STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195613	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at St Christina	122 Hillsdale Drive Pineville, LA 71360

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 0600

Level of Harm - Actual harm

Residents Affected - Few

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45213

Based on interview, and record review, the facility failed to ensure a resident's right to be free from physical abuse by another resident for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. The facility failed to protect Resident #1 from being punched and kicked by Resident #2 on 09/18/2024, and pushed down on the ground by Resident #2 on 10/04/2024.

This failed practice resulted in an actual harm situation for Resident #1 on 09/18/2024 at 3:00 p.m., when a CNA reported Resident #1 was on the floor after wandering into Resident #2's room, and Resident #2 was kicking Resident #1 in the chest and abdominal areas with bare feet; and on 10/04/2024 at approximately 3:50 p.m., when Resident #2 pushed Resident #1 from behind, causing him to fall to the floor face first. Resident #1 was transported to the emergency roiagnom on [DATE], and diagnosed with Laceration of [NAME] Border of Upper Lip, which required 5 Prolene sutures.

Findings:

Review of the facility's policy Abuse Prevention and Prohibition undated and provided on 10/21/2024, read in part . Each resident has the right to be from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents

3. Physical Abuse may include an aggressive act, including inappropriate physical contact that is harmful, or to cause injury or harm to a resident.

b. Examples: hitting, slapping, pinching, biting, shoving; and kicking.

Resident #1

Review of Resident #1's medical record revealed an admitted [DATE], with diagnoses that included: Cerebral Infarction, Chronic Kidney Disease, Schizoaffective Disorder, Aneurism of Unspecified Site, Personal History of Traumatic Brain Injury, Major Depressive Disorder, and Anxiety Disorder.

Review of Resident #1's Admission MDS with an ARD of 08/26/2024, revealed a BIMS was not conducted as Resident #1 was rarely/never understood, and had moderately impaired cognitive skills for daily decision making. Review of the MDS revealed Resident #1 did not require a mobility device, but required moderate assistance with ambulating 10 feet and 50 feet.

(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: 195613	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Legacy at St Christina		STREET ADDRESS, CITY, STATE, ZIP CODE 122 Hillsdale Drive Pineville, LA 71360	

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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Care Plan with a Target date of 11/18/2024, revealed in part . 1. I am at risk for falls r/t unsteady gait and history of falls. 10/04/2024 I had a fall from physical contact with another resident resulting in laceration to lip, sent out of facility to ER. Interventions: Monitor for changes in my condition that may warrant increased supervision/assistance, and notify the physician. 2. I reside in the secure care unit related to wandering behaviors, and difficult redirection. Interventions: Approach me positively and in a calm, accepting manor. Monitor and document my behavior. Provide diversional activities for me. Staff is aware of my wandering/elopement behavior. 3. I have cognitive loss r/t Schizoaffective Disorder, MDD, Anxiety. Interventions: Please approach me from the front in a calm, unhurried manner. Report any changes to my doctor and family. Resident #2 Review of Resident #2's medical record revealed an admitted [DATE], with diagnoses that included: Schizoaffective Disorder Bipolar Type, Anxiety Disorders Unspecified, Extrapyramidal and Movement Disorder, and Drug Induced Subacute Dyskinesia. Review of Resident #2's Quarterly MDS with an ARD of 08/06/2024, revealed a BIMS score of 15, indicating intact cognition. Review of the MDS indicated Resident #2 did not require a mobility device, or supervision with ambulating 10 feet and 50 feet. Review of Resident #2's Care Plan with a Target date of 11/09/2024, revealed in part . 1. Continued Behavior Care Plan. Interventions: Administer behavior medications per physician order. Attempt to redirect me when I become aggressive. Direct me to a quiet place to allow me to calm down. 2. I display physically and verbally aggressive behavior. I have history of pacing/wandering, delusions, and refusal of care. Interventions: Administer my behavior medications as ordered by my physician. Identify causes for my behavior and reduce factors that may provoke me. Place me in area where observation is possible - Secure Unit. 09/18/2024 Resident to Resident Abuse Review of facility investigative notes for Resident #1 and Resident #2 dated 09/18/2024 at 3:00 p.m., read in part . On 09/18/2024, at approximately 3:00 p.m., staff reported that Resident #2 had made physical contact with Resident #1. Investigation by S1 DON, revealed that Resident #1 had wandered into Resident #2's room while both staff members were with other residents. S5 CNA reported that she heard noises coming from Resident #2's room, and upon entering the room, S5 CNA observed Resident #2 making physical contact with Resident #1. Review of a statement by S5 CNA dated 09/18/2024 read in part . (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	I (S5 CNA) was observing other residents at the back of the hall, when I heard Resident #2 yelling get him out my room. I ran to see what was going on, and saw Resident #2 making physical contact towards Resident #1 . Review of investigative notes read in part .Resident #1 was removed from Unit A and placed on another hall while Resident #2 remained on Unit A .On 09/21/2024, Resident #1 continued to require frequent supervision and became difficult to redirect .Resident #1 was placed on 1:1 and then he agreed to go for Inpatient Psychiatric treatment .the facility feels that Resident #1's wandering was the root cause of the incident on 09/18/2024. Review of Resident #1's completed task for increased supervision revealed Q30 minute monitoring was done when he return to the Unit A on 10/01/2024. Review of Resident #1's Nurses' Notes read in part . 10/01/2024 at 5:40 p.m. - Resident #1 returned to the facility. Interview on 10/21/2024 at 2:28 p.m. with S5 CNA revealed Resident #1 went into Resident #2's room on 09/18/2024. S5 CNA reported when she entered, she saw Resident #1 on the floor, and Resident #2 kicking Resident #1's chest/abdominal areas. S5 CNA revealed Resident #2 did not have shoes on. Interview on 10/24/2024 at 2:53 p.m. with S1 DON, revealed on 09/18/2024 at approximately 3:00 p.m., S5 CNA reported she heard a noise coming from Resident #2's room. S5 CNA reported Resident #1 was on the floor, and Resident #2 was kicking him in the side of chest area with bare feet. S1 DON revealed Resident #1 was not injured. S1 DON stated Resident #2, who was lucid and able to say what he did or did not do, admitted to punching and kicking Resident #1 because he was in his room. 10/04/2024 Resident to Resident Abuse Resident #1 Review of Resident #1's Nurses' Notes read in part . 10/04/2024 at 4:26 p.m. - Incident/Behavior Note documented by S2 ADON: Writer was called to unit where resident had gotten pushed by another resident. Resident #1 was on the floor with medium size puddle of blood draining from his left side of upper lip. Resident did not lose LOC as stated by staff that witnessed it, applied pressure to area .called for Resident #1 to be sent for further evaluation. 10/04/2024 at 3:50 p.m. - Incident/Behavior Note documented by S1 DON: Late Entry - Staff reported that Resident #2 pushed Resident #1 from behind without warning. Resident #1 fell to the floor, face first, causing a laceration to his lip. Staff immediately called for assistance. S6 FNP present in facility .assessed resident, provided first aid, and gave orders to send to ER for evaluation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Legacy at St Christina		STREET ADDRESS, CITY, STATE, ZIP CODE 122 Hillsdale Drive Pineville, LA 71360	

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of S6 FNP's Progress Note for Resident #1, dated 10/04/2024, revealed in part .complaints of being pushed by another resident, hitting face on floor causing laceration to lip with bleeding. PE: Chronically ill appearing. Upper lip laceration. Neurological Status: AA, Confusion. Superficial injury of head; contusion of lip, initial encounter. Plan: refer to ER for suturing. Review of Resident #1's emergency room Visit Notes dated 10/04/2024, revealed in part . Patient with a complex laceration to his left [NAME] border, with a small arterial bleed. Patient's cognitive disability has made it very difficult to apply pressure and close the wound. Patient was given 10 mg of Valium, 5 mg of Haldol, as well as Benadryl, and then placed in restraints. I (Doctor) was able to close the laceration using 5, 5.0 Prolene sutures. Resident #2 Review of Resident #2's Nurses' Notes read in part . 10/04/24 at 3:52 p.m. Incident/Behavior Note documented by S1 DON: Staff reported that Resident #2 is delusional, stating that he is a doctor, a football player, amongst other various occupations. He was observed making physical contact with another resident. 10/04/2024 at 4:50 p.m. Incident/Behavior Note documented by S1 DON: Late Entry for 4:00 p.m.: Staff reported that Resident #2 pushed Resident #1 from behind without warning. Resident #1 fell to the floor face first, causing a laceration to his lip. Staff immediately called for assistance. Interview on 10/23/2024 at 11:05 a.m. with S3 CNA, revealed on 10/04/2024 around 3:50 p.m., Resident #1 was walking down the hall of Unit A, when Resident #2 immediately came out of Room A and pushed Resident #1 from behind. S3 CNA reported this caused Resident #1 to fall to the floor. S3 CNA stated she rounds on the residents in the unit every 30 minutes. Interview on 10/23/2024 at 11:30 a.m. with S4 LPN revealed on 10/04/2024 approximately 15 minutes after lunch, Resident #2 bee lined it down Unit A, Hall A, and pushed Resident #1 down. S4 LPN reported Resident #1 was frail with an unsteady shuffled gait. S4 LPN reported Resident #1 was bleeding excessively from his mouth. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/23/2024 at 2:16 p.m. with S7 CNA revealed they always have 2 CNAs providing care on the Unit A. S7 CNA reported one CNA would monitor the residents walking around and on patio while the other would round on the residents in the rooms. S7 CNA revealed he rounded on the residents every 15 minutes. Interview on 10/23/2024 at 3:18 p.m. with S2 ADON, revealed she was present in the facility on 10/04/2024 when S1 DON got a phone call from a CNA on Unit A, informing S1 DON of an incident occurring between Resident #1 and Resident #2. S2 ADON reported they immediately ran to Unit A, saw Resident #1 on the ground with blood, and Resident #2 was cursing. Interview on 10/23/2024 at 3:34 p.m. with S1 DON, revealed she received a call from S4 LPN notifying her of the incident between Resident #1 and Resident #2. S1 DON reported Resident #2 pushed Resident #1 and he (Resident #1) had blood coming from his mouth.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45213 Based on interview and record review, the facility failed to ensure an allegation of resident to resident abuse was reported immediately, but not later than 2 hours after the allegation was made, to the State Survey Agency for 1 (Resident #1) of 3 (Resident #1, Resident #2, and Resident #3) sampled residents. Findings: An alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but no later than: Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. Resident #1 Review of Resident #1's medical record revealed an admitted [DATE], with diagnoses that included: Cerebral Infarction, Chronic Kidney Disease, Schizoaffective Disorder, Aneurism of Unspecified Site, Personal History of Traumatic Brain Injury, Major Depressive Disorder, and Anxiety Disorder. Review of Resident #1's Admission MDS with an ARD of 08/26/2024, revealed a BIMS was not conducted as Resident #1 was rarely/never understood, and had moderately impaired cognitive skills for daily decision making. Review of Resident #1's Care Plan with a Target date of 11/18/2024, revealed in part . I reside in the secure care unit related to wandering behaviors, and difficult redirection. Interventions: Approach me positively and in a calm, accepting manor. Monitor and document my behavior. Provide diversional activities for me. Staff is aware of my wandering/elopement behavior. Resident #2 Review of Resident #2's medical record revealed an admitted [DATE], with diagnoses that included: Schizoaffective Disorder Bipolar Type, Anxiety Disorders Unspecified, Extrapyramidal and Movement Disorder, and Drug Induced Subacute Dyskinesia. Review of Resident #2's Quarterly MDS with an ARD of 08/06/2024, revealed a BIMS score of 15, indicating intact cognition. Review of Resident #2's Care Plan with a Target date of 11/09/2024, revealed in part . (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I display physically and verbally aggressive behavior. I have history of pacing/wandering, delusions, and refusal of care. Interventions: Administer my behavior medications as ordered by my physician. Identify causes for my behavior and reduce factors that may provoke me. Place me in area where observation is possible - Secure Unit. Interview on 10/24/2024 at 2:53 p.m. with S1 DON, revealed on 09/18/2024 at approximately 3:00 p.m., S5 CNA reported she heard a noise coming from Resident #2's room. S5 CNA reported Resident #1 was on the floor, and Resident #2 was kicking him in the side of chest area with bare feet. S1 DON revealed Resident #2, who was lucid, and could say what he did and did not do, admitted to punching and kicking Resident #1. S1 DON reported she did not complete a SIMS report for the incident.