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	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on a record review and interview, the facility failed to provide care and services that met professional standards of quality by failing to ensure that a resident's medical record reflected whether Physician's Orders were implemented or refused. The facility failed to document whether wound care was or was not provided for 1 (Resident #3) of 3 (Resident #1, Resident #2, and Resident #3) residents reviewed for skin and pressure ulcers. Review of facility undated policy titled, Skin/Wound Documentation Policy and Procedure, revealed in part. Skin and wounds will be documented upon admission, readmission, weekly, and as needed. The facility shall follow the practitioner's orders for treatment of the pressure ulcer (injury). With each dressing change, or at least weekly, the pressure ulcer (injury) wound shall be assessed and documented. Pressure ulcer (injury) documentation should include, in part.date and time of initial and subsequent treatments. Review of Resident #3's medical record revealed an admit date of 03/10/2025 with the following diagnoses in part. Chronic Osteomyelitis Left Ankle and Foot, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side, Dysarthria following Cerebral Infarction, Epilepsy, Peripheral Vascular Disease, Presence of Vascular Implants and Grafts, Cellulitis of Left Lower Limb, and history of Venous Thrombus and Embolism. Record Review of Resident #3's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 06/10/2025 revealed Resident #3 had a BIMS score of 15, which indicated intact cognition. Resident #3 had documented 1 unhealed, unstageable pressure ulcer. Record review of Resident #3's Active Physician Orders read in part. Order Date 07/10/2025- Treatment #1: Stage 4 Left Lateral Foot: Cleanse with wound cleanser, pat dry, apply collagen with silver to wound bed, cover with calcium alginate, cover with dry dressing daily until healed. Record review of Resident #3's care plan with initiation date of 03/13/2025, revealed Resident #3 had an unstageable pressure ulcer to her left lateral foot with interventions that included in part. Provide treatment as ordered by physician. On 07/21/2025 at 2:32 p.m., review of Resident #3's Treatment Administration Record (TAR) revealed no documentation of treatment provided and/or refused for Stage 4 Left Lateral Foot on 07/16/2025 and 07/17/2025. During an interview on 07/22/2025 at 12:57 p.m., with S3LPN and S8RN, Resident #3's 07/2025 TAR was reviewed. S3LPN confirmed Resident #3 did not have any wound care documentation for 07/16/2025 and 07/17/2025, and should have. S3LPN and S8RN confirmed that if Resident #3 had refused care on those dates, refusal should have been documented on Resident #3's TAR and was not.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure residents who are unable to carry out ADLS (Activities of Daily Living) received the necessary services to maintain personal hygiene for 1 (Resident #3) of 3(Resident #1, Resident #2, Resident #3) residents reviewed for Activities of Daily Living (ADL) care. The facility failed to ensure a Bath/Shower was provided for Resident #3.A review of facility undated policy titled, Quality of Care Policy and Procedure, read in part. It is the policy of our company that each resident receives the necessary care to attain or maintain the highest practicable physical, mental and psychological well-being, in accordance with the resident's comprehensive assessment and plan of care. Review of Resident #3's medical record revealed an admit date of 03/10/2025 with the following diagnoses in part. Chronic Osteomyelitis Left Ankle and Foot, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side, Dysarthria following Cerebral Infarction, Epilepsy, Peripheral Vascular Disease, Presence of Vascular Implants and Grafts, Cellulitis of Left Lower Limb, Dependence of Wheelchair, Generalized Anxiety Disorder, and history of Venous Thrombus and Embolism.Review of Resident #3's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 06/10/2025 revealed Resident #3 had a BIMS score of 15, which indicated intact cognition. Resident #3 had 1 documented unhealed, unstageable pressure ulcer. Resident #3 required moderate assistance for shower/bathing and dependent for all transfers.Review of Resident #3's care plan with initiation date of 03/13/2025, revealed Resident #3 required assistance for all Activities of Daily Living (ADLs) with interventions that included in part. assist resident in bathing, hygiene, and grooming task.Review of Resident #3's electronic health record-facility task titled Bathing/Shower Scheduled (Three times weekly) Specify days:(Monday, Wednesday, Friday OR Tuesday, Thursday, Saturday) with a lookback period of 30 days, revealed Resident #3 had 3 documented baths in the past 30 days.During an interview on 07/22/2025 at 8:45 a.m. Resident #3 revealed she had not received a bath in two weeks and would like a bath daily.During an interview on 07/22/2025 at 9:10 a.m., with S5CNA revealed the facility's bath schedules are determined by gender. S5CNA revealed women were bathed every Tuesday, Thursday, Saturday and men were bathed every Monday, Wednesday, and Friday. S5CNA revealed residents' baths/showers were documented in the resident's electronic chart and/or facility whirlpool binder. Review of whirlpool binder with S5CNA for month of 07/2025, revealed Resident #3 had a bath refusal on 07/12/2025. S5CNA reviewed Resident #3's electronic medical record which revealed Resident #3's last documented bath was on 07/09/2025.During interview on 07/22/2025 at 1:12 p.m. review of Refusal binder with S2DON, revealed Resident #3 refused a bath on 07/12/2025 and 07/15/2025. S2DON acknowledged Resident #3 did not receive a bath within the past 2 weeks, and the Resident's medical record did not contain documented baths and/or all refusals as required.During interview on 07/22/2025 at 1:30 p.m. with S4Corporate revealed he developed the Refusal binder to track and trend cause of refusals and reviewed the binder weekly. S4Corporate verbalized Resident #3 was overlooked by him during this process, and he had not addressed Resident #3's bath refusals.During interview on 07/23/2025 at 9:40 a.m. S6CNA revealed Resident #3 did not refuse care. During interview on 07/23/2025 at 9:43 a.m. S7CNA revealed Resident #3 did not refuse care.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview the facility failed to maintain housekeeping and maintenance services necessary to maintain a sanitary and orderly interior. This deficient practice had the potential to affect the 124 resident's that resided at the facility. Findings:Observation on 07/21/2025 at 11:45 a.m. of Resident #2's room (Room B) revealed the floor had hair and a dark brown substance near the bed area. The wall near Resident #2's bed had a moderate amount of a splattered substance that was tan and pink in color. The window blinds in the room had broken pieces and was in disrepair.Observation on 07/21/2025 at 11:49 a.m. of Room A area revealed a large puddle of yellow liquid on the floor. The area smelled of urine. Interview with S4Corporate at time of observation confirmed the floor was unsanitary and was in need of cleaning. Observation on 07/21/2025 at 11:56 a.m. of Hall A, near Room C revealed a ceiling tile with a moderate sized amount of mold. Interview with S10HK at time of observation revealed the ceiling had been leaking, for at least a few weeks, and she had reported it to S9Maintenance. Interview with S9Maintenance at time of observation confirmed the ceiling tile was in need of replacement.Observation on 07/22/2025 at 9:04 a.m. of Room B revealed the wall near Resident #2's bed had a moderate amount of a splattered substance that was tan and pink in color. The window blinds in the room had broken pieces and was in disrepair. Observation on 07/23/2025 at 1:47 p.m. of Room B revealed the splattered substance on the wall next to Resident #2's bed remained and his blinds had broken pieces. Interview with Resident #2 revealed the splattered substance and broken blinds had been in this manner for quite some time. Resident #2 voiced he would like his wall cleaned and blinds replaced. Interview on 07/23/2025 at 1:49 p.m. with S1ADMIN confirmed Resident #2's wall was in need of cleaning, and the window blinds were in disrepair and needed replacement.