration since Resident #1 did not complain of pain or injuries at that time. He stated he knew he should have told them at the time the incident occurred. On 03/16/2026 at 1:25 p.m., an interview was conducted with Resident #1. He stated he had to be transported by the facility van to go to doctor's appointments. He stated on 02/17/2026, he fell out of the van when the van was leaving the facility. He stated S3TD loaded him in his wheelchair into the back of the van and placed a seat belt around him. He stated when they were leaving the facility I just fell out the door and I don't know how that happened. He stated he did not have any injuries or pain. He stated S2DON and S9NP checked on him after the incident occurred. On 03/16/2026 at 3:10 p.m., an interview was conducted with S1ADM. She stated she was aware of the incident that occurred with Resident #1 falling out of the facility transport van on 02/17/2026. She stated the facility was made aware of the incident when a passerby, who witnessed the incident, notified the facility. She stated she and S2DON reviewed the video surveillance which showed the facility van exiting the parking lot and it hit a pot hole, causing the back door to open, the ramp to come out and down, and Resident #1 to roll down the ramp, and land on the gravel road. She stated S3TD got out of the van and assisted Resident #1 in getting back into the van in a regular seat, then left the facility. She stated S2DON and S8TD went to meet S3TD and Resident #1 at his appointment. She stated S2DON assessed Resident #1 for any injuries or pain upon arriving to the doctor's office. She stated S8TD drove Resident #1 back to the facility in the facility transport van and S3TD rode back to the facility with S2DON in his private vehicle. She stated S3TD was sent home on suspension upon return to the facility. She stated S3TD was terminated on 02/18/2026 after investigation for not following facility's safe transportation policy of residents and for not reporting the incident immediately to Administration. She stated Resident #1 was assessed by S9NP and no injuries or pain were reported. She stated she called S10MS to request an inspection of the van. She stated she locked the keys to the van in her office drawer to ensure no one was able to use it. She stated the next morning she, S10MS, and S12CM assessed the van and found the latch of (continued on next page)</p>		

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She stated starting on 02/18/2026, she began weekly ride alongs with the approved transport drivers which would continue for 6 weeks, in-serviced the transport drivers on securing the residents with the appropriate seat belts and safety straps while in the van, performed a Vehicle Driver In Service Checklist on each approved transport driver, and scheduled a training with a 3rd party person to train all approved transport drivers on wheelchair securement and lift operations. She stated she also added gravel to the exit driveway to fill the pot hole. On 03/16/2026 at 3:10 p.m., an interview was conducted with S2DON. He stated he was made aware of the incident on 02/17/2026 where Resident #1 fell out of the van when a passerby, that witnessed the incident, came into the facility after the incident occurred and informed him of what they witnessed. He stated he reviewed the video surveillance and saw the van exiting the facility, hit a pot hole, causing the back door to open, the ramp come out, and Resident #1 roll down the ramp, and onto the gravel driveway. S2DON stated S3TD exited the van, assisted Resident #1 getting up off the gravel driveway, placed Resident #1 into a regular seat in the van, and drove off. He stated he asked S8TD to ride with him in his private vehicle to the destination the van was going. S2DON stated he assessed Resident #1 when he arrived to the destination. He stated he then had S8TD drive the facility van with Resident #1 back to facility. On 03/17/2026 at 8:05 a.m., an interview was conducted with S9NP. She stated the facility notified her Resident #1 had fallen out of the facility transport van on 02/17/2026. She stated she was informed S2DON assessed Resident #1 and he had no injuries, did not hit his head, and did not complain of any pain. She stated she did a full assessment on 02/18/2026 and noted no injuries and no complaints of pain. On 03/17/2026 at 9:52 a.m., an interview was conducted with S10MS. He stated the facility transport van was inspected monthly to ensure it was in good working condition. He stated part of that check was to ensure all seat belts and safety belts were present and in working condition. He stated the vehicle doors were also inspected to ensure they worked properly. He stated the van was inspected 02/04/2026 and all doors and seat belts were working properly. He stated the wheelchair seat belts and safety straps were in the van and in good repair. He stated no one reported to him an issue with the van door, seat belts, or safety straps prior to the incident on 02/17/2026. He stated no work orders had been placed regarding the van. He reviewed the facility Maintenance Log from 12/01/2025 through 03/17/2026 and confirmed no work orders were reported/listed regarding the facility transport van. He reviewed the facility's Monthly Facility Vehicle Inspection Form dated 01/01/2026 through 03/17/2026 and confirmed no issues were noted related to the doors or seat belts of the van. He stated S3TD never told him the back door to the van was not working properly or that he did not have wheelchair seat belts or safety straps. He confirmed he inspected the van after the incident with S1ADM and S12CM present. He stated he found that the back door latch was completely loose. He stated all seat belts were working properly, the ramp was working properly, and the wheelchair seat belts and safety straps were noted to be present in the van. On 03/17/2026 at 1:13 p.m., a telephone interview was conducted with S12CM. He stated he inspected the van on 02/18/2026, after the incident occurred. He stated himself, S1ADM, and S10MS were also present during the inspection. He stated the back door latch was loose upon inspection. He stated all seat belts were in good repair and the wheelchair safety straps/seat belts were available and in good repair in the vehicle. On 03/16/2026 at 1:30 p.m., an interview was conducted with S7TD. She stated she had been trained on how to load, secure, and safely transport residents in the facility prior to transporting residents. She stated she never had an incident occur when she transported a resident but had she, she would notify Administration immediately. She stated (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>beginning on 02/18/2026 she received additional training on safely securing the residents in the van, the Administrator began performing weekly ride alongs, and a 3rd party company came to the facility to train her on how to properly use the ramp on the van and how to properly use the safety straps/seat belts for wheelchairs. She stated if any equipment needed to safely transport a resident was not working properly or not available she would not transport the resident and she would notify Administration. On 03/16/2026 at 1:40 p.m., an interview was conducted with S8TD. She stated prior to transporting residents, she was trained on how to load, secure, and safely transport residents. She stated she never had an incident occur when she transported a resident but had she, she would notify Administration immediately. She stated if there was a safety concern with the van, seat belt, lift, or any securing devices necessary for the residents safety needs, she would not transport the resident and would notify Administration immediately. She stated the transportation vans were routinely checked to ensure safety of the residents during transport. She stated starting on 02/18/2026 she received additional training by S1ADM on how to safely securing the residents in the van, Administration had been accompanying her for weekly for ride alongs, and a 3rd party company came to the facility and trained on how to properly use the ramp on the van and how to properly use the safety straps/seat belts for wheelchairs. On 03/18/2026 at 2:50 p.m. a telephone interview was conducted with S22MT. He stated he was a 3rd party Master Trainer. He stated he was contracted by S1ADM to come to the facility on [DATE] to train employees on the proper way to secure residents during transportation in the facility van, the appropriate way to secure the wheelchair straps and seat belt, and how to properly open/close/secure the van loading ramp. He stated he demonstrated to all three of the approved facility transport drivers these techniques and had them perform a return demonstration to ensure they performed them correctly. He stated all three individuals perform the return demonstrations appropriately and were given certificates of completion. On 03/17/2026 at 12:38 p.m., an observation was made of a resident being loaded onto the Facility Transport Van by S7TD and S8TD, Resident #R1 was in a wheelchair. No safety concerns were identified. The facility implemented the following actions to correct the deficient practice prior to surveyor entry on 03/16/2026: On 2/17/2026 at 12:30pm, S3TD was transporting Resident #1 when he fell out of the van. A bystander came in off the street around 12:45pm to report that the incident occurred. S2DON, immediately reviewed the video surveillance.12:30 p.m., Resident #1 noted falling out of the van as S3TD exits the parking lot.12:31 p.m., S3TD placed Resident #1 back into the van into a regular van seat.12:32 p.m., Van leaves facility site.12:45 p.m., Bystander notifies staff and S2DON reviews video footage.12:56 p.m., Local Police Department called facility to see if any assistance was needed.Approx. 1:15 p.m., S2DON and S8TD met S3TD at the appointment he was at and assessed Resident #1 and obtained a statement. No injuries noted and no complaints of pain. Resident #1's statement I fell out the van but I'm alright. S9NP notified and attempted to notify the RP multiple times.S1ADM opened SIMS on 3/18/2026 at 2:13 p.m., 1. The following corrective actions were taken: S2DON drove S3TD back to the facility and S8TD drove resident back to the facility on the regular van seat using the van seatbelt. S3TD was suspended pending investigation. On 2/18/2026, Resident #1 was assessed by S9NP with no injuries noted or complaints of pain.2. All residents who ride in their wheelchairs in the facility van had the potential to be effected by the alleged deficient practice:a. Van keys were locked in S1ADM's office on 2/17/2026 for the remainder of the day, and the van was not used again. Corporate Maintenance Coordinator, Maintenance Supervisor, and S1ADM inspected van the next day on 2/18/2026. The latch on the back door closure was missing screws. Wheelchair straps and regular seat seatbelts available and in working order. Wheelchair ramp and latches in good working order. Van was taken out of service and removed from site.b. On 2/18/2026, S1ADM in-serviced transportation staff on Proper restraint for residents transported via wheelchair-demonstration. Notifying Administrator and/or DON immediately of any issues on incidents/Review of van forms/ binder. Residents who can safely transfer to van seat may ride in a traditional seat. The following employees were in attendance: S2DON, S7TD, S17SSD, S18ADON, S19QA, S8TD, S20TTS, (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>S4LPN, and S21ESS.c. S3TD was terminated on 2/18/2026.d. On 2/18/2026, Administrator completed a ride along with S8TD and S7TD and completed Driver In-service Checklist and the Transportation Policy Acknowledgement Form.e. On 03/03/2026, a 3rd party consultant provided training with certificates of completion for: S7TD, S8TD, S1ADM, and S21ESS.f. Administrator ordered items discussed during 3rd party training. On 03/03/2026 seatbelt lock (can be used for residents who may try to remove their seatbelt) was ordered. On 03/04/2026, Q-strait loops which improve wheelchair securement hook attachment were purchased. Items were received on 03/05/2026 and placed into van on 03/06/2026.3. Measures that will be taken to ensure the alleged deficient practice will not recur are:a. On 2/18/2026 transportation monitoring was initiated weekly and will continue for 6 weeks. Administrator and/or Designee complete a weekly ride along with van drivers to ensure resident safety, proper securement, and safe driving.b. Facility borrowed a van from sister facility to continue resident transports and Driver Inservice Checklists were completed.c. Vans were rented so bariatric residents could be safely transported and Driver Inservice Checklists were completed.d. Facility has also scheduled ambulance transfers as needed.4. The facility will monitor to make sure that the solutions were sustained by:a. Administrator and/or Designee also intends to continue training and ride along with each approved van driver approximately every 6 months on going. Initial training completed 2/18/2026. 5. Completion Date: March 4th, 2026 Review of the three approved Facility Transport Drivers training (S1ADM, S7TD, and S8TD) revealed all had Certificates of Completion on Wheelchair Securement and Lift Operations per 3rd party Provider (S22MT), completed Company Owned Vehicle Driver Inservice Checklist, had ongoing weekly ride alongs with Administration since 02/18/2026, and all reviewed and signed Transportation Policy Acknowledgment Form. All department managers were trained and signed off on proper placement of van straps on 02/18/2026.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure an allegation of neglect was reported to the administrator immediately and to the State Survey Agency within 24 hours for 1(#1) of 5 residents investigated for neglect. Review of the facility's undated policy titled Abuse Reporting and Investigation Policy and Procedure revealed in part, the following:Policy:1. All reports of resident neglect shall be promptly reported to local, state, and federal agencies (as defined by current regulations).Reporting:1. All alleged violations involving neglect will be reported by the facility Administrator, or his/her designee, and in turn they will notify to the following persons or agencies, as applicable:a. The State licensing/certification agency responsible for surveying/licensing the facility.2. An alleged violation neglect will be reported immediately, but not later than:b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury.E. Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. A facility must report incidents of alleged neglect and all situation in which the facility has cause to believe that the physical or mental health and/or welfare of a resident has been or may be adversely affected by neglect caused by another person. Neglect may include, but is not limited to:-Failure to provide the timely, consistent, safe, adequate, and appropriate care and services as needed. Review of the facility's undated policy titled Transportation Policy Acknowledgment Form revealed in part, the following:All incidents and accidents, no matter how minor or major, must be reported immediately to the Administrator- wrecks, resident injury, employee injury, falls, attempted elopement from facility vehicle, etc. Review of Resident #1's clinical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included Ataxia. Review of the facility's incident report dated 02/17/2026 at 12:30 p.m. revealed the following:Resident: Resident #1Incident Location: OutsidePerson Preparing Report: S2DONIncident Description: As S3TD was leaving the parking lot, the rear door of the van opened which led to Resident #1 rolling backwards into the parking lot.Injury: No injuries Review of S1ADM's written statement dated 02/17/2026 at 12:30 p.m. revealed the following:On 02/17/2026 at 12:30 p.m., S3TD was transporting Resident #1 when he fell out the van. Video footage was reviewed, incident occurred in gravel side of the parking lot. At 12:31 p.m. S3TD put Resident #1 back into the facility van, and at 12:32 p.m. the van left the facility's parking lot. Review of S3TD's Disciplinary Report dated 02/18/2026 revealed S3TD was terminated for carelessness and failure to obey safety rules. Further review revealed S3TD failed to properly restrain resident in van and did not report incident. On 03/17/2026 at 9:03 a.m., a telephone interview was conducted with S3TD. He stated he was responsible for transporting residents in the facility van. He stated he was driving the facility van on 02/17/2026 at 12:30 p.m. when Resident #1 fell out of the van. He stated he did not tell Administration when Resident #1 fell out of the van since Resident #1 did not complain of pain or injuries at that time. He stated he knew he should have told them at the time the incident occurred. On 03/16/2026 at 3:10 p.m., an interview was conducted with S2DON. He stated he was made aware Resident #1 fell out of the van on 02/17/2026 at 12:45 p.m. He stated S3TD did not notify him at the time the incident occurred and should have. S2DON stated he informed S1ADM on 02/18/2026 at 12:50 p.m. after a passerby notified the facility Resident #1 fell out of the van while S3TD was driving. On 03/17/2026 at 12:40 p.m., an interview was conducted with S1ADM. She stated she was responsible for reporting neglect to the state agency. She stated she was informed of the incident, where Resident #1 fell out of the van during transport, on 02/17/2026 at 12:50 p.m. by S2DON. She stated she did not consider the incident to be neglect, and she did not report it to the state agency. She confirmed S3TD's failure to secure Resident #1 in the van prior to transport, which resulted in the resident falling out of the van, was neglect and should have been reported in the 24-hour timeframe.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the services provided as outlined in the comprehensive care plan met quality professional standards. The facility failed to ensure nursing staff administered supplements per professional standards for 1 (#2) of 3 sampled residents reviewed. Findings: Review of Resident #2's clinical record revealed he was admitted to the facility on [DATE] with diagnoses which included Chronic Combined Systolic And Diastolic Congestive Heart Failure, Type 2 Diabetes Mellitus With Other Circulatory Complications, Vitamin Deficiency and Generalized Muscle Weakness. On 03/16/2026 at 10:00 a.m., Resident #2's current Physician orders were reviewed and revealed, no current order for the house supplement. An interview was conducted with S15LPN on 03/16/2025 at 2:35 p.m. She stated Resident #2 had a decreased appetite and refused at times to eat his meals. She stated on 03/09/2026, she notified S9NP Resident #2 was not eating. She stated S9NP gave her a verbal order to administer 4 ounces of house supplement to Resident #2 anytime he was refusing to eat a meal. She stated she forgot to enter the verbal order for Resident #2's house supplement. She stated between 03/09/2026 and 03/16/2026, she administered 4 ounces of the house supplement to Resident #2 at least four times, but could not recall when it was administered. She confirmed she should not have administered the house supplement to Resident #2 without entering the order. An interview was conducted with S9NP on 03/17/2026 at 7:50 a.m. She stated Resident #2 had a decreased appetite and recently began refusing to eat some of his meals. She stated sometime last week, she gave a verbal order to S15LPN to administer the house supplement to Resident #2 if he refused to eat and would agree to take it. She stated if Resident #2 was administered the house supplement it should have been entered as an order. An interview was conducted with S16LPN on 03/17/2026 at 12:45 p.m. She stated she was assigned to Resident #2 today from 6:00 a.m. to 6:00 p.m. She stated she administered 4 ounces of the house supplement to Resident #2 this morning with his morning medications. She reviewed Resident #2's clinical record and confirmed there was no order to administer the house supplement. She stated she was not sure if she should have administered the house supplement to Resident #2 without an order. An interview was conducted with S2DON on 03/17/2026 at 3:00 p.m. He reviewed Resident #2's clinical record and confirmed there was no documented evidence the house supplement was ordered for Resident #2. He confirmed nurses' should not have administered the house supplement to Resident #2 without an order entered in the clinical record.</p>		

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 03/18/2026
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident at risk for pressure ulcer development received care consistent with professional standards of practice, to prevent pressure ulcers. This deficient practice was evidenced by failing to ensure a resident with orders for a pressure reducing seat cushion intervention was implemented for 1 (#2) of 3 residents reviewed who were at risk for pressure ulcers. Findings: Review of Resident #2's clinical record revealed he was admitted to the facility on [DATE] with diagnoses which included Chronic Combined Systolic And Diastolic Congestive Heart Failure, Type 2 Diabetes Mellitus With Other Circulatory Complications, Morbid Severe Obesity Due To Excess Calories, and Generalized Muscle Weakness. Review of Resident #2's Quarterly MDS with an ARD of 02/10/2026 revealed a BIMS of 04, which indicated he was severely cognitively impaired. Further review of the MDS revealed he was dependent on staff assistance for chair/bed-to-chair transfers, was at risk for pressure ulcer development, and required a pressure reducing device for his chair. Review of Resident #2's current Physician Orders revealed an order for a pressure reducing seat cushion every shift which started on 07/23/2025. Review of Resident #2's current Care Plan revealed the following, in part: Focus: Resident is at risk for pressure ulcers and other skin impairments related to Obesity, Diabetes Mellitus, occasional incontinence, and impaired mobility. Uses wheelchair. Interventions: 07/23/2025 New Order: Pressure reducing seat cushion. An observation was made of Resident #2 on 03/16/2026 at 8:13 a.m. He was in his room seated in a wheelchair with no pressure reducing seat cushion observed. An interview was attempted with Resident #2, but he was unable to be interviewed due to his cognitive status. An observation was made of Resident #2 on 03/16/2026 at 11:10 a.m. He was in his room seated in a wheelchair with no pressure reducing seat cushion observed. An interview was conducted with S14CNA on 03/16/2026 at 2:20 p.m. She stated Resident #2 required two person total assistance with transfers, incontinent care, and was at risk for pressure ulcers. She stated Resident #2 was out of bed in the wheelchair when she arrived for her shift today. She stated she and S15LPN transferred Resident #2 back to bed after lunch. She confirmed there was no pressure relieving cushion in Resident #2's wheelchair or in his room. An interview was conducted with S15LPN on 03/16/2026 at 2:35 p.m. She stated Resident #2 was at risk for pressure ulcer development and had a physician order for a pressure reducing seat cushion when he was in the wheelchair. She stated she and S14CNA transferred Resident #2 from the wheelchair to his bed after lunch. She confirmed there was no pressure relieving cushion in Resident #2's wheelchair or in his room and there should have been. An interview was conducted with S2DON on 03/17/2026 at 3:00 p.m. He stated Resident #2 was at risk for pressure ulcer development. He reviewed Resident #2's Physician Orders and confirmed a pressure reducing seat cushion should be used anytime Resident #2 was out of bed in the wheelchair.</p>		