

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 02/27/2025
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)
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51596</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice and the resident's person centered plan of care, for 1 (Resident #3) of 3 (Resident #1, Resident #2, and Resident #3) residents sampled for quality of care. This deficient practice resulted in a delay in treatment of a wound to Resident #3's right elbow, and development of cellulitis of the right elbow that required antibiotic treatment.</p> <p>This failed practice resulted in an actual harm for Resident #3 on 02/26/2025 at 2:26 p.m., when the resident was observed to have a wound to his right elbow, with edema and erythema noted. On 02/21/2025 at 11:38 p.m., Resident #3 sustained a 1cm x 1cm skin tear to the right elbow as a result of a fall, and first aid was administered at that time. Wound care was ordered on 02/23/2025 to clean right elbow scratch with NS, apply Triple Antibiotic Ointment (TAO) and cover with clean dry dressing until healed, monitor for S/S of complications. Resident #3 did not receive the ordered treatment to the right elbow on 02/23/2025 and 02/24/2025, and there was no documentation that wound care was provided on 02/25/2025. S9 NP examined Resident #3 on 02/26/2025 at 2:36 p.m., and diagnosed Resident #3 with Cellulitis of the wound on his right elbow, ordered wound care, and prescribed an oral antibiotic on 02/26/2025 at 2:36 p.m.</p> <p>Findings:</p> <p>Review of Resident #3's medical record revealed an admitted [DATE], with diagnoses that included Hemiplegia following Cerebral Infarction.</p> <p>Review of Resident #3's Quarterly MDS with an ARD of 12/31/2024, revealed a BIMS score of 00, which indicated severe impairment. Resident #3 used a manual wheelchair for mobility.</p> <p>Review of the facility's Incident Log dated 01/28/2025 to 02/26/2025, revealed Resident #3 had an incident with a skin tear noted on 02/21/2025. The location of the skin tear was not noted.</p> <p>Review of the facility's Un-Witnessed Fall Report dated 02/21/2025, revealed, in part .Resident #3 was found on the floor with his wheelchair beside him. Resident #3 had a bruise, and a skin tear to his right elbow that measured 1cm x 1cm. Resident #3 had a hematoma and swelling to the right forearm, and was unable to tell the nurse what happened.</p> <p>(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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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>Review of Resident #3's Nurse's Note dated 02/21/2025 at 11:30 p.m., revealed, in part .Resident #3 was found on the floor. Resident #3 had a bleeding wound to the right elbow.</p> <p>Review of Resident #3's Physician Orders revealed an order on 02/23/2025 to clean right elbow scratch with NS, apply TAO, and cover with clean dry dressing until healed, monitor for S/S of complications.</p> <p>Review of Resident #3's Treatment Administration Record (TAR) for 02/2025, revealed, in part .wound care to the resident's right elbow was documented as administered on 02/23/2025 and 02/24/2025 by S2 DON. There was no documentation that wound care was provided on 02/25/2025.</p> <p>Interview with S5 ADON on 02/26/2025 at 11:25 a.m., revealed there had not been any wound care of the skin tear to Resident #3's right elbow since the incident occurred on 02/21/2025.</p> <p>Observation of Resident #3 on 02/26/2025 at 11:42 a.m., revealed a wound to Resident #3's right elbow, with edema and erythema noted.</p> <p>Interview with S6 LPN on 02/26/2025 at 11:51 a.m. revealed she was the facility's treatment nurse. S6 LPN confirmed she was not aware of Resident #3's wound to the right elbow, and did not provide any wound care to Resident #3 until 02/26/2025.</p> <p>Interview with S2 DON on 02/26/2025 at 2:07 p.m., revealed she entered the order for Resident #3's wound care on 02/26/2025, with a start date of 02/23/2025. S2 DON stated she signed Resident #3's wound care TAR on 02/23/2025 and 02/24/2025 because I know it was done. S2 DON stated she did provide wound care to Resident #3 on 02/25/2025, but did not sign the TAR. S2 DON stated that did not provide wound care to Resident #3's right elbow on 02/23/2025 and 02/24/2025; however, initialed on those dates because she knew wound care had been provided, and the nurse did not initial.</p> <p>Interview with S9 NP on 02/26/2025 at 2:36 p.m. revealed she had just examined Resident #3, and diagnosed Resident #3 with Cellulitis of the wound on his right elbow, ordered wound care, and prescribed an oral antibiotic.</p> <p>Interview with S7 RN on 02/27/2025 at 10:50 a.m., revealed she was the treatment nurse at the facility on 02/23/2025. S7 RN confirmed she did not provide wound care to Resident #3 on that day.</p> <p>Interview with S8 RN on 02/27/2025 at 10:55 a.m., revealed she was the treatment nurse at the facility on 02/22/2025. S8 RN confirmed she did not provide wound care to Resident #3 on that day.</p> <p>Interview conducted with S2 DON on 02/27/2025 at 12:35 p.m., revealed Resident #3 did not receive wound care on 02/22/2025, 02/23/2025, and 02/24/2025, but should have. S2 DON stated Resident #3 was diagnosed with Cellulitis of the right elbow, and required antibiotic treatment, after not receiving wound care as he should have.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>51596</p> <p>Based on interviews, and record reviews, the facility failed to maintain accurate medical records in accordance with accepted professional standards and practices. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. A wound care order was documented for Resident #3 when received by facility; 2. Documentation on the Treatment Administration Report (TAR) was accurate for Resident #3; and 3. Wound care was documented for Resident #3. <p>Findings:</p> <p>Interview with S5 ADON on 02/26/2025 at 11:25 a.m. revealed Resident #3 had a fall with a wound to his right elbow on 02/21/2025. S5 ADON confirmed there should have been an order for wound care for Resident #3, but there was not.</p> <p>Interview with S2 DON on 02/26/2025 at 2:07 p.m., revealed she was not at the facility on 02/21/2025, and was notified by S10 RN via telephone that Resident #3 had fallen and had a wound to his right elbow. S10 RN notified the provider on 02/21/2025 at 11:38 p.m., and was given an order for wound care. S2 DON stated on 02/25/2025 she realized the order for wound care had not been documented or entered. S2 DON stated she performed wound care for Resident #3 on 02/25/2025; however, she did not document it. S2 stated she entered the order for wound care on 02/26/2025, with a start date of 02/23/2025. S2 DON confirmed the order for wound care was not documented or entered when the order was given on 02/21/2025, but should have been. S2 DON stated that she initialed that wound care was performed on 02/23/2025 and 02/24/2025.</p> <p>Review of Resident #3's 02/2025 MAR revealed wound care was initialed by S2 DON as being done on 02/23/2025 and 02/24/2025.</p> <p>Interview with S2 DON on 02/26/2025 at 2:07 p.m. confirmed that she initialed that wound care was performed on 02/23/2025 and 02/24/2025.</p> <p>During interview on 02/27/2025 at 12:35 p.m., S2 DON confirmed she documented wound care was provided on Resident #3's TAR on 02/23/2025 and 02/24/2025. S2 DON stated that did not provide wound care to Resident #3's right elbow on 02/23/2025 and 02/24/2025; however, initialed on those dates because she knew wound care had been provided, and the nurse did not initial. S2 DON confirmed this documentation in Resident #3's record on 02/23/2-25 and 02/24/2025 was not accurate. S2 DON confirmed she did provide wound care to Resident #3 on 02/25/2025, but did not document the wound care. She confirmed the wound care should have been documented.</p>		