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	09/30/2025

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 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. (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

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to ensure a resident's right to be free from resident to resident physical abuse for 1 (Resident #2) of 4 (Resident #1, Resident #2, Resident #3, Resident #4) sampled residents. This deficient practice resulted in Actual Harm for Resident #2 on 09/21/2025 at 3:30 pm, when Resident #2 was hit by Resident #4 in the face with his left fist. Resident #2 was sent to a local emergency department where he received treatment for a facial contusion. Findings: Review of the facility policy titled Abuse Prevention and Prohibition revealed in part. Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals. Abuse defined: Abuse means the willful infliction of injury, unreasonable confinement intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse may include resident to resident, staff to resident, or family/visitor to resident. Physical abuse: May include an aggressive act, including inappropriate physical contact that is harmful or likely to cause injury or harm to a resident. Examples include hitting, slapping, pinching, biting, shoving, and kicking. Resident #2 Review of the clinical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses that include in part.Cerebral Infarction due to Embolism of Right Cerebellar Artery; Displaced Fracture of Upper End of Left Humerus; Diabetes; Hemiplegia and Hemiparesis following a Cerebral Infarction affecting Left Dominant Side; and Schizoaffective Disorder. Review of Resident #2's Quarterly Minimum Data Set (MDS) with an ARD of 07/01/2025 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. Resident #2 was dependent or required substantial/ maximum assistance with activities of daily living (ADLS). Review of Resident #2's care plan dated 03/05/2025 read in part. On 09/21/2025 I was trying to stop my roommate from leaving the room and physical contact was made. I have bruising noted to the left side of my face and eye orbital. Review of the facility's incident report dated 09/21/2025 at 3:30 p.m. by S2 DON read in part. Resident #2 tried to stop Resident #4 from leaving the room, resulting in a physical altercation. Injuries to Resident #2 included bruising to the left side of Resident #2's face and orbital area. Resident #2 was transferred to a local emergency department for treatment. Review of an Emergency Department record dated 09/21/2025 revealed in part.Resident #2 was sent to the hospital for an evaluation after being assaulted by his roommate. Diagnoses include: Facial Contusion and Physical Assault. Review of a Radiology report dated for 09/21/2025 read in part. Exam: CT Maxillofacial w/o contrastHistory: Assault, nose/ear bleeding, possible facial fracture, face trauma Impression: Mild soft tissue swelling and/or hemorrhage in the subcutaneous fat overlying the left side of the face. Otherwise unremarkable CT scan of the facial bones. Review of Resident #2's 09/2025 Physician Orders revealed a treatment order dated 9/27/2025 to monitor left eye and left side of face daily related to bruising. Observation on 09/29/2025 at 10:40 a.m. revealed Resident #2 had periorbital bruising to the left eye. Interview with Resident #2 at this time revealed he was hit in the eye by another resident. Resident #4 Review of the clinical record for Resident #4 revealed an original admit date of 06/12/2025 with a re-entry date of 09/17/2025 with diagnoses that include in part. Bipolar Disorder; Episodic Manic Severe with Psychotic Features; Anxiety; Depression; Moderate Intellectual Disabilities; Congestive Heart Failure; and Chronic Obstructive Pulmonary Disease. Review of Resident #4's admission MDS with an ARD of 06/24/2025 revealed Resident #4 had a BIMS score of 4, indicating severely impaired cognition. Resident #4 required minimal assistance with ADLs. Review of Resident #4's care plan dated 06/13/2025 read in part. I display behavior related to Impulse Disorder and Moderate Intellectual Disabilities. On 09/21/2025 my roommate was trying to stop me from leaving my room and trying to bite me, so I made contact with roommate. Interview on 09/29/2025 at 11:47 a.m. with Resident #4 revealed that Resident #2 was lying on a mat on the floor, attempting to hit and bite Resident #4's legs. Resident #4 reported that the behavior made him angry, and he struck Resident #2 with his left fist. Resident #4 experienced pain and swelling of the left hand following the altercation and, an x-ray was ordered. Observation of Resident #4's left hand revealed minimal swelling. On 09/29/2025 at 1:18 p.m., a telephone interview with S4 Nurse Practitioner revealed she was notified of the altercation on 09/21/2025 and was informed that Resident #2 sustained facial bruising and bleeding from his nose and left ear. Resident #2 was subsequently sent to the Emergency Department for evaluation and treatment. On 09/29/2025 at 3:51 p.m.

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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. Based on interview and record review the facility failed to ensure an allegation of staff to resident sexual abuse and resident to resident physical abuse was reported to the State Survey Agency immediately, but not later than 2 hours after the staff to resident sexual abuse and resident to resident physical abuse was discovered, for 2 (Resident #1 and Resident #2) of 4 (Resident #1, Resident #2, Resident #3, and Resident #4) sampled residents. Findings:Review of an undated facility policy titled “Abuse Prevention and Prohibition” revealed in part . “An alleged violation of abuse…will be reported immediately, but not later than: Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury - to the mandated state agency per reporting criteria within guidelines of notification of an alleged abuse.” Resident #1 Review of Resident #1's medical record revealed an admission date of 04/08/2025, a discharge date of 09/25/2025, with diagnoses that included in part…Intellectual Disabilities, Schizoaffective Disorder; Anxiety Disorder; Major Depressive Disorder, Single episode; Pain; Hypertensive Heart Disease with Heart Failure; and Atrial Fibrillation. Review of Resident #1's Quarterly Minimum Data Set (MDS) with an ARD of 07/15/2025 revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate impaired cognition. Resident #1 was independent with eating and required supervision with toileting and personal hygiene. Interview on 09/26/2025 at 11:50 a.m. with S2 DON revealed that she was notified on 09/22/2025 at approximately 10:00 a.m. that there had been an allegation that Resident #1 was sexually abused at a movie theatre outing by an unnamed facility staff member. S2 DON stated she immediately notified S1 ADM of the allegations of staff-to-resident sexual abuse. In an interview on 09/30/2025 at 11:50 a.m., S1 ADM revealed he did not think the allegation of staff-to-resident sexual abuse involving Resident #1 on 09/22/2025 needed to be reported or opened in the Statewide Incident Management System (SIMS). S1 ADM revealed that this allegation of sexual abuse was not reported. Resident #2 Review of Resident #2's medical record revealed an admission date of 03/05/2025, with diagnoses that included in part…Cerebral Infarction due to Embolism of Right Cerebellar Artery; Displaced Fracture of Upper End of Left Humerus; Diabetes; Hemiplegia and Hemiparesis following a Cerebral Infarction affecting Left Dominant Side; and Schizoaffective Disorder. Review of Resident #2's Quarterly Minimum Data Set (MDS) with an ARD of 07/01/2025 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. Resident #2 was dependent or required substantial/ maximum assistance with activities of daily living (ADLS). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/30/2025 at 11:05 a.m., an interview with S2 DON revealed she was made aware of the alleged resident to resident abuse involving Resident #2 that occurred on 09/21/2025. S2 DON stated she was responsible for SIMS reporting but required administrative approval before entering an incident, which she did not receive from S1 Administrator. S2 DON confirmed that the alleged abuse was not reported into the SIMS, but should have been. On 09/30/2025 at 11:45 a.m., an interview with S1 Administrator confirmed he was aware of the alleged resident to resident abuse involving Resident #2 on 09/21/2025, but chose not to initiate a SIMS report, due to he felt it was not warranted.