

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195443	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER Legacy Nursing and Rehabilitation of Tallulah		STREET ADDRESS, CITY, STATE, ZIP CODE 32 Crothers Drive Tallulah, LA 71282	
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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to immediately inform the responsible party of tests results for 1 (#1) of 3 (#1, #2, and #3) residents reviewed for notification of change. The facility failed to ensure that resident #1's responsible party was notified of the resident's x-ray results, in a timely manner. Findings: Review of the medical record revealed resident #1 was re-admitted to the facility on [DATE] with diagnoses that included in part, Alzheimer's disease, psychotic disturbance, mood disturbance, anxiety and a personal history of other diseases of the musculoskeletal system and connective tissue. Review of the annual Minimum Data Set, dated [DATE] revealed resident #1 had a Brief Interview for Mental Status score of 11 which indicated the resident had moderate cognitive impairment with daily decision making skills. Further review revealed resident #1 required assistance with activities of daily living. On 03/31/2025 at 12:15 p.m., an observation revealed resident #1 lying in bed, resting with her right arm exposed. An observation of resident #1's right forearm revealed an area approximately the size the palm of the hand with a faint pinkish color to center of the area. Review of the nursing progress notes dated 03/07/2025 at 10:33 a.m. revealed resident #1 was seen per Nurse Practitioner (NP) with new orders for an x-ray of resident #1's right shoulder/arm. Review of patient report dated 03/07/2025 revealed resident #1 had an x-ray of the right shoulder with 2+ views. The report was electronically signed on 03/07/2025 at 1:23 p.m. by the interpreting physician. Further review revealed S3Licensed Practical Nurse (LPN) had signed and dated the report on 03/07/2025. Review of the medical record revealed there was no documented evidence of resident #1's responsible party being notified of the x-ray report results. On 04/02/2025 at 4:45 p.m., S2Director of Nursing (DON) confirmed resident #1's responsible party had not been notified of the x-ray results in a timely manner. On 04/02/2025 at 5:00 p.m., S1Administrator was notified of the above findings.		

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