STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676238	A. Building B. Wing	10/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - North	11020 Dessau Rd Austin, TX 78754

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observations, interviews and record review the facility failed to ensure personal privacy include personal care. The facility must protect and promote the rights of the resident for 1 of 8 (#14) residents in that Resident #14 was observed twice in a public area with parts of her breast showing from her slit dress on the sides. This failure could affect all residents and could result in a loss of dignity and respect at the facility. The Findings were: Record review of Resident #14's face sheet dated 10/13/2022 revealed she was admitted on [DATE]. readmitted on [DATE] with diagnoses of schizophrenia, mood disorder, need assistance with personal care, abnormal posture, vascular dementia, major depressive disorder, encephalopathy, abnormalities of gait and mobility and generalized muscle weakness. Record review of Resident #14's [NAME] assessment dated [DATE] revealed section C-Cognitive Patterns was a BIMS score of 7/15 (severe impairment), section C Delirium-she had disorganized thinking, section G-Functional Status she required extensive assistance with her ADLs, dressing, she had no impairments in extremities, she mobilized with a wheelchair, and section H she was incontinent of bowel/bladder. Record review of Resident #14's care plan dated 8/9/2022 revealed her ADL self-Care performance defect related to debility, dementia for .dressing . staff propels wheelchair for mobility, promotes dignity by ensuring privacy, required 2-person transfer with Hoyer lift. Resident #14 had an ADL self-care performance deficit related it debility, dementia, staff propels wheelchair for mobility, promote dignity by ensuring privacy, transfers with 2-person assistance with Hoyer lift, and she required 2-person assistance to dress. Observation on 10/12/2022 at 2 PM in the small dining room Resident # 14's was sitting in her wheelchair and part of her breast was exposed. Interview on 10/12/2022 at 2:05 PM revealed Resident #14 was not interviewable and did not respond to questions. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/12/2022 at 2:08 PM with wound care nurse verbally confirmed Resident #14's part of breast was exposed in public area due to slit on the sides of her dress. Observation on 10/13/2022 at 2:12 PM in the large dining room Resident # 14's was sitting in her wheelchair and part of breast was exposed. Interview on 10/13/2022 at 2:14PM with wound care nurse confirmed Resident $14's part of dress was exposed in public area due to slit on the sides of her dress. The wound care nurse reported to the DON that Resident #14's dresses and exposed her breast. The wound care nurse stated she noticed several dresses that were slit on the sided and were brought in by family. Interview on at 10/14/2022 at 9:51 AM CNA F stated Resident #14 was a 2 person assist, she stated she put her dress on that day, the family does not want her wearing brazier, so she said she tried to tuck in her slit dress on the sides, into the wheelchair, so her breast does not come out. CNA F stated Resident #14 part of breast had not happened while she was in a public area, but Resident #14 tends to maneuver her breast with her hand. CNA F stated Resident #14 was confused at times and had seen her breast exposed when in her room, in private area. CNA F stated she had not noticed any other resident with inappropriate clothing. CNA F stated the family brought the several dresses with the sides slit. Interview on at 10/16/2022 at 10:43 AM with the DON stated she pulled the dresses with slits on the side and called family. The DON stated its a team efforts to make sure residents wear clothes that are appropriate and to communicate to departments with any concerns and talk to family. Record review of policy Resident Rights, dated 10/4/2016 revealed Respect and Dignity, you have the right to be treated with respect and dignity, including the right to: reside and receive services in the facility with reasonable accommodation of your needs and preferences .

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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 - Immediate jeopardy to resident health or safety 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** 41937 Based on observations, interviews, and record reviews the facility failed to prevent the use of verbal, mental, physical abuse, and/or corporal punishment for 2 of 3 residents (#24 and #75) reviewed for abuse. 1. Resident #24 experienced a fractured wrist when CNA A attended her bedside. The facility did not assess all residents for safety. The facility did not in-service all staff for abuse, neglect, exploitation prevention. 2. Resident #75 was a victim of verbal/mental abuse that resulted in Resident #75 being sent to the hospital via ambulance and received medications. An IJ was identified on 10/14/2022. The IJ began on 10/3/2022 and removed on 10/4/2022. The facility took action to remove the IJ before the survey began. While the IJ was removed on 10/4/2022, the facility remained out of compliance at a scope of isolated and a severity level of actual harm because all staff had not been trained on abuse and neglect policies and procedures. These failures could place residents at risk for harm by physical, verbal, mental, abuse. The findings include: A record review of Resident #24's admission record, dated 10/14/2022, revealed an admitted [DATE] with diagnoses which included vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain), hemiplegia and hemiparesis (a complete loss of strength or paralysis on one side of the body), displaced oblique fracture of shaft of left ulna (a broken forearm where the break is at an angle and the bone has moved out of alignment). A record review of Resident #24's annual MDS assessment, dated 8/05/2022, revealed, Resident #24 was [AGE] years old resident, who had been residing at the facility for the past 6 years. Resident #24 had no hearing difficulties, used glasses, had clear speech and could make themselves understood as well as could understand others. Resident #24 had upper mobility limitations and required extensive 2 person assist with activities of daily life. Resident #24 required a wheelchair and could not walk. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a record review of the facilities provider investigation report dated 10/03/2022 revealed the statement made by LVN B, statement from LVN B 7P-7 A 10/3/2022 at 4:00 AM resident was yelling from her room business went to resident room approximately at 4:00 AM, 10/3/2022 resident in bed supine position. I asked resident if anything wrong. residents start complaining that CNA that black lady she came and changed my brief she punched my mouth and twisted my left arm. resident mouth had dry blood and lips. assessment done head to toe. fresh blood on left side upper gum noted and dry blood on lips. no other bruises of redness noted. Resident Evil to move upper and lower extremities except pain to left forearm and left wrist. CNA removed from room and sent home. deal when and RN C in facility notified. on call nurse practitioner notified and new orders received for staff X-ray left shoulder, elbow, and wrist. family brother notified and situation explained to brother. in addition to my statement; approximately at 4:00 AM when this nurse went to the residence room due to resident yelling out, I entered room I asked Resident #24 what's wrong and she told me black lady came changed my brief and punched me in my mouth and twisted my left arm. while this nurse was talking to resident CNA A came in room and telling patient, you accusing me I punched you and hurt you. I haven't even made it into your room. I didn't change you yet. I asked her CNA A what time you came last time and CNA A said, around 1:00 AM to 1:30 AM I haven't changed her and she's accusing me, I'm gonna lose my job. CNA A said, let me change her. this nurse told CNA A let me check her and you can go. when this nurse opened patients brief the brief was completely dry. During an interview on 10/12/2022 at 10:20 AM the ADON stated the facility learned of an allegation of physical abuse incident on the early morning of 10/3/2022 involving Resident #24 and CNA A. The ADON stated the facility initiated an investigation which resulted in the termination of CNA A. The ADON stated he was responsible for assessing Resident #24's peers for safety and assessed 4 residents on Resident #24's hallway, 400-Hall, after the report of the abuse allegation, Residents #16, #38, #52, and #66. The ADON stated no other residents were assessed for safety. The ADON stated CNA A routinely worked on the hallway Resident #24 resided on. A record review of the facility's 10/2/ to 10/3/2022 staff schedule revealed CNA A was assigned CNA duties on 400-hall. Further reviews of the facility's schedules revealed CNA A was assigned 100-hall and also 400-hall CNA duties the previous week. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/12/2022 at 11:10 AM the DON stated the facility learned, early in the morning of 10/3/2022, Resident #24 alleged CNA A hurt her. The DON stated the facility maintained cameras with recording capabilities on the hallway Resident #24 resided on (400-hallway). The DON stated she reviewed the recordings which reflected 10/03/2022 02:00 AM to 06:00 AM. The DON stated the footage revealed CNA A checked on Resident #24 several times prior to 05:00 AM, in refute to CNA A claims she had not. The DON stated the recording revealed just prior to 05:00 AM CNA A made a body gesture prior to entering the room which was interpreted by the DON as a deep breath motion with hand gestures, entered the room and after a couple of minutes exited the room and entered the adjacent room across the hallway, left the door ajar, and watched Resident #24's door. The DON stated at this time in the timeline Resident #24 began loudly calling out for help to which LVN B came to Resident #24's bedside. The DON stated while LVN B was attending Resident #24 and receiving report CNA A entered the room and began yelling at Resident #24, why are you lying! .i have not been in your room! . The DON stated LVN B de-escalated the incident and removed CNA A from the room, CNA A was asked to leave the room and CNA A wrote a statement. The DON stated LVN B reported Resident #24 claimed CNA A hit her. The DON stated LVN B reported the incident to RN C and RN C reported the allegation to her, DON. The DON stated she had CNA A clock out and suspended CNA A pending an investigation. The DON stated the Administrator was given a report and the Administrator reported the incident to the state agency. The DON stated the investigation revealed CNA A was inconsistent with her accounts of the incident, Resident #24 was diagnosed with a left ulna, forearm, fracture, and CNA A was terminated on 10/6/2022. The DON stated 4 residents were assessed for safety and an in-service for abuse, neglect, and exploitation prevention was prepared and all staff were in the process of receiving the in-service. The DON stated the in-service record was in the in-service logbook at the nurse's station. The DON stated the ADON also in-serviced staff at a staff meeting on 10/7/2022. The DON stated not all staff had been in-serviced but were being in-serviced as they reported to work. A record review of Resident #35's admission record revealed an admitted [DATE], with diagnoses which included moderate dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), hypertension (high blood pressure), and osteoarthritis (the protective cartilage that cushions the ends of the bones wears down over time). During an observation and interview on 10/12/2022 at 1:48 PM Resident #35 stated, she was an auditory witness to the alleged abuse of her roommate Resident #24 on the early morning on 10/3/2022. Resident #35 stated CNA A had been in their room several times that early morning. Around 5:00 AM she heard CNA A and Resident #24 yelling out. I heard her (CNA A) yell at her (Resident #24), cuss at her, and I heard them wrestling; with Resident #24 crying out and yelling back STOP HITTING ME .OWW!, CNA A yelled back at her MOVE YOUR HAND! Resident #24 yelled I CAN'T!. Resident #35 stated she heard CNA A leave and Resident #24 continued to cry out for help. LVN B entered the room and received report from Resident #24 that she had been hit by CNA A. Resident #24 stated, that black B**** hit me!. CNA A entered the room and Resident #24 identified CNA A as hitting her. CNA A continued yelling at Resident #24 and accused Resident #24 of lying and left the room. During an observation and interview on 10/13/2022 at 01:12 PM Resident #24 was in her room seated in her wheelchair. Resident presented with a soft cast to her left wrist. Resident #24 stated someone hit her [when she referred to her soft cast] but could not remember any further details. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/14/2022 at 11:45 AM Resident #24's Representative stated the facility's SW called him on in the morning of 10/03/2022, between 7-9 AM. The SW said there was an incident, [Resident #24] was screaming and when the nurse went into Resident #24's room, Resident #24 stated CNA A twisted her arm, slapped her face, and covered her mouth. Resident #24's representative stated the SW reported they found blood in Resident #24's mouth. Resident #24's representative stated the DON called him later that day (10/3/2022), she told me they were investigating and getting x-ray's .I called her back and she told me CNA A was fired. Resident #24's representative stated the x-rays revealed Resident #24 had a fractured left forearm bone and Resident #24 was sent to the hospital for treatment of the broken forearm. Resident #24's representative stated, he and Resident #24 attended an orthopedic specialist appointment after the fracture was discovered, The doctor reported Resident #24 received the fracture from a grabbing twisting motion, not consistent with a fall. A record review of the facility's human resources employee time records during the period 10/3/2022 to 10/10/2022 revealed 109 employees worked in the facility. A record review of the facility's in-service logbook revealed an abuse, neglect, exploitation prevention in-service dated 10/3/2022, indicated only 26 unique staff signed they received the in-service. A record review of the facility's in-service logbook revealed an abuse, neglect, exploitation prevention in-service dated 10/7/2022, indicated only 27 unique staff signed they received the in-service. A record review of the facility's 400-hall (the hall Resident #24 resided on), census dated 10/3/2022 revealed, the facility's 400-hall had 29 available beds with only 1 bed empty. Personnel file for CNA A reviewed, no concerns regarding checks completed and no disciplinary action occurred prior to this event. Record review of Resident #24's medical records revealed x-rays images, dated 10/3/2022, which revealed a fracture to Resident #24's left Forearm at the wrist. During an interview on 10/16/2022 at 01:37 PM the administrator stated, The question on why the IJ happened, I don't believe the in servicing was effective to reach all levels of staff, prior t the IJ. The Administrator stated more residents who were cared for by CNA A, could have been assessed for safety. 2. Record review of Admission Record, printed 10/14/2022 at 3:36 PM, revealed Resident #75 was a [AGE] year-old-female, admitted [DATE] with the following diagnoses: conversion disorder with seizures or convulsions [mental condition in which a person experiences neurologic symptoms not associated to illness or injury; symptoms are real and beyond the persons control]; chest pain; non-ST elevation myocardial infarction [less damage causing form of a heart attack]; coronary artery disease [major blood vessels of the heart narrow] without angina pectoris [chest discomfort or shortness of breath]. Record review of Brief Interview for Mental Status (BIMS) single page form, dated 7/28/2022 signed by the SLP, revealed a BIMS score of 14/15 for Resident #75 [indicative of intact cognition]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review quarterly MDS [Minimum Data Set] dated 7/31/2022 revealed, Resident #75 had a Summary BIMS score of 10, indicative of moderately impaired cognition with fluctuating disorganized thinking and received psychological therapy on 2 days for at least 15 minutes in the 7 days prior to the MDS submission. Record review of Nursing Progress Note written by LVN JJ on 7/26/2022 at 7:16 AM revealed Resident #75 had complaints of chest pains, received 2 doses of 0.4 [Nitrostat] with no resolution of pain; sent to emergency room via emergency medical services. Record review of Medication Administration Record for July 2022 revealed Resident #75 received 2 doses of Nitrostat Sublingual 0.4 milligram on 7/25/2022 . Record review of hospital Discharge Instructions dated 7/27/2022 revealed Resident #75 had troponin levels less than 0.1 nanograms per milliliter [elevated troponin levels, greater than 0.4 nanograms per milliliter indicate a cardiac event]. admitted [DATE] at 2:57 AM. Reason for visit listed as CP [chest pain]. In addition to laboratory results, documentation revealed Resident received a chest x-ray and an abdominal ultrasound [reports not included]. Record Review of Nursing Progress Note written by LVN JJ on 7/28/2022 at 7:40 AM revealed Resident #75 was readmitted to facility. Record review of Psychological Services Progress Note dated 7/29/2022 at 5:20 PM by PSY D [Psychology Doctor] revealed documentation that Resident #75 expressed anxiety associated with a recent encounter with nursing staff. Record Review of email dated 7/29/2022 at 5:15 PM from PSY D to the ADM [Administrator], the SW [Social Worker], and the DON [Director of Nursing] revealed notification of Resident #75 concern that her recent hospitalization was prompted by an argument Resident #75 had with an unnamed nursing staff. Record review of single page In-Servicing dated 7/29/2022 signed by CNA E indicates topics presented by the ADON included: Talk to residents with dignity and respect; Ensure appropriate communication with family and residents; Continue to provide excellent care to residents; Try to keep your voice at a modest level when talking with residents; Keep them informed with what is going on. Simple comments like I'll be back in 5 minutes to check on her goes a long way. In a group interview on 10/13/2022 at 10:58 AM with the DON and ADON, the ADON stated their policies and procedures to prevent abuse begins at recruiting, we check employees backgrounds, EMR [Employee Misconduct Registry], OIG [Office of Inspector General], checking references and skills check offs. The DON stated the facility reinforced training and education via [computer-based training] courses completed within the first 21 days of employment, Abuse/Neglect/Exploitation, reporting burnout, On-The-Job training and the administrative staff was on the floor and met residents, talked to staff, managed burn out by giving staff positive feedback, providing morale boosters. The DON stated the facility reinforced training for reporting immediately any allegations of Abuse/Neglect/Exploitation and identified to all staff the Abuse Prevention coordinator as the ADM. The DON stated the SW has also provided reinforced training for reporting any grievances. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 10/13/2022 at 1:45 PM, Resident #75 stated she was speaking with her roommate's family regarding care not provided timely to the roommate when an unnamed CNA rushed into the room, and yelled, You don't need to telling (sp) about other residents! Resident #75 clutched one hand at the base of her throat when she relayed, This startled me and scared me. Resident #75 stated she started having chest pains after that. Resident #75 reported having chest pains to the nurse on duty and received 2 doses of Nitroglycerin. Resident #75 stated the pain continued and an ambulance was called to take her to the hospital. Resident #75 stated she knew it wasn't a real heart attack when the chest pain evaporated as soon as the ambulance pulled into the hospital parking lot. It was like I just needed to get away from here. Resident #75 stated she was embarrassed she was taken by ambulance to the hospital and, It wasn't a real emergency. Resident #75 further stated that she felt that the unnamed CNA tore her up for speaking out of turn even though the family of her roommate specifically asked her to keep an eye on their loved one. Resident #75 stated this had occurred several months ago, and that she had no problems with the CNA since then . Resident #75 could not recall the name of the CNA. Resident #75 stated the CNA was still working, but she had not seen her for several days. Resident #75 provided description: female, big butt. In an interview on 10/13/2022 at 7:30 PM, the DON recalled being notified afterhours that Resident #75 had some issue regarding an interaction with staff. The DON stated she tasked the ADON with speaking with resident about the situation. The DON stated the focus was more on the fact that Resident #75 was relaying HIPAA type information about other residents and should not be responsible for relaying details to the family members. The DON stated Resident #75 had a big heart and was very protective of her peers, especially her roommate. The DON stated at the time, the events did not rise to the level of an allegation of abuse. In an interview on 10/14/2022 at 9:25 AM the DON stated Resident #75 was assessed on the evening of 10/13/2022 and had no signs or symptoms of distress. The DON stated that the allegation of abuse was reported within 1 hour of learning about Resident #75's recollection of the event on 10/13/2022. The DON stated that upon further review and through their internal investigation the alleged perpetrator was CNA E, who was currently on leave. The DON stated the Nurse on duty had quit and did not return any of the facility phone calls. The DON provided telephone contacts for both CNA E and LVN JJ. [Neither CNA E nor LVN JJ returned phone calls for interviews prior to exit of survey.] In an interview on 10/14/2022 at 10:42 AM, the ADON stated he had assessed Resident #75 back then at the time she returned from the hospital, as instructed by his DON and the event was not recalled in a way that rose to the level of an allegation of abuse. The ADON stated he provided an on-the-spot In-Servicing on customer service to CNA E. In a group interview on 10/14/2022 at 11:19 AM, with the ADM, DON and ADON present, the DON stated the incident occurred towards the end of July 2022. The DON stated the ADM, the DON, and the SW were made aware via an email from the Psychologist that Resident #75 was upset about an interaction with nursing staff causing Resident #75 being sent to the hospital. The DON then notified the ADON to assess Resident #75. The ADON stated the allegation was not reported as it did not rise to the level of verbal abuse based on the assessment at the time. The DON stated the alleged staff member continued to work, after being in-serviced. The DON stated the alleged staff member was not currently working as she was on leave, out of state for a funeral. The DON stated the last time the alleged staff member worked was more than a week prior to survey entrance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a group interview on 10/14/2022 at 11:27 AM with the SW, DON and ADM, the ADM stated she had reported to state on 10/13/2022 for possible abuse based on the 10/13/2022 conversation with Resident #75. The DON stated the resident indicated she felt startled. The DON stated she did not feel it was verbal abuse, but the resident seemed intimidated by the loud volume, and harsh tone of voice CNA E used. The DON stated the CNA would be trained upon return to work. The DON stated an additional training course would be provided to all staff entitled, Trust Building Through Effective Communication. The ADM added she concurred with the DON and ADON responses to questions and added, we don't put anybody on the floor without the training needed; and I supervise my staff. In an interview on 10/14/2022 at 2:30 PM, the PsyD stated Resident #75 expressed being embarrassed for being sent to the hospital after having an altercation with the CNA that triggered chest pain. The PsyD stated the session was on 7/29/2022 between 4:40 and 5:20 PM. The PsyD stated after reviewing the notes she made at the time, she characterized the event as an argument. The PsyD stated Resident #75 would initially minimize her emotional state but would eventually accurately report her state of mind after some rapport building. PsyD stated since that event, Resident #75 had not displayed any increase in maladaptive behaviors or reported a decrease in engaging in coping mechanisms. PsyD stated Resident #75 had not reported increased intensity or frequency of anxiety. PsyD stated she immediately reported the concerns via email to the ADM, the SW and the DON. In an interview on 10/16/2022 at 11:03 AM Resident #75 stated she had been checked on by facility staff but could not recall any of the questions they might have asked. Resident #75 stated she had no concerns with abuse or neglect and had no fear of staff or residents at this facility. Resident #75 reiterated she had a problem when one staff member tore me up one side and down another, a few months back when she was overheard responding to her roommates' family when they asked how the roommate was being treated. Resident #75 stated tore me up meant the staff scolded her loudly for providing information to the family. Resident #75 stated at the time, it made her mad because she felt she was doing the right thing for her roommate, then it made her feel bad, as if she had done something wrong to upset her care providers. Resident #75 reiterated that this was the event that sent her to the hospital unnecessarily a few months back. Resident #75 stated she was embarrassed she used up all those resources and it was just a panic attack. Record review of Nursing Administration Policy/Procedure under Leadership section, and Nursing Services subject, revised 05/2007, revealed Each Resident is free from verbal, sexual, physical or mental abuse, corporal punishment, and involuntary seclusion. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - North	11020 Dessau Rd Austin, TX 78754

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Policy/Procedure-Administration under Section: Resident Rights and Subject: Abuse - Prevention of And Prohibition Against, revised 11/28/2017, revealed, it is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Further under section C Training, topics included prohibiting and preventing all forms of abuse .; identifying what constitutes abuse .; recognizing signs of abuse .; reporting abuse .; procedures for reporting incidents; understanding behavior symptoms of residents that may increase the risk of abuse and neglect and how to respond. These symptoms include . aggressive and or catastrophic reactions of residents. Under section D - Prevention, the facility will take action to prove protect and prevent abuse . By supervising staff to identify and correct any inappropriate or unprofessional behaviors. Under section E identification the facility will assist staff in identifying abuse . including mental slash verbal abuse . In addition, under Section I - Definitions, abuse is defined as willful infliction of entry, unreasonable confinement, intimidation . with resulting physical harm pain or mental anguish. Willful as used in this definition of abuse means individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. During an interview on 10/16/2022 at 01:37 PM the administrator stated, The question on why the IJ happened, I don't believe the in servicing was effective to reach all levels of staff. Due to the above failures this was determined to be an Immediate Jeopardy (IJ) on 10/14/2022. The administrator was notified. The Administrator was provided with the IJ template on 10/14/2022 at 05:40 PM. The facility's Plan of Removal was accepted on 10/15/2022 at 10:00 AM and included: Verification -of the facility's Plan of Removal for Legend Oaks North [NAME] and surveyors monitoring: Immediate Action Medical Director / Resident's physician notified of IJ. During an interview on 10/15/2022 4:16 PM the medical Director stated the facility reported the incident on 10/3/2022 where Resident #24 was diagnosed with a left wrist ulna fracture allegedly by CNA A's mistreatment. The Medical Director stated he reviewed the Plan of Removal and was satisfied and had no new orders. In-service with quiz was started on 10-14-22 for employees. The in-service will include: a. Types of abuse with definitions, b. Contact and name of Abuse Coordinator c. Timeframes for reporting RN Clinical Resource to review facility ANE policy with leadership team. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/15/2022 at 4:02 PM the DON stated she, and the facility's leadership received training from the facility's RN Clinical Resource Nurse to include the HHSC Power Point presentation Abuse, Neglect, and Exploitation (ANE) in long-Term Care. A record review of the facility's IJ Plan of removal in service records, dated 10/15/2022, revealed Abuse, Neglect, Exploitation Post Test: 1. Abuse can be willful and negligent physically, emotionally and sexually. True / False; 2. Give 3 examples ____; 3. One of the signs of neglect is you forgot to give the Resident a toast on her breakfast tray. True / False .(etc). A record review of the facility's IJ in-service training, dated 10/15/2022, revealed the facility utilized the HHSC Abuse, Neglect, and Exploitation (ANE) in long-Term Care, Power Point training. Further review revealed an attendance sign in sheet which included: LNFA Administrator RN DON RN CR During an interview on 10/15/2022 at 4:20 PM the DON and the Administrator stated the residents were assessed for Brief Mental Interview Statuses and assessed for safety and injury, 100% of the residents who were scored between 12-15, no mental cognitive impairment. A record review of the facility's Resident Safe Survey records, dated 10/14/2022 through 10/15/2022, revealed 100% of the residents who had no mental cognition impairment, were assessed for safety and injury, Here at [Facility] has a staff member ever been rough with you or hurt you? Made you feel afraid or humiliated / degraded? Said mean things to you, hurt you (hit, slapped, shoved, handled you roughly) made you feel uncomfortable (touched you inappropriately)? .[etc.,] ED, DON or designee will oversee completion of training and conduct training Completion of training will be 10/15 and those on leave have been contacted and instructed to complete training prior to working assigned shift. All new hires will complete training during orientation and before working first shift. During observations, interviews, and record reviews from 10/14/2022 to 10/16/2022 surveyors interviewed all staff, who were not on leave, regarding ANE training and reviewed records regarding ANE in-service training. During an Interview on 10/16/2022 at 4:30 PM the DON stated she and her ADON and charge nurses had supervised and ensured all employees completed the in-service training to include Abuse, Neglect, Exploitation Prevention and Reporting. Interviews for 06:00 AM to 2:00 PM work shift: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/15/2022 at 12:30 PM CNA Z stated she works on the 6:00 AM to 2:00 PM shift. CNA Z stated she received in-service training on the evening of 10/14/2022 in a staff meeting where she was given instructions on who was the abuse, neglect exploitation coordinator, the administrator, and educated on the different types of abuse, sexual, physical, mental, and verbal. CNA Z stated she was to immediately report any allegations of ANE. During an interview on 10/15/2022 at 12:30 PM CNA F stated she works on the 6:00 Am to 2:00 PM shift. CNA F stated she received in-service training on the evening of 10/14/2022 in a staff meeting where she was given instructions on who was the abuse, neglect exploitation coordinator, the administrator, and educated on the different types of abuse, sexual, physical, mental, and verbal. CNA F stated she was to immediately report any allegations of ANE. During an interview on 10/15/2022 at 1:30 PM CNA FF stated she works on the 6:00 Am to 2:00 PM shift. CNA FF stated she received in-service training on the evening of 10/14/2022 in a staff meeting where she was given instructions on who was the abuse, neglect exploitation coordinator, the administrator, and educated on the different types of abuse, sexual, physical, mental, and verbal. CNA FF stated she was to immediately report any allegations of ANE. Interviews for 02:00 PM to 10:00 PM work shift: During an interview on 10/15/2022 at 02:43 PM MA BB stated he works on the 6:00 Am to 2:00 PM shift. MA BB stated he received in-service training on the evening of 10/14/2022 in a staff meeting where she was given instructions on who was the abuse, neglect exploitation coordinator, the administrator, and educated on the different types of abuse, sexual, physical, mental, and verbal. MA BB stated she was to immediately report any allegations of ANE. During an interview on 10/15/2022 at 03:57 PM LVN CC stated he works on the 02:00 PM to 10:00 PM shift. LVN CC stated he received in-service training on the evening of 10/14/2022 in a staff meeting where he was given instructions on who was the abuse, neglect exploitation coordinator, the administrator, and educated on the different types of abuse, sexual, physical, mental, and verbal. LVN CC stated he was to immediately report any allegations of ANE. During an interview on 10/15/2022 at 08:57 PM CNA Y stated he works on the 02:00 PM to 10:00 PM shift. CNA Y stated he received in-service training on the evening of 10/14/2022 in a staff meeting where he was given instructions on who was the abuse, neglect exploitation coordinator, the administrator, and educated on the different types of abuse, sexual, physical, mental, and verbal. CNA Y stated he was to immediately report any allegations of ANE. In an interview on 10/15/22 at 7:15 p.m. with CNA O stated she work the day and evening shift (6-2 shift and 2-10 shift). CNA O stated she was in-serviced on 10/14/22 on abuse, the different types of abuse, reporting abuse, and signs of abuse. The CNA O was able to state the different types of abuse, signs of abuse and would report abuse right away to the Administrator who was the Abuse Coordinator. Interviews for the 10:00 PM to 06:00 AM shift: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/15/2022 at 03:23 PM CNA DD stated he works on the 10:00 PM to 06:00 AM shift. CNA DD stated he received in-service training on the evening of 10/14/2022 in a staff meeting where he was given instructions on who was the abuse, neglect exploitation coordinator, the administrator, and educated on the different types of abuse, sexual, physical, mental, and verbal. CNA DD stated he was to immediately report any allegations of ANE. In a telephone interview on 10/15/2022 at 8:46 PM, CNA K, who works overnights, stated In-Servicing occurred within the previous 24-hour period that included the types of abuse, neglect, exploitation, and mistreatment; how to recognize abuse or neglect to include allegations; who to report to, and the time frame to report. In a telephone interview on 10/15/2022 at 9:30 PM, LVN N, who works overnights, stated In-Servicing occurred within the previous 24-hour period that included the types of abuse, neglect, exploitation, and mistreatment; how to recognize abuse or neglect to include allegations; who to report to, and the time frame to report. Interviews for the 07:00 AM to 07:00 PM work shift: During an interview on 10/15/2022 at 1:30 PM LVN AA stated she works on the 7:00 AM to 7:00 PM shift. LVN AA stated she received in-service training on the evening of 10/14/2022 in a staff meeting w [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 32218 44906 Based on observation, interview and record review, the facility failed to ensure that all allegations involving abuse were reported immediately, but no later than 2 hours after the allegation was made to the Administrator of the facility and to other officials including the State Survey Agency (HHSC), in accordance with State law through established procedures for 2 of 4 residents (#75, #254) reviewed for abuse, in that; 1.The facility failed to report to the state agency an allegation of physical abuse from Resident #75. 2. CNA F failed to report to administrative staff an allegation of abuse when Resident #254 stated she hit him in his eye. These deficient practices could place residents at risk for abuse, neglect or mistreatment allegations not being thoroughly investigated which could impact the residents' ability to reach their highest practicable level of wellbeing. The findings were: 1. Record review of Admission Record , printed 10/14/2022 at 3:36 PM, revealed Resident #75 was a [AGE] year-old-female, admitted [DATE] with the following diagnoses: conversion disorder with seizures or convulsions [mental condition in which a person experiences neurologic symptoms not associated to illness or injury; symptoms are real and beyond the persons control]; chest pain; non-ST elevation myocardial infarction [less damage causing form of a heart attack]; coronary artery disease [major blood vessels of the heart narrow] without angina pectoris [chest discomfort or shortness of breath]. Record review of Brief Interview for Mental Status (BIMS) single page form, dated 7/28/2022 signed by the SLP, revealed a BIMS score of 14/15 for Resident #75 [indicative of intact cognition]. Record review quarterly MDS [Minimum Data Set] dated 7/31/2022 revealed, Resident #75 had a Summary BIMS score of 10, indicative of moderately impaired cognition with fluctuating disorganized thinking and received psychological therapy on 2 days for at least 15 minutes in the 7 days prior to the MDS submission. Record review of Nursing Progress Note written by LVN [Licensed Vocational Nurse] JJ on 7/26/2022 at 7:16 AM revealed Resident #75 had complaints of chest pains, received 2 doses of 0.4 [Nitrostat] with no resolution of pain; sent to emergency room via emergency medical services. Record review of Medication Administration Record for July 2022 revealed Resident #75 received 2 doses of Nitrostat Sublingual 0.4 milligram on 7/25/2022. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of hospital Discharge Instructions dated 7/27/2022 revealed Resident #75 had troponin levels less than 0.1 nanograms per milliliter [elevated troponin levels, greater than 0.4 nanograms per milliliter indicate a cardiac event]. Record Review of Nursing Progress Note written by LVN JJ on 7/28/2022 at 7:40 AM revealed Resident #75 was readmitted to facility. Record review of Psychological Services Progress Note dated 7/29/2022 at 5:20 PM by PSY D [Psychology Doctor] revealed documentation that Resident #75 expressed anxiety associated with a recent encounter with nursing staff. Record Review of email dated 7/29/2022 at 5:15 PM from PSY D to the ADM [Administrator], the SW [Social Worker], and the DON [Director of Nursing] revealed notification of Resident #75 concern that her recent hospitalization was prompted by an argument Resident #75 had with an unnamed nursing staff. Record review of single page In-Servicing dated 7/29/2022 signed by CNA [Certified Nursing Assistant] E indicates topics presented by the ADON [Assistant Director of Nursing] included: Talk to residents with dignity and respect; Ensure appropriate communication with family and residents; Continue to provide excellent care to residents; Try to keep your voice at a modest level when talking with residents; Keep them informed with what is going on. Simple comments like I'll be back in 5 minutes to check on her. Goes a long way. In a group interview on 10/13/2022 at 10:58 AM with the DON and ADON, the ADON stated their policies and procedures to prevent abuse begins at recruiting, we check employees backgrounds, EMR [Employee Misconduct Registry], OIG [Office of Inspector General], checking references and skills check offs. The DON stated the facility reinforced training and education via [computer-based training] courses completed within the first 21 days of employment, Abuse/Neglect/Exploitation, reporting burnout, On-The-Job training and the administrative staff was on the floor and met residents, talked to staff, managed burn out by giving staff positive feedback, providing morale boosters. The DON stated the facility reinforced training for reporting immediately any allegations of Abuse/Neglect/Exploitation and identified to all staff the Abuse Prevention coordinator as the ADM. The DON stated the SW has also provided reinforced training for reporting any grievances. In an interview on 10/13/2022 at 1:45 PM, Resident #75 stated she was speaking with her roommate's family regarding care not provided timely to the roommate when an unnamed CNA rushed into the room, and yelled, You don't need to telling (sp) about other residents! Resident #75 clutched one hand at the base of her throat when she relayed, This startled me and scared me. Resident #75 stated she started having chest pains after that. Resident #75 reported having chest pains to the nurse on duty and received 2 doses of Nitroglycerin. Resident #75 stated the pain continued and an ambulance was called to take her to the hospital. Resident #75 stated she knew it wasn't a real heart attack when the chest pain evaporated as soon as the ambulance pulled into the hospital parking lot. It was like I just needed to get away from here. Resident #75 stated she was embarrassed she was taken by ambulance to the hospital when it wasn't a real emergency. Resident #75 further stated that she felt that the unnamed CNA tore her up for speaking out of turn even though the family of her roommate specifically asked her to keep an eye on their loved one. Resident #75 stated this had occurred several months ago, and that she had no problems with the CNA since then. Resident #75 could not recall the name of the CNA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/13/2022 at 7:30 PM, the DON recalled being notified afterhours that Resident #75 had some issue regarding an interaction with staff. The DON stated she tasked the ADON with speaking with resident about the situation. The DON stated the focus was more on the fact that Resident #75 was relaying HIPAA type information about other residents and should not be responsible for relaying details to the family members. The DON stated Resident #75 had a big heart and was very protective of her peers, especially her roommate. The DON stated at the time, the events did not rise to the level of an allegation of abuse. In an interview on 10/14/2022 at 9:25 AM the DON stated Resident #75 was assessed on the evening of 10/13/2022 and had no signs or symptoms of distress. The DON stated that the allegation of abuse was reported within 1 hour of learning about Resident #75's recollection of the event. The DON stated that upon further review and through their internal investigation the alleged perpetrator was CNA E, who was currently on leave. The DON stated the Nurse on duty had quit and did not return any of the facility phone calls. The DON provided telephone contacts for both CNA E and LVN JJ. [Neither CNA E nor LVN JJ returned phone calls for interviews prior to exit of survey.] In an interview on 10/14/2022 at 10:42 AM, the ADON stated he had assessed Resident #75 back then at the time she returned from the hospital, as instructed by his DON and the event was not recalled in a way that rose to the level of an allegation of abuse. The ADON stated he provided an on-the-spot In-Servicing on customer service to CNA E. In a group interview on 10/14/2022 at 11:19 AM, with the ADM, DON and ADON present, the DON stated the incident occurred towards the end of July 2022. The DON stated the ADM, the DON, and the SW were made aware via an email from the Psychologist that Resident #75 was upset about an interaction with nursing staff causing Resident #75 being sent to the hospital. The DON then notified the ADON to assess Resident #75. The ADON stated the allegation was not reported as it did not rise to the level of verbal abuse based on the assessment at the time. The DON stated the alleged staff member continued to work, after being In-Serviced. The DON stated the alleged staff member was not currently working as she was on leave, out of state for a funeral. The DON stated the last time the alleged staff member worked was more than a week prior to survey entrance. In a group interview on 10/14/2022 at 11:27 AM with the SW, DON and ADM, the ADM stated she had reported to state for possible abuse based on the 10/13/2022 conversation with Resident #75 . The DON stated the resident indicated she felt startled. The DON stated she did not feel it was verbal abuse, but the resident seemed intimidated by the loud volume, and harsh tone of voice CNA E used. The DON stated the CNA was of a different culture and had a flat affect, and brusque manner. The DON stated the CNA would be trained upon return to work. The DON stated an additional training course would be provided to all staff entitled, Trust Building Through Effective Communication. The ADM added she concurred with the DON and ADON responses to questions and added, we don't put anybody on the floor without the training needed; and I supervise my staff. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/14/2022 at 2:30 PM, the PsyD stated Resident #75 expressed being embarrassed for being sent to the hospital after having an altercation with the CNA that triggered chest pain. The PsyD stated the session was on 7/29/2022 between 4:40 and 5:20 PM. The PsyD stated after reviewing the notes she made at the time, she characterized the event as an argument. The PsyD stated Resident #75 would initially minimize her emotional state but would eventually accurately report her state of mind after some rapport building. PsyD stated since that event, Resident #75 had not displayed any increase in maladaptive behaviors or reported a decrease in engaging in coping mechanisms. PsyD stated Resident #75 had not reported increased intensity or frequency of anxiety. PsyD stated she immediately reported the concerns via email to the ADM, the SW and the DON. In an interview on 10/16/2022 at 11:03 AM Resident #75 stated she had been checked on by facility staff but could not recall any of the questions they might have asked. Resident #75 stated she had no concerns with abuse or neglect and had no fear of staff or residents at this facility. Resident #75 reiterated she had a problem when one staff member tore me up one side and down another, a few months back when she was overheard responding to her roommates' family when they asked how the roommate was being treated. Resident #75 stated tore me up meant the staff scolded her loudly for providing information to the family. Resident #75 reiterated that this was the event that sent her to the hospital unnecessarily a few months back. Resident #75 stated she was embarrassed she used up all those resources and it was just a panic attack. Record review of Nursing Administration Policy/Procedure under Leadership section, and Nursing Services subject, revised 05/2007, revealed Each Resident is free from verbal, sexual, physical or mental abuse, corporal punishment, and involuntary seclusion. Record review of Policy/Procedure-Administration under Section: Resident Rights and Subject: Abuse - Prevention of And Prohibition Against, revised 11/28/2017, revealed, it is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Further under section C Training, topics included prohibiting and preventing all forms of abuse .; identifying what constitutes abuse .; recognizing signs of abuse .; reporting abuse .; procedures for reporting incidents; understanding behavior symptoms of residents that may increase the risk of abuse and neglect and how to respond. These symptoms include . aggressive and or catastrophic reactions of residents. Under section D - Prevention, the facility will take action to prove protect and prevent abuse . By supervising staff to identify and correct any inappropriate or unprofessional behaviors. Under section E identification the facility will assist staff in identifying abuse . including mental slash verbal abuse . In addition, under Section I - Definitions, abuse is defined as willful infliction of entry, unreasonable confinement, intimidation . with resulting physical harm pain or mental anguish. Willful as used in this definition of abuse means individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. 2. Review of Resident #88's face sheet dated 10/14/2022 revealed the resident was admitted to the facility on [DATE] and had diagnoses that included acquired absence of right leg below knee, chronic systolic (congestive) heart failure (a condition in which the heart does not pump blood as well as it should), essential (primary) hypertension (abnormally high blood pressure that is not the result of a medical condition), chronic kidney disease stage 3 (mild to moderate damage to the kidneys function, where they are less able to filter waste and fluid out of the blood) and Type 2 diabetes mellitus (the body either does not produce enough insulin or it resists insulin). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #88's MDS dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score revealed 15, cognitively intact. Further review of the MDS revealed the resident required extensive assistance of 1 staff person with transfers, dressing and personal hygiene. Review of Resident #254 face sheet dated 10/15/2022 from the resident's closed medical record revealed the resident was admitted [DATE], discharged on [DATE] and had diagnoses that included chronic diastolic (congestive) heart failure (the left ventricle of the heart has become stiff and cannot fill with blood), cerebral palsy (a congenital disorder of movement, muscle tone or posture due to abnormal brain development, often before birth) and acute respiratory failure with hypoxia (impairment of gas exchange between the lungs and the blood causing the body to be deprived of adequate oxygen in the body tissues). Review of Resident #254's Quarterly MDS dated [DATE] from the resident's closed medical record revealed the resident had a BIMS score of 9, moderately impaired cognitive status. Further review of the MDS revealed the resident required extensive assistance of 2 staff members for bed mobility, dressing and personal hygiene. In an interview on 10/13/2022 at 2:25 p.m. with Resident #88 revealed approximately 6 months ago CNA F and an agency staff were providing peri-care to his former roommate, #254. The resident stated he overheard his roommate say, Why did you sock me in the eye? to CNA F. Resident #88 reported the CNA did not respond to the question and the resident did not see the incident because the privacy curtain was pulled. The resident reported they had informed Resident #254's responsible party and thought he had told the facility. Resident #88 reported he thought he had spoken to the Social Worker about the incident. The resident reported CNA F was no longer allowed to come into his room. In an interview on 10/14/2022 at 9:30 a.m. with the Social Worker revealed she had not heard about the incident until it was reported to the administrative staff the previous day by another surveyor. The Social Worker stated she spoke to Resident #88 and the resident was upset because CNA F did not apologize to Resident #254 but believed it was an accident. In an interview on 10/14/2022 at 9:35 a.m. with the DON she stated CNA F had not been going into Resident #88's room because she thought she might be accused of something she did not do. The DON reported she was not aware about the incident until yesterday, 10/13/2022. The DON reported either Resident [NAME] hit himself with his own hand or the aide accidentally hit him. The DON stated Resident #88 did not think it was intentional. The DON stated CNA F was suspended pending outcome of the investigation. In an interview on 10/14/2022 at 9:48 a.m. with CNA F she revealed she thought the incident occurred 8 months to a year ago. The CNA stated Resident #254 had needed peri-care and because he required two staff members during care, she had an agency aide with her. The CNA stated after she completed providing peri-care for Resident #254 she was putting on his shirt when the resident stated, Why did you hit me in the eye?. She stated she explained to the resident she had not hit him in the eye. The agency aide was also present and did not see anyone hit him in the eye. CNA F stated after the resident had made the accusation, she did not want to go into his room again. The CNA stated she never reported the incident to anyone. The CNA reported she was suspended pending outcome of the investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the incident report revealed it was dated 10/13/2022, after the administration was informed about the allegation by the survey team. Review of the facility policy, Abuse: Prevention of and Prohibition Against, Revised 11/28/2019, under the heading, H. Reporting/Response revealed, 1. All allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator. And 2. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on interview and record review the facility failed to submit a significant change within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the residents health status and requires interdisciplinary review or revision of the care plan, or both.) for 1 of 8 (#46) residents in the 400 hall in that: Resident #46 was on hospice services, but no significant change was made on her MDS. This could affect all resident with significant changes in health and could result in residents not provided services. The Findings were: Record review of Resident #46's face sheet dated 10/13/2022 revealed she was admitted on [DATE], readmitted on [DATE] with diagnoses of dementia, cognitive communication deficit, abnormal posture, and reduced mobility. Record review of Resident #46's physician consolidated order revealed she started hospice services on 6/9/2021. Record review of Resident #46's Significant change MDS dated [DATE] revealed she was not on hospice services. Resident #46's Quarterly MDS dated [DATE] revealed she was on hospice services. Record review of Resident #46's care plan dated 7/31/2022 revealed she was on hospice services. Interview on 10/15/2022 at 10:37 AM with MDS stated she had started working on May 2022. The MDS nurse stated Resident #46 did not have a significant change for hospice services. The MDS nurse stated the MDS department and IDT team was responsible for making sure residents MDS and care plans were accurate. The MDS nurse stated she followed the CMS RAI [NAME]. The current MDS stated this was completed before she started working at the facility. Record review of the Policy MDS Assessments dated October 2019 revealed Coding tips and special populations-if a nursing home resident elects the hospice benefit, the nursing home is required to complete an MDS Significant Assessments.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observations, interviews and record reviews the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment for 1 of 1 (#24) in that: Resident #24 had a diagnoses of mental illness and was not referred for a PASSAR evaluation (II). This could affect all residents with mental illness and could result in a decrease in PASSAR services. The Findings were: Record review of Resident #24 face sheet dated 10/15/2022 revealed she was admitted on [DATE], readmitted on [DATE] with diagnoses of major depressive (4/17/2019), dementia, schizophrenia (11/1/2016, 4/20/2020), epilepsy, seizures, vascular dementia (4/17/2019) and cognitive communication deficit. Record review of Resident #24's face sheet revealed her payer source was Medicaid/Medicare. Record review of Resident #24's PASARR level 1 was dated 9/30/2016 and was negative. No other PASARR was completed. Record review of Resident #24's consolidated orders for October 2022 revealed her diagnoses was major depressive disorder 4/17/2019) and schizophrenia (11/1/2016). Record review of Resident #24's Annual MDS dated [DATE] revealed in section I Active Diagnoses, Psychiatric/Mood disorder was documented depression, psychotic disorder and schizophrenia. In MDS for Resident #24, section N Medications was documented antipsychotic and antidepressant. Record review of Resident #24's care plan dated 8/18/2022 was documented currently on antidepressant medications use related to depression and psychotropic medications use related to schizoaffective with diagnoses of major depressive disorder and schizophrenia. No PASARR serviced were care planned. Interview on 10/12/2022 at 11:57 AM with Resident #24 revealed she was confused when surveyor asked her a question, she did not respond appropriately. Interview on 10/15/2022 at 10:30 AM with MDS nurse stated she started in May 2022 and Resident #24 should have been triggered as PASSAR for her mental illness diagnoses. Interview on 10/15/2022 at 12:27 PM with the SW (social worker) stated not sure why Resident #24 was not trigger for PASSAR service, with a mental illness and will call previous MDS. SW never returned for response. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on at 10/15/2022 at 2:33 PM with MDS nurse stated the PASSAR for Resident # 24 should have been a positive PASSAR. Interview on at 10/16/2022 at 10:31 AM with the DON stated the MDS nurse and SW would be responsible for ensuring residents had a PASARR. Record review of policy Resident Assessments (no date) revealed: The facility will designee a n individual to follow up on all residents have received a PASRR level i screening. If facility serves a resident with a positive PASSR level i screening, the facility must have obtained a PASSR level II evaluation form to local authority or have documented attempts to follow with the local authority to obtain the PASSR level II evaluation. Procedure: Nursing individual must: A coordinate with referring entities to ensure that any person seeking admission to a Medicaid certified NF received a PASRR level I screening for an intellectual disability, related to developmental disability or mental illness prior to admission. B Coordinate with the local authority to ensure a PASRR level II evaluation is conducted when a determination of intellectual disability, developmental disability and mental illness is made.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32218 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for the resident, consistent with the resident rights, that included measurable objectives and timeframe's to meet a resident's medical, nursing, and mental, and psychosocial needs that were identified in the comprehensive assessment, for 3 of 9 residents (Residents #13, #18, #88) reviewed for comprehensive care plans. 1. The facility failed to develop a comprehensive care plan that addressed Resident #13's behaviors toward her roommates. 2. The facility failed to develop a comprehensive care plan that addressed Resident #18's pacemaker. 3. The facility failed to develop a comprehensive care plan that addressed Resident #88's code status. These deficient practices could place residents at risk for not receiving the appropriate care and services needed to maintain optimal health. The findings were: 1. Review of Resident #13's face sheet dated 10/15/2022 revealed the resident was admitted to the facility on [DATE] and had diagnoses that included cognitive communication deficit, essential hypertension (abnormally high blood pressure that is not the result of a medical condition), unspecified dementia unspecific severity without behavioral disturbance, psychotic disturbance, move disturbance, and anxiety, chronic embolism and thrombosis (a blood clot that forms in the vein) of unspecified deep veins of right lower extremity, and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Review a resident #13's Quarterly MDS dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, moderately impaired cognitive status. Further review of the MDS revealed Resident #13 required extensive assistance of one person for transfers, dressing and personal hygiene. Review of Resident #13's care plan initiated 3/2/2022 revealed the resident was on psychotropic medication (Seroquel) related to behavior management/insomnia and a care plan initiated 3/4/2022 revealed the resident was at risk for psychosocial well-being related to the pandemic. In an interview on 10/11/2022 at 11:57 a.m. with Resident #13 revealed the facility was discharging the resident because she did not want a roommate. The resident denied the allegation. In an interview on 10/11/2022 at 12:07 p.m. with the facility Social Worker (SW) revealed Resident #13 received a 30-day notice to discharge because she did not get along with other residents placed in the room with her. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/15/2022 at 9:27 a.m. with the Administrator revealed Resident #13 was given a 30-day notice for discharge because she was aggressive and verbally abusive to her roommates. In an interview 10/15/2022 at 9:44 a.m. with the Social Worker, after she reviewed Resident #13's care plans she revealed she had not created a care plan addressing the resident's behaviors toward her roommates, but she should have. 2. Review Resident #18's face sheet dated 10/13/2022 revealed the resident was admitted to the facility on [DATE] and had diagnosis that included type 2 diabetes mellitus without complications, respiratory disorders (lung disease) in diseases classified elsewhere, essential hypertension (high blood pressure that's not a result of a medical condition), chronic kidney disease stage 2 (kidney disease status still mild) and heart failure (a condition in which the heart cannot pump or fill blood adequately). Review of a physician progress note dated 9/8/2022 revealed the resident reported she had not been seen by cardiology for her pacemaker since she moved to Texas and believed it's been years since she saw a doctor for it. Review of Resident #18's October 2022 Order Summary Report revealed referral to cardiac electrophysiologist for routine follow up of pacemaker with an order date of 9/9/2022. Review of Resident #18's Annual MDS dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 9, moderately impaired cognitive status. Review of Resident #18's care plans, last revision date 7/27/22, did not reveal a care plan for a pacemaker. In an interview on 10/12/2022 at 3:21 p.m. with Resident #18 she revealed she had a pacemaker. In an interview on 10/15/2022 at 9:41 AM with the MDS Coordinator , after looking over resident #18's physician orders and care plans, revealed had not created a care plan for the resident's pacemaker. 3. Review of Resident #88's face sheet dated 10/14/2022 revealed the resident was admitted on [DATE] and had diagnosis that included type 2 diabetes mellitus with diabetic chronic kidney disease (damage of small blood vessels throughout the body due to diabetes, affecting the kidneys), mixed hyperlipidemia (an inherited condition in which levels of certain lipids or fats in the blood are higher than they should be), major depressive disorder, heart disease, and essential hypertension. Review of Resident #88's October 2022 Order Summary Report revealed an order for full code with an order date of 8/30/2022. Review of Resident #88's most recent MDS dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, cognitively intact. Review of Resident #88's care plans, last review dated 9/30/2022, revealed there was not a care plan for the residents code status. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/15/2022 at 9:41 a.m. with the MDS coordinator she revealed the social worker usually wrote the care plans for a residence code status. In an interview on 10/15/2022 at 9:45 a.m. with the social worker revealed she used to write the code status care plans but recently the MDS Coordinator began writing code status care plans. After reviewing the resident's record, the social worker revealed she could not find a care plan for Resident #88 full code status. The social worker stated they write code status care plans whether the resident was full code or had a Do Not Resuscitate order. In an interview on 10/15/2022 at 9:41 AM with the MDS coordinator she stated the care plans directed a resident's care and made sure that care was provided and being followed up. Review of the facility policy, Comprehensive Resident Centered Care Plan with the revision date of January 2022 revealed 4. the facility interdisciplinary team will develop and implement a comprehensive person-centered care plan for each president within seven days of completion add the resident minimum data set and will include residence needs identified in the comprehensive assessment, any specialized services as a result of PASARR recommendation and residence goals and desired outcomes, preferences for future discharge and discharge plans.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observation, record review and interview, the facility failed to assure medications were secured in locked compartments and accessible only to authorized personnel for 1 (Resident #96) of 30 residents reviewed for storage of medication; in that: A souffle cup with 4 unidentified medications and a plastic cup of clear liquid was observed unattended on the Residents' bedside table. This deficient practice could lead to unintended ingestion of unprescribed medications by another resident, visitor, or staff. The findings were: Record review of Admission Record revealed Resident #96 was an [AGE] year-old female, admitted on [DATE] with the following diagnoses: age-related cognitive decline; generalized muscle weakness; unsteadiness on feet. Record review of annual MDS dated [DATE], revealed Resident #96 had a BIMS [Brief Interview for Mental Status] Summary Score of 15, indicative of intact cognition with fluctuating disorganized thinking. Record review of Care Plan revised on 10/04/2022 revealed Resident #96 had a focus area of at risk for impaired cognitive function with associated interventions: administer medications as ordered; keep routine consistent; monitor/document/report to MD any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness .Care Plan does not address self-administration of medications. Record review of order summary report printed10/13/2022 at 9:49 AM, revealed active orders for oral administration: Dr. Sears' Primal Force Anti-Aging Omega Rejuvenol tablet with instructions give one tablet every day for supplement with a start date of 9/13/2022; Ascorbic Acid [Vitamin C] Tablet 500 milligram with instructions give one tablet two times a day for supplement with a start day of 4/30/2021; Ginseng Capsule with instructions give 1 capsule by mouth one time a day for supplement with a start date of 9/13/2022; PreserVision AREDS 2 with instructions to give 1 capsule by mouth two times a day for supplement with a start date of 4/16/2022; MiraLAX Powder with instructions to give 17 gram by mouth two times a day for constipation with a start date of 10/4/2022. Orders do not reflect self-administration of medications. Record review of Assessments tab of electronic health record, printed 10/13/2022 at 9:49 AM, do not reflect an assessment for safe self-administration of medications was documented. Record review of Progress Notes tab of electronic health record, printed 10/16/2021 at 2:26 PM, do not reflect any documentation related to safe self-administration of medications program. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 10/13/2022 at 9:14 AM in room [ROOM NUMBER] at bed B with Resident #96 there was a souffle cup with 4 unidentified pills in it and a cup of an unidentified liquid in it. In an interview on 10/13/2022 at 9:22 AM, Resident #96 stated the liquid was MiraLAX delivered the evening before [10/12/2022] around 7:30 PM, and the pills were a smart pill, a pill for general wellness, vitamin C, and a pill for my eyes. Resident #96 stated the pills had been provided to her around 7:30 or 8:00 AM that morning. Resident #96 stated the NP had given special permission for Resident #96 to hold on to her medications so that she may take them on a full stomach. Resident #96 stated she did not like much of the breakfast and therefore did not eat much. Resident #96 stated she would take the liquids and pills when her lunch tray was delivered. Resident #96 stated if she did not take her medications on a full stomach she would get sick. In an interview on 10/13/2022 at 9:55 AM, LVN AA stated there were 4 pills in a clear souffle cup, but she could not confirm what the liquid was. LVN AA stated MiraLAX should dissolve completely in water. LVN AA stated she had not administered any medications to Resident #96. LVN AA stated Resident #96 was on MA G's case load today. LVN AA left the medications at the bedside with Resident #96 when LVN AA exited the room. In an interview on 10/13/2022 at 10:19 AM, MA G stated she had delivered the medications in the souffle cup to Resident #96 earlier that morning. MA G stated Resident #96 frequently would not want to take medications without food. MA G stated Resident #96 had expressed to her that she did not like what was going to be served for breakfast and would take the medications at lunch. MA G stated she left the medications with the resident as per the resident's request. MA G stated the electronic Medication Administration Record did not include instructions for self-administration of medications for Resident #96. MA G stated she would remove the medication, consult with a Registered Nurse, and if allowed administer the medications at lunch. In an interview on 10/13/2022 at 10:25 AM, ADON stated none of the Residents are currently on a self-administration program. ADON stated medications should not be left at the bedside. ADON stated the staff administering medications should stay until the medications are swallowed. In an interview on 10/13/2022 at 11:00 AM, the DON stated the NP was on site, and she would ask the NP to come to the conference room for an interview. [The NP did not show up for the interview and was not interviewed prior to survey exit.] In an interview on 10/16/2022 at 3:02 PM, the DON stated it is the responsibility of the ADON, DON, and the Pharmacist Consultant to train staff on safe medication administration. The DON stated training is conducted during on boarding for new hires, annually, and periodic skills check off is done with the Pharmacist Consultant at least quarterly. The DON stated additional In-Servicing is done as needed and on-demand. The DON stated it is the ADON, the Pharmacist Consultant, and her responsibility to ensure compliance via spot checks, and Pharmacist Consultant observations. The DON stated the risk for leaving medications unattended at Resident #96's bedside was low, as Resident #96 was conscientious not to leave the medications unattended; the roommate was non-ambulatory; and there were virtually no residents that wandered into other resident rooms on that hall. Record review of Medication Administration Policy and Procedure revised 05/2007 revealed in Step 8. The person administering medication must remain with the resident until all medication has been swallowed.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observations, interviews and record reviews the facility failed to meet the nutritional needs of residents in accordance with established national guidelines for 2 of 8 (#12, #42) reviewed for supplements and faild to ensure that the menu was followed for 1 of 1 meal observed in that: 1. Resident #12 did not get his fortified pudding and magic cup on the lunch tray. 2. Resident #46 did not get her magic cup on the lunch tray. 3. The facility did not serve margarine during the lunch meal as per the menu on [DATE]. This failure could place residents at risk for dissatisfaction, poor intake, and diminished quality of life. The findings were: 1. Record review of Resident #12's face sheet revealed he was admitted on [DATE] revealed he was admitted on [DATE] with diagnoses of epilepsy (a neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain), cognitive communications deficit, dysphagia (difficulty or discomfort in swallowing, as a symptom of disease.), intellectual disabilities and quadriplegia (paralysis of all four limbs). Record review of Resident #12's diet order card revealed a puree honey diet supplements included was fortified pudding and magic cup. Record review of Resident #12's chart in the weight sections revealed Resident #12 was gaining weight. Record review of Resident #12's Quarterly MDS dated [DATE] revealed in section C- Cognitive Patterns was severely impaired and section G Functional status required total to extensive assistance with ADLs, eating he required total dependence with 1-person physical assistance. Record review of Resident #12's care plan dated [DATE] revealed he had a potential problem related to diet restrictions of honey thicken liquids, and puree diet, need for staff assistance by mouth, provide and serve died as orders, provide assistance with meals. Observation on [DATE] at 12:40 PM with CNA GG was feeding lunch to Resident #12 and on his plate, he received a puree diet, no magic up or fortified pudding. Interview on [DATE] 12:40 PM with CNA GG was feeding Resident #12 puree diet with no magic up or fortified pudding (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 5:28 PM with CNA HH was serving tray to Resident # 12 revealed on his dinner tray had no supplements on trays. Interview on [DATE] at 5:28 PM with CNA HH was serving tray Resident # 12 and confirmed no supplements on trays. CAN HH stated the diet order cards listed supplements should be on resident trays. Interview on [DATE] at 6:10 PM with LVN CC stated the preferences were a list of choices residents may get on their tray. Interview in [DATE] at 6:00 PM with Dietary Aide II stated she gets the resident foods ready on the trays and stated the diet order card supplements were to be on the resident trays. 2. Record review of Resident #46's face sheet dated [DATE] revealed she was admitted on [DATE], readmitted on [DATE] with diagnoses of dementia, cognitive communication deficit, abnormal posture, and reduced mobility. Record review of Resident #46's diet order card revealed puree nectar, supplements she had magic cup. Record review of Resident #46's chart in the weight sections revealed Resident #46's weight was stable. Record review of Resident #12's Quarterly MDS dated [DATE] revealed in section C- Cognitive Patterns her BIMS score was ,d+[DATE] (moderately impaired) and section G Functional status required total to extensive assistance with ADLs, eating she required extensive assistance withe 1-person physical assistance. Record review of Resident #12's care plan dated [DATE] revealed she had an ADL Self-Care performance deficits related to debility, diagnosis of multiple sclerosis, had right shoulder limitation-moderate, bilateral ankle minimal assist-interventions-eating assist at mealtimes with set up tray only. Observation on [DATE] at 11:05 ma with Resident #46 revaled she did not have a magic cup on her lunch tray. Interview on [DATE] at 9:15 AM with Assist Dietary manager JJ stated the staff had discussed the missing supplements for the 2 residents, Resident #12 and#46. A. Manager stated he had told the dietary aides to make sure the supplements for residents were on the trays, he stated the preferences/supplements were to be on resident trays and served to residents. Interview on [DATE] 10:39 AM with DON stated the dietary department was responsible to ensure the supplants were on resident trays when served. The DON stated that the nurses on hall should make sure the supplements listed on the diet orders are on the resident's tray. The DON stated the dietary department was responsible for making sure residents diet/supplements were accurate on the resident meal trays. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of policy Menu compliance dated ,d+[DATE] revealed It is the policy of this facility to adhere to menus and .to provide adequate nutrition to the residents. The end results of tray line accuracy and menu compliance are -resident maintain nutritional adequacy .The dietary manager or designee will monitor try line service to ensure menus are being followed and served correctly. 3. Review of the lunch menu for [DATE] revealed fried fish, southwest coleslaw, cornbread, blueberry cobbler, margarine, coffee tea. Observation on [DATE] from 11:55 a.m. to 12:56 p.m. revealed the kitchen was serving the lunch. Observation throughout the meal service revealed staff did not provide margarine for any of the food plates served. In an interview on [DATE] 22 at 12:56 AM with dietary aide KK revealed she had forgot to serve margarine with all the lunch meals served. The aid reported she forgot because there was too much going on during meal service. In an interview on [DATE] at 2:51 p.m. with the assistant dietary supervisor LL revealed margarine was an important part of the meal because it adds more calories and can be used for moisture and added flavor. Review of the facility policy Dietary, Subject: Menu Compliance, revised 11 2016 revealed It is the policy of this facility to adhere to menus and recipes as written in order to provide adequate nutrition to the residence and The end results of tray line accuracy in menu compliance are clients residents maintain nutritional adequacy, decreased resident complaints, and improved satisfaction of families. 32218

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676238	A. Building B. Wing	10/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - North	11020 Dessau Rd Austin, TX 78754

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observations, interviews and record review the facility failed ensure store and serve food in accordance with professional standards for food service safety for 3 of 8 (#10. #46, #52) residents with food items in personal refrigerator in that: 1. Resident #10 personal refrigerator had a container of cream cheese with no open date. 2. Resident #46 personal refrigerator had 2 food times wrapped in foil and bottle of ensure with no open date. 3. Resident #52 personal refrigerator had small bowel of pudding with no open date. This could affect all residents with personal refrigerator and could result in food borne illness. The Findings were: 1. Record review of Resident #10's face sheet dated 10/12/2022 revealed she was admitted on [DATE], readmitted on [DATE] with diagnoses of multiple sclerosis, dementia, major depressive disorder and muscle weakness. Observation on 10/11/2022 at 11:24 AM in Resident #10's room, she had a personal refrigerator that contained a container of cream cheese with no open date. Interview on 10/11/2022 at 11:25 AM with Resident #10 stated the staff get her food items from her personal refrigerator for her because she could not reach the refrigerator. Interview on at 10/12/2022 at 10:39 AM CNA MM stated Resident # 10 personal refrigerator had no open date on the cream cheese. 2. Record review of Resident #46's face sheet dated 10/13/2022 revealed she was admitted on [DATE], readmitted on [DATE] with diagnoses of dementia, cognitive communication deficit, abnormal posture, and reduced mobility. Observation on 10/11/2022 at 11:05 AM in Resident #46's room, she had a personal refrigerator 2 food times wrapped in foil with no open dates and bottle of ensure with no open date. Interview on 10/11/2022 at 11:06 AM with Resident #46 stated she was not sure what was in her personal refrigerator and staff help her get food items from refrigerator because she is not able to get out of bed. Interview on 10/12/2022 at 10:40 AM CNA MM stated Resident # 10 personal refrigerator had no open date for 2 food times wrapped in foil and bottle of ensure. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #52's face sheet dated 10/13/2022 revealed she was admitted on [DATE], readmitted on [DATE] with diagnoses of Alzheimer's disease, need assistance with personal care, cognitive deficit, unsteady on feet, and muscle wasting. Observation on 10/11/2022 at 10:59 AM in Resident #52's room, she had a personal refrigerator with a small bowel of pudding with no open date. Interview on 10/11/2022 at 10:59 AM with Resident #52's stated she was not sure what was in her personal refrigerator and staff help her with food items. Interview on 10/12/2022 at 10:42 AM CNA MM stated Resident # 10 personal refrigerator had no open date for the small bowl of pudding. Interview on 10/16/2022 10:39 AM with DON discussed the food items in resident personal refrigerator with no open date stated the CNAs usually are in and out of the resident personal refrigerator and look to see if food items are good. No policy was provided before exiting facility.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews and record reviews the facility failed to maintain medical records on each resident that were complete and accurate, in accordance with accepted professional standards and practices for 1 of 3 residents (Resident #97) reviewed for accurate records. Resident #97 medical records did not include a physician's order for laboratory test performed. This deficient practice could place residents at risk for harm by inaccurate records. The findings include: A record review of Resident #97's admission record, dated 10/14/2022, revealed an admitted [DATE] with diagnoses which included hypertension (high blood pressure), cerebral infarction .occlusion .left anterior cerebral artery, and Deep Vein Thrombosis (a blood clot in a deep vein, most commonly in the legs or pelvis). A record review of Resident #97's care plan, dated 10/14/2022 revealed, [Resident #97] is on anticoagulant therapy related to deep vein thrombosis .RN C A record review of Resident #97's medical records revealed an admission note authored by NP, on 9/27/2022, with an intended laboratory order for PT/INR 9/28 [Prothrombin is a protein made by the liver. It is one of several substances known as clotting (coagulation) factors. PT Prothrombin time measures the time clots form in a sample). A record review of Resident #97's medical records revealed RN C assessed Resident #97 on 9/27/2022 for admission. A record review of Resident #97's medical records revealed a final result for a PT/INR lab, collection date: 9/28/2022, signed by NP on 9/30/3022. During an interview on 10/14/2022 at 3:50 PM RN C stated she admitted Resident #97 on 9/27/2022. RN C stated she called the laboratory and set up a PT/INR lab draw for Resident #97 on 9/28/2020. RN C stated the procedure is for the nurse who receives the order to place the order in the resident's electronic record and then call the laboratory to schedule the order. RN C stated she failed to record residents NP's order for a PT/INR for 9/28/2022 in the Resident's medical record. RN C stated Resident #97 did receive the venipuncture, did receive laboratory results which were reported to the NP but the order was not documented. RN C stated the inaccurate record could have placed residents at risk for harm by not providing the interdisciplinary team accurate data in providing care for residents. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/14/2022 at 04:11 PM the DON stated RN C assessed Resident #97 for admission on 9/27/2022 and did not document the NP's order for Resident #97's PT/INR venipuncture on 9/28/2022. The DON stated the failure was not per facility policy which called for residents to have accurate medical records and for nurses to document all prescribers' orders. The DON stated Resident #97 did receive the anticoagulant medication as ordered, did receive the laboratory services as ordered but the order for the initial laboratory order was not entered into Resident #97's medical record by RN C. the DON stated the inaccurate record could have placed residents at risk for harm by not accurately documenting residents care. A policy regarding the documentation of prescribers' orders was requested but not provided by the exit date 0f 10/16/2022.