

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 01/28/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>51096</p> <p>Based on observation, interview, and record review the facility failed to maintain a clean, safe, comfortable and homelike environment by failing to ensure the cleanliness and good repair of patient care equipment for 2 (Resident #52 and Resident #39) of 40 total sampled residents.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled Reusable Medical Devices Cleaning Policy and Procedure read in part .</p> <p>Purpose: To keep reusable medical devices clean and prevent transmission of infection.</p> <p>Policy: Reusable medical devices will be cleaned after each resident use to prevent spread of infection.</p> <p>Procedure: 1. All surface areas of the machine will be cleaned with disinfectant wipe according to manufacture recommendations.</p> <p>Equipment and Supplies: 7. Any reusable medical device</p> <p>Resident #52</p> <p>Observation on 01/26/2025 at 10:30 a.m. revealed Resident #52's wheelchair cushion was soiled with a large amount of brown substance.</p> <p>Observation on 01/27/2025 at 09:41 a.m. revealed Resident #52's wheelchair and black wheelchair cushion was visibly dirty.</p> <p>Observation on 01/28/2025 at 10:23 a.m. revealed Resident #52 sitting in his wheelchair with visible brown dried substances to the black cushion and side of Resident #52's wheelchair.</p> <p>Interview with S13 CNA on 01/28/2025 at 10:29 a.m. revealed that Resident #52's wheelchair was dirty with a dried brown substance and should have been cleansed before use.</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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with S12 LPN on 01/28/2025 at 10:35 a.m. revealed that Resident #52's wheelchair and cushion was dirty and needed to be cleaned, but had not been.</p> <p>Interview with S14 Housekeeping Supervisor on 01/28/2025 at 4:00 p.m. revealed CNAs were responsible for cleaning resident wheelchairs.</p> <p>Interview with S3 ADON on 01/28/2025 at 4:09 p.m. revealed that it is everyone's job to clean the resident wheelchairs, if staff observe that wheelchairs are visibly soiled that the wheelchairs are to be cleaned with disinfectant wipes. S3 ADON stated she was unsure of a scheduled day for cleaning resident wheelchairs and stated housekeeping was ultimately responsible for keeping up with resident wheelchairs.</p> <p>44315</p> <p>Observation on 01/26/2025 at 3:08 p.m. revealed cracks and tears to the arm pads, exposing the material of Resident #39's wheelchair.</p> <p>Observation on 01/27/2025 at 10:37 a.m. of Resident #39 awake sitting up in wheelchair propelling himself down the hall. Observation of both of the arm pads of Resident #39's wheelchair cracked and torn. Interview at this time with Resident #39 revealed that the arms of his wheelchair had been like this for about 2 years now.</p> <p>Interview on 01/27/2025 at 10:42 a.m. with S15 CNA revealed she had worked since 09/2024 and reported that Resident #39's arms of his wheelchair have been cracked and torn since she had started working here but had not reported it.</p> <p>Interview with 01/27/2025 at 10:44 a.m. with S16 Maintenance revealed that he was not aware of Resident #39's wheelchair was in disrepair. S16 Maintenance confirmed that Resident #39's wheelchair was in disrepair and should have been reported to him.</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44315</p> <p>Based on record review and interview, the facility failed to transmit/encode a Discharge MDS (Minimum Data Set) Assessment accurately for 1 (Resident #100) of 1 sampled resident reviewed for resident assessments. The total sample size was 40 residents. Findings:</p> <p>Review of Resident #100's clinical record revealed an admitted [DATE] with diagnoses that included Bipolar Disorder, current episode mixed, Severe without Psychotic Features, Sepsis, unspecified organism, Type 2 Diabetes Mellitus, Major Depressive Disorder, unspecified Mood (Affective) Disorder, Anxiety Disorder and Essential (Primary) Hypertension.</p> <p>Review of Resident #100's Discharge Summary dated 11/19/2024 read in part .</p> <p>Resident #100 requested to transfer to sister facility. Resident #100 only stayed at facility one night and wanted to leave AMA. Resident #100 decided she would prefer to be transferred to another nursing home and her spouse agreed. Resident #100 was transported by staff with her medications and all of her belongings. Signed by S19 SSD.</p> <p>Review of the facility's MDS transmission report revealed an ARD (Assessment Reference Date) of 11/19/2024 was encoded as an unplanned (facility initiated) discharge.</p> <p>Interview on 01/28/2025 at 2:27 p.m. with S18 MDS revealed she had input data incorrectly for Resident #100's Discharge MDS Assessment as an unplanned facility-initiated discharge. S18 MDS reported that Resident #100's Discharge MDS should have been input as a planned resident-initiated discharge because the Resident #100 requested to leave facility and go to another specific nursing home.</p> <p>Interview on 01/28/2025 at 2:30 p.m. with S3 ADON confirmed Resident #100's MDS transmission report should have been encoded as a resident-initiated discharge instead of a facility-initiated discharge. S3 ADON confirmed Resident #100's MDS assessment transmission report was completed incorrectly on 11/19/2024.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46773</p> <p>Based on interview and record review the facility failed to ensure services were provided according to the residents plan of care for 2 (#33 and #91) out of a sample of 40 residents. The facility failed to follow the following physician's orders for monthly labs for Resident #33 and failed to ensure wound care was provided for Resident #91 as ordered.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled Lab/Diagnostic Monitoring Log Policy and Procedure on 01/28/2025 read in part Purpose: To ensure all labs and diagnostics are completed and followed up on for all residents as ordered by the physician. Procedure: All nurses are responsible for: 1. Making sure labs/diagnostics are being performed.</p> <p>Resident #33</p> <p>Review of Resident #33's medical records revealed an admitted [DATE] with diagnoses that included: Type 2 Diabetes Mellitus, Cerebellar Stroke Syndrome, Unspecified Convulsions, Generalized Anxiety Disorder and Conversion Disorder with seizures or Convulsions.</p> <p>Review of Resident #33's 01/2025 Physician's Order read in part</p> <p>11/07/2023-Trileptol Oral Tablet 150 MG (Oxcarbazepine) Give 1 tablet by mouth 2 times a day.</p> <p>11/07/2023-Trileptol Oral Tablet 300 MG (Oxcarbazepine) Give 1 tablet by mouth 2 times to equal 450 mg twice daily.</p> <p>11/07/2023-Trileptol level every month (Jan, Feb, Mar, Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec)</p> <p>Review of Resident #33's Care plan with a review date of 03/23/2025 read in part .I am at risk for injury related to a seizure disorder. Interventions: obtain my lab work as ordered.</p> <p>Review of Resident #33's medical record revealed missing Trileptol lab results for 02/2024, 04/2024, 06/2024, and 07/2024.</p> <p>Interview on 01/28/2025 at 9:40 a.m. with S2 Interim DON confirmed that Resident #33's Trileptol levels for 02/2024, 04/2024, 06/2024, and 07/2024 were not drawn, but should have been.</p> <p>44315</p> <p>Review of Resident #91's Medical Record revealed an admitted [DATE] with diagnoses that included Type 2 Diabetes Mellitus, Encounter for Surgical Aftercare following Surgery on the Skin and Subcutaneous Tissue, Vitamin D Deficiency and Essential (Primary) Hypertension.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #91's Physician's Orders for 01/2025 revealed the following order dated 01/16/2025: Cleanse with NS or wound cleanser, pat dry, monitor surgical openings for signs of infection, cover with dry dressing, secure with tape daily until resolved every day shift for post-surgical incision.</p> <p>Review of Residents #91's TAR for 01/2025 revealed documentation of wound care treatment dated 01/25/2025 initiated by S9 LPN coded 9 = other/See Progress Notes: Resident #91 out to IOP (Intensive Outpatient Program)</p> <p>Review of Resident #91's Progress Note by S9 LPN dated 01/25/2025 at 12:56 p.m. read in part . Resident is alert, skin warm/dry, respirations even/unlabored. Left for IOP today at 8:30 a.m. Wounds are being dressed per wound care nurse.</p> <p>Review of Resident's Quarterly MDS with an ARD of 01/07/2025 revealed a BIMS score of 13, indicative of intact cognition.</p> <p>Review of Resident #91's Care Plan with a Target date of 03/05/2025 revealed resident with impaired skin integrity related to surgical wound to back. Interventions initiated on 01/13/2025 included in part . I need wound care as ordered by my physician.</p> <p>Observation in Resident #91's room on 01/26/2025 at 10:50 a.m. of S7 LPN treatment nurse performing wound care treatment to Resident #91's lower back. At this time of observation revealed Resident #91's dressing dated 01/24/2025. S7 LPN revealed the dressing must not have been changed yesterday due to Resident #91's orders are for his wound care dressings are to be changed daily. Interview at this time with Resident #91 revealed that his wound care dressing was not done yesterday (Saturday, 01/25/2025) because he had went out for his appointment.</p> <p>Interview in Resident #91's room on 01/26/2025 at 11:05 a.m. with S9 LPN reported Resident #91 had went to IOP yesterday on 01/25/2025 and came back about 1:45 p.m. S9 LPN revealed that she had not done Resident #91's wound care treatment because she thought the treatment nurse did his treatment. S9 LPN revealed that she was not aware of Resident #91's treatment was not done on 01/25/2025.</p> <p>Telephone interview on 01/27/2025 at 04:30 p.m. with S6 RN revealed she had worked on 01/25/2025. S6 RN reported Resident #91 was not in the facility while she was working and had not done his treatment that day. S6 RN revealed that she reported to S8 LPN that she had not performed wound care treatment to Resident #91 because he had went out to IOP and had still not returned from IOP at the end of her shift.</p> <p>Interview on 01/27/2025 at 4:41 p.m. with S8 LPN revealed that she had worked on 01/25/2025 and had helped S6 RN chart on Resident 91's TAR that treatment was not performed due to Resident #91 was out of facility to IOP. S8 LPN reported that she had not performed Resident #91's treatment when he returned from IOP. S8 LPN further revealed that she had not reported to S9 LPN that Resident #91's treatment was not done that day and should have done so.</p> <p>Interview on 01/27/2025 at 4:45 p.m. with S3 ADON stated the treatment nurse, S7 LPN had called in on 01/25/2025 and the prn S6 RN was called in to work to replace treatment nurse. S3 ADON reported the nursing staff should have communicated with each other and reported to Resident #91's nurse in order to have his wound care treatment done when he returned from IOP and did not.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 01/28/2025 at 2:15 p.m. with S3 ADON confirmed Resident #91's wound care treatment was not performed as ordered for 01/25/2025 and should have been done.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51082</p> <p>Based on observation, record review, and interview the facility failed to provide care and services that met professional standards of quality by failing to ensure physician's orders were implemented as ordered. The facility failed to ensure the correct tube feeding was administered at a continuous rate for 1 (#67) of 1 residents reviewed for tube feeding. Total sample size was 40.</p> <p>Findings:</p> <p>Review of the Facility's undated Policy titled Enteral Nutritional Therapy, (Tube Feeding) Policy and Procedure revealed in part .All enteral tube feedings shall have care according to physician orders.</p> <p>Review of Resident #67's medical record revealed an admitted [DATE] with a re-entry date of 05/07/2024 with diagnoses that included in part .Cerebral infarction unspecified; Schizoaffective Disorder, Bipolar type; Type 2 Diabetes Mellitus; Dysphagia following Cerebral Infarction; Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side; Paranoid Schizophrenia; Unspecified Dementia.</p> <p>Review of Resident #67's Annual MDS with an ARD of 01/19/2025 revealed a BIMS summary score not conducted due to Resident #67 is rarely/never understood. Resident #67 required substantial/maximal assistance for transfers and personal hygiene. Resident #67 has parenteral feeding and a PEG tube.</p> <p>Review of Resident #67's Care Plan with a Target date of 02/06/2025 revealed in part .I am NPO (Nothing by Mouth). I have a PEG tube. Interventions included: 06/10/2024-Registered Dietician recommendation to change enteral feeding to continuous. Glucerna 1.5 at 55 ml/hr (milliliters per hour) and water at 45 ml/hr.</p> <p>Review of Resident #67's 01/2025 Physician's Orders revealed in part .enteral feed-Glucerna 1.5 continuous at 55 ml/hr; enteral feed-Enteral Water Continuous: 45 ml/hr per PEG via pump.</p> <p>Review of Resident #67's Progress notes revealed a nursing progress note dated 01/20/2025 revealed in part . Resident lying in bed, PEG running continuous feeding at 55 ml/hr with flush of 45 ml/hr.</p> <p>Observation of Resident #67 on 01/26/2025 at 10:29 a.m. revealed a bottle of Jevity 1.5 with about 600 mls (milliliters) inside hanging on pole, next to Resident #67. Tube feeding turned off, and detached from resident.</p> <p>Observation of Resident #67 on 01/26/2025 at 12:21 p.m. revealed a bottle of Jevity 1.5 with about 600 mls inside hanging on pole, next to Resident #67. Tube feeding turned off, and detached from resident.</p> <p>Observation of Resident #67 on 01/26/2025 at 2:04 p.m. revealed a bottle of Jevity 1.5 with about 600 mls inside hanging on pole, next to Resident #67. Tube feeding turned off, and detached from resident.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with S4 LPN on 01/26/2025 at 2:07 p.m. revealed Resident #67 gets Glucerna 1.5 for tube feeding at a continuous rate. S4 LPN stated she hung the last bottle of Glucerna 1.5 on Friday evening. S4 LPN confirmed the Jevity 1.5 was the incorrect formula administered and the tube feeding was to be continuous and had not.</p> <p>Interview with S2 Interim DON accompanied with S3 ADON on 01/26/2025 at 2:30 p.m. confirmed the above findings.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51096</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary service to maintain good nutrition for 1 (Resident #52) resident reviewed during dining services in a total of 40 sampled residents. The facility failed to provide assistance during meal time to Resident #52.</p> <p>Findings:</p> <p>Review of the Facility's undated Policy titled Meal- Time Assistance Policy and Procedure revealed in part .</p> <p>Policy: All residents who require assistance with meals will be provided assistance.</p> <p>Purpose: To ensure residents receive adequate nutrition.</p> <p>Procedure:</p> <p>1. Assistance will be provided to residents as needed.</p> <p>Review of Resident #52's clinical record revealed an admitted [DATE] with diagnoses which included in part . Huntington's disease, contracture-right hand, drug induced subacute dyskinesia, and deficiency of other vitamins.</p> <p>Review of Resident #52's Quarterly MDS with an ARD of 11/19/2024 revealed a BIMS was not conducted: resident rarely/never understood. Resident had modified independence. Resident used a wheelchair. Resident required setup or clean-up assistance with eating; partial/moderate assistance with oral hygiene, lower body dressing and personal hygiene; supervision or touching assistance with toileting hygiene, showering/bathing, upper body dressing; substantial/maximal assistance with putting on/taking off footwear.</p> <p>Review of Resident #52's Care Plan dated 12/2/2024 revealed in part . I am at risk for weight loss with interventions to include . I need my meals served as ordered by my physician. I require staff assistance for all ADL's with interventions to include . help me with my tray setup and I require assistance with feeding.</p> <p>Review of Resident #52's 01/2025 Physician's Orders revealed in part . Regular diet, Regular texture, Regular Fluid consistency; Double portions and seated at the assist table to be fed with a start date of 11/7/2023.</p> <p>Observation in the Dining Hall on 01/26/2025 at 11:59 a.m. revealed Resident #52 eating lunch that consisted of baked ham, veggie blend, scalloped potatoes and a brownie for dessert. Resident #52 dropped large amounts of food in his lap and his arm shook as he attempted to place potatoes in his mouth. Resident #52 was not being assisted with meal by staff. Observation of Resident #52's meal ticket read to assist with meals.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with S10 CNA on 01/26/2025 at 12:09 p.m. revealed that Resident #52 feeds himself and normally eats all of his food except a few bites. S10 CNA stated that Resident #52 does not sit at the Assistance table.</p> <p>Observation in the Dining Hall for lunch on 01/27/2025 at 11:38 a.m. revealed Resident #52 was seated at the table designated for feeding/assistance with meals. Lunch consisted of chicken fried chicken, creamy white gravy, buttered mashed potatoes, parslied carrots, dinner roll with butter and cake. Food items were removed from serving tray and were placed in front of Resident #52 and a staff member walked away. Resident #52 was observed picking up a large chicken patty and ate it using his hands without assistance from staff. Resident #52 was observed eating with no assistance for 20 minutes. Resident #52 consumed 80% of his meal. A significant amount of food was observed in Resident #52's lap and on his bib. Resident #52 was observed struggling to reach for his cake and this surveyor inquired if he would like assistance. Resident #52 nodded and stated yeah. This surveyor notified staff.</p> <p>Interview with S11 CNA on 01/27/2025 at 11:59 a.m. revealed Resident #52 was to be assisted with meals and was not.</p> <p>Interview with S3 ADON on 01/27/2025 at 12:04 p.m. confirmed that Resident #52 should have been assisted with his meal, but was not.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46773</p> <p>Based on interview and record review, the facility failed to ensure staff followed a resident's person centered plan of care, by failing to use 2-person physical assistance when transferring a resident from wheelchair to bed for 1 (Resident #55) of 3 (Resident #55, Resident #79, and Resident #251) residents reviewed for accidents.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled Transfer Activities Policy and Procedure on 01/28/2025 revealed in part . Purpose: To transfer the resident from bed to chair or toilet safely. Procedure: 1. Obtain assistance of another individual if necessary, for safe transfer.</p> <p>Review of Resident 55's medical records revealed an admitted [DATE] with diagnoses that included: Hypertensive Heart disease with Heart Failure, Schizoaffective Disorder, Major Depressive Disorder, and Peripheral Vascular Disease.</p> <p>Review of Resident #55's Quarterly MDS with an ARD of 09/17/2024 revealed a BIMS score of 14, indicative of intact cognition. Resident #55 required 2-person physical assist for bed mobility and transfers. Resident #55 had range of motion impairment for bilateral upper and lower extremities and required a wheelchair device for mobility.</p> <p>Review of Resident #55's Care Plan with a Target date of 04/06/2025 revealed in part .</p> <p>Resident #55 is at risk for falls related to a history of unsteady balance, seizure activity and cognitive deficits. Interventions included in part . Assess for any injuries with any fall and Hoyer Lift Transfer (11/27/2024).</p> <p>Review of a facility report dated 11/27/2024 revealed in part S5 CNA was putting Resident #55 into the bed and he pulled against her, which caused him to hit his head leaving a superficial laceration with moderate amount of blood. Resident #55 was seen by the facility MD who was visiting at the time with new orders to continue neuro checks. Resident #55 had complaints of pain and Tylenol was given. Resident #55 stated he hit his head while getting into bed.</p> <p>Interview on 01/27/2025 at 2:17 p.m. with S5 CNA revealed Resident#55 was a 2-person assist with hoyer lift. S5 CNA revealed on 11/27/2024 she transferred Resident #55 by herself without a hoyer lift after calling for help from fell ow staff, but no one came. S5 CNA stated during the transfer Resident #55 tensed, jerked backwards, and hit his head on the wooden headboard that caused a cut to the back of his head and it began bleeding. S5 CNA stated she immediately notified the nurse on duty and the MD was called.</p> <p>Interview on 01/28/2025 at 08:38 a.m. with Resident #55 stated he recalled a staff member transferred him and he cut on his head on his headboard. Resident #55 stated the laceration did not require a bandage.</p> <p>(continued on next page)</p>		

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 01/28/2025
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/28/2025 at 1:45 p.m. with the facility MD revealed he made a visit on Resident #55 on the day of the incident. The facility MD revealed Resident #55's laceration to his head was superficial and he did not feel as though wound care was necessary as the bleeding had already stopped. The facility MD stated at the time Resident #55's neuro exam was normal and he did not feel as though he needed to be sent out to the hospital for further testing. The facility MD stated he ordered staff to continue neuro checks on Resident #55 and to notify him for any changes in his condition.</p> <p>Interview on 01/28/2025 at 1:05 p.m. with S3 ADON revealed Resident #55's transfer status prior to the incident on 11/27/2024 was 2-person physical assist. S3 ADON revealed on 11/27/2024 Resident #55 was being put back to bed by S5 CAN, and he pulled against her, and hit his head. S3 ADON stated Resident #55 was assessed, the MD was notified, and neuro checks were initiated. She revealed all CNA and nursing staff were in-serviced on transfers.</p> <p>Interview on 01/28/2025 at 1:25 p.m. with S2 Interim DON revealed that she started as interim DON in the facility 2 days ago. S2 Interim DON reviewed the investigation of the incident that occurred on 11/27/2024 and stated that due to poor communication, Resident #55 was transferred by 1 staff member resulting in a superficial laceration to his head after hitting his headboard. S2 Interim DON confirmed that Resident #55 should have been transferred by 2 staff members at the time of the incident, but was not.</p>		

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NAME OF PROVIDER OR SUPPLIER Legacy at St Christina		STREET ADDRESS, CITY, STATE, ZIP CODE 122 Hillside Drive Pineville, LA 71360	
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44844</p> <p>Based on observation, interview and record review the facility failed to provide respiratory care consistent with professional standards for 2 (Resident #67 and Resident #81) of 4 sampled Residents reviewed for respiratory care. The facility failed to ensure equipment was properly labeled and stored. Total sample size was 40.</p> <p>Findings:</p> <p>Resident #81</p> <p>Review of Resident #81's medical record revealed an admitted [DATE] with diagnoses that included in part . Chronic Obstructive Pulmonary Disease, Asthma, Respiratory Infection, Pneumonia in Diseases Classified Elsewhere and Dementia.</p> <p>Review of Resident #81's active Physician orders revealed the following order with a start date of 08/23/2024:</p> <p>Administer Oxygen at 2 Liters per minute via nasal cannula as needed for Shortness of Breath.</p> <p>Review of Resident #81's Care Plan with a Target date of 02/04/2025 revealed in part .I have Asthma, Chronic Obstructive Pulmonary Disease or Chronic Lung Disease with interventions that included in part .I need Oxygen when I have a respiratory crisis, administer nebulizer treatments as ordered.</p> <p>Observation on 01/26/2025 at 11:00 a.m. of Resident #81's nasal cannula revealed it lying on top of an oxygen concentrator uncovered and undated.</p> <p>Interview on 01/26/2024 at 11:17 am with Resident #81 revealed he had his oxygen on the previous night and that morning.</p> <p>Interview on 01/26/2025 at 11:48 a.m. with S9 LPN revealed Resident #81 used his oxygen as needed. S9 LPN confirmed resident #81's nasal cannula was uncovered and undated and it should have been.</p> <p>51082</p> <p>Resident #67</p> <p>Review of Resident #67's medical record revealed an admitted [DATE] with a re-entry date of 05/07/2024 with diagnoses that included in part .Cerebral infarction unspecified; Schizoaffective Disorder, Bipolar type; Type 2 Diabetes Mellitus; Acute Bronchiolitis; Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side; Paranoid Schizophrenia; and Unspecified Dementia.</p> <p>Review of Resident #67's Annual MDS with an ARD of 01/19/2025 revealed a BIMS summary score was not conducted due to Resident #67 is rarely/never understood.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Legacy at St Christina		STREET ADDRESS, CITY, STATE, ZIP CODE 122 Hillside 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.

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #67's 01/2025 physician orders revealed in part .12/14/2024: Ipratropium-Albuterol Solution-1 vial inhale orally every 4 hours as needed; Airway Inhalation Treatment.</p> <p>Review of Resident #67's Care Plan with a target date of 02/06/2025 revealed in part . I am on a Respiratory Therapy Program. Interventions: Administer my nebulizer treatments as ordered by my physician. Watch me for any side effects and effectiveness of medication.</p> <p>Observation of Resident #67 on 01/26/2025 at 10:29 a.m. revealed a nebulizer concentrator and respiratory suction uncovered and undated.</p> <p>Observation of Resident #67 on 01/26/2025 at 12:21 p.m. revealed nebulizer concentrator and respiratory suction uncovered and undated.</p> <p>Observation of Resident #67 on 01/26/2025 at 2:04 p.m. revealed nebulizer concentrator and respiratory suction uncovered and undated.</p> <p>Interview with S4 LPN on 01/26/2025 at 2:07 p.m. confirmed the nebulizer and respiratory suction should have been covered and dated, but had not.</p>

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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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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>44844</p> <p>Based on record review and interview the facility failed to ensure there was sufficient nursing staff available at all times to provide nursing and related services to meet the resident's needs and safety in a manner that promotes each residents rights, physical, mental and psychosocial well-being. The facility failed to ensure there was sufficient staff on Saturday 09/28/2024, to provide care and services for residents residing in the facility. The facility census was 96.</p> <p>Findings:</p> <p>Review of the Payroll Based Journal (PBJ) staffing data submission for fiscal year 2024, Quarter 4 revealed in part .one star staffing rating (triggered), and excessively low weekend staffing (triggered).</p> <p>Review of a Staffing Pattern Reporting Form for 07/01/2024 - 09/30/2024 revealed in part . On 09/28/2024, the facility's census was 110 residents. Minimum staffing hours required for that day was 258.5 hours; however, the total number of nursing hours provided on 09/28/2024 was 256.5.</p> <p>Interview on 01/28/2025 at 4:56 p.m. with S2 Interim DON, confirmed the facility did not provide sufficient nursing staff hours on 09/28/2024. S2 Interim DON confirmed the facility was 2 hours short of the minimum required hours to meet the residents' needs and safety.</p>		