

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2026
NAME OF PROVIDER OR SUPPLIER  Legacy Pointe at Ucf		STREET ADDRESS, CITY, STATE, ZIP CODE  2120 Hestia Loop Oviedo, FL 32765	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed to develop an individualized person-centered care plan related to urinary tract infection (UTI) for 1 of 1 resident reviewed for care plans, of a total sample of 28 residents, (#47). Findings: Resident #47 was admitted to the facility on [DATE] with diagnoses including lower back pain with left side sciatica, spinal stenosis, epigastric mass, heart disease, diverticulosis and bacteria in the urine. Review of the Minimum Data Set (MDS) admission assessment with an assessment reference date of 3/09/26 revealed resident #47 had a Brief Interview for Mental Status score of 15/15, which indicated she was cognitively intact. Her active diagnosis included urinary tract infection in the past 30 days. Review of resident #47's electronic medical record (EMR) revealed an advanced practice nurse progress note dated 3/13/26 which indicated resident #47 had complained of lower abdominal pain and pain during urination and a urine culture was ordered. laboratory results dated [DATE] showed she had Escherichia Coli (E-Coli) in her urine indicating a urinary tract infection. Review of physician orders revealed an order dated 3/15/26 for Macrobid 100 milligrams twice a day for seven days for UTI. There were no orders related to any necessary precautions related to the infection. Review of resident #47's EMR revealed a baseline care plan which indicated she had an infection, but the care plan was not individualized to specify the type of infection. The interventions included contact isolation, droplet isolation, and standard precautions but did not specifically indicate which type of precautions were appropriate for her type of infection. On 3/18/26 at 12:30 PM, the Registered Nurse (RN) MDS Interim Coordinator reviewed resident #47's care plan and verified the presence of a baseline care plan for infection that was initiated on 3/04/26. She verified the care plan did not identify the infection and did not specify which precaution, if any, was appropriate for the infection. The RN MDS Coordinator acknowledged the care plan was not resident specific, individualized, and should have been updated to include the type of infection, type of precautions necessary and antibiotic therapy.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to adhere to proper infection control practices related to Enhanced Barrier Precautions (EBP) for 1 of 1 resident reviewed for wound care, of a total sample of 48 residents, (#7). Findings:Review of resident #7's medical record revealed he was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, chronic kidney disease, history of non-ST elevation myocardial infarction, atrial fibrillation, heart failure, hypertension, glaucoma, cognitive communication deficit, history of non-Hodgkin lymphoma in remission. Review of current physician orders on 3/16/26 revealed resident #7 had multiple wounds with active orders for wound care to the coccyx, left heel, and spine wounds. Orders included daily wound care treatments, offloading interventions, and topical treatments. The resident had active orders for Enhanced Barrier Precautions related to a wound infection. Review of the February 2026 Medication Administration Record and Treatment Administration Record revealed resident #7 received intravenous (IV) antibiotic therapy, including Meropenem, and oral medication Linezolid for his wound infection. The resident also had a midline IV with orders for routine flushing, dressing changes, and monitoring of the IV site for signs and symptoms of infection. MRSA is a type of bacteria that can be resistant to several antibiotics. The risk increases for people with nursing home stays and can cause serious problems both in and out of healthcare settings including pneumonia, bloodstream infections, surgical site infections, sepsis and death. MRSA spreads through contact with infected people, wounds, or things that have touched infected skin and are carrying the bacteria. In the healthcare setting, contact precautions including gloves and a gown, strict hand hygiene and appropriate use of masks and eye protection during high-risk procedures are recommended, (retrieved on 4/01/26 from www/cdc.gov). On 3/16/26 at 10:52 AM, resident #7's wound care was observed with Registered Nurse (RN) B and Licensed Practical Nurse (LPN) C. On the resident's door an EBP sign was posted which indicated that use of a gown and gloves were required during high-contact care. RN B performed hand hygiene before the wound care was started; however, she did not don a gown prior to initiating the high-contact care. During the wound care RN B leaned on the resident's bed, touched the resident's leg and foot, and came into contact with multiple environmental surfaces without wearing a gown to prevent the spread of any bacteria. RN B held the resident's leg and foot while the cart nurse cleansed the wound. On 3/17/26 at 11:27 AM, LPN C confirmed the EBP sign on resident #7's door. LPN C stated she was aware of the requirement to wear a gown and gloves before providing wound care and acknowledged all staff who were providing high contact care should be wearing the appropriate protective equipment including a gown and gloves. Review of the facility's undated policy and procedure for Enhanced Barrier Precautions revealed staff were required to wear gown and gloves during high-contact resident care activities, including wound care, to prevent transmission of multidrug-resistant organisms.</p>		