

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/14/2025
NAME OF PROVIDER OR SUPPLIER  Legacy Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  2817 Kent Street Bryan, TX 77802	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for two (Resident #1 and Resident #2) of four resident reviewed for catheters.</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure Resident #1 had catheter care orders from 04/02/2025 to 05/07/2025.</li> <li>2. The facility failed to ensure Resident #2 had catheter care orders from 05/09/2025 to 05/13/2025.</li> </ol> <p>These failures could place residents who required incontinent care at risk for development of new or worsening urinary tract infections or pain.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet dated 05/14/2025 revealed an [AGE] year-old man admitted on [DATE] with diagnoses of obstructive and reflux uropathy (blockage in urinary tract that prevents normal urine flow), dehydration, dysphagia (difficulty swallowing), and other acute osteomyelitis, right ankle and foot.</p> <p>Review of Resident #1's admission MDS dated [DATE] reflected a BIMS score of 12 which indicated a moderate cognitive impairment. Further review revealed Resident #1 was always incontinent.</p> <p>Review of Resident #1's nursing admission assessment completed by LVN A dated 04/02/2025 reflected Resident #1 was admitted from another facility with foley catheter and it was in place at the time of admission. Further review reflected indwelling catheter was selected as present but catheter care option was not selected.</p> <p>Review of Resident #1's care plan dated 05/07/2025 reflected Resident #1 used an indwelling catheter. Interventions included to change tubing and bag as appropriate, provide catheter care every shift and watch for acute behavioral changes.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's physician orders reflected order with start date of 05/07/2025 input by LVN B an order for a urethra catheter for obstructive uropathy and included orders to monitor that catheter was intact, check for catheter bag, tubing was secure, bag was below level of bladder and assess for pain or discomfort every shift. Further review of discontinued orders from 04/02/2025 to 05/07/2025 reflected no orders for catheter care between admission and 05/07/2025.</p> <p>Review of Resident #1's May 2025 MAR reflected there was no pain indicated related to urinary catheter. Further review reflected catheter care was provided daily and started on 05/07/2025 with no documented concerns or issues.</p> <p>Review of Resident #1's April 2025 MAR reflected there were no orders included for catheter care. Further review reflected pain was monitored in April 2025 and Resident #1 indicated no pain.</p> <p>Review of Resident #1's transfer / discharge report dated 04/02/2025 reflected a medication review report dated 04/02/2025 and included orders to change foley catheter monthly and as needed and provide catheter care every shift and as needed.</p> <p>Review of Resident #1's urology appointment note dated 04/15/2025 reflected catheterization was performed and Resident #1 tolerated procedure well.</p> <p>Review of Resident #1's POC response for last 30 days reflected dates of 05/07/2025 to 05/14/2025 reflected care was provided between these days and included to empty bag, document color of urine, ensure dignity covers were present and tubing was secured. No issues were noted in these responses.</p> <p>Review of Resident #2's face sheet dated 05/14/2025 reflected a [AGE] year-old male admitted on [DATE] with diagnoses of metabolic encephalopathy (a condition where the brain's function is impaired due to an imbalance in the body's metabolism), acute respiratory failure with hypoxia (a condition where the body's tissues are not getting enough oxygen), retention of urine (inability to completely empty the bladder when urinating), and anxiety disorder (excessive fear and worry that interfere with daily life).</p> <p>Review of Resident #2's nursing admission assessment completed by LVN C dated 05/09/2025 reflected Resident #2 was incontinent of bowel and bladder upon admission and had a foley catheter. Further review reflected indwelling catheter option was not selected and catheter care was also not selected.</p> <p>Review of Resident #2's care plan dated 5/12/2025 reflected he was on EBP for an indwelling medical device with interventions for staff to wear PPE during high contact activities (bathing, showering).</p> <p>Review of Resident #2's physician orders reflected an order with a start date of 05/13/2025 included orders to monitor that catheter was intact, check for catheter bag, tubing was secure, bag was below level of bladder and assess for pain or discomfort every shift and as needed.</p> <p>Review of Resident #2's May 2025 MAR reflected catheter care / monitoring began 05/13/2025 with no documented concerns.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #2's POC response for last 30 days reflected dates of 05/13/2025 and 05/14/2025 reflected care was provided between these days and included to empty bag, document color of urine, ensure dignity covers were present and tubing was secured. No issues were noted in these responses.</p> <p>During an interview on 05/14/2025 at 1:21 PM, Resident #2 stated he had no concerns or issues with his catheter. Resident #2 stated he had no pain or burning and that he received catheter care at least once a day.</p> <p>During an interview on 05/14/2025 at 12:42 PM, CNA E stated catheter care was performed every time the resident's brief was changed. She stated she also had to wear PPE because the resident had EBP. CNA E stated even if catheter care was not trigger in the resident's POC catheter care was required because it was part of her job. CNA E stated it was obvious that a resident had a catheter. CNA E stated that on the POC she was supposed to document the resident's output, empty the bag at the start and end of her shift. CNA E stated any change was supposed to be reported to the nurse. CNA E stated changes could have been cloudy urine.</p> <p>During an interview on 05/14/2025 at 12:50 PM, CNA F stated that for catheter care she was required to empty the bag, clean around the resident's private area, document color and output. CNA F stated this was documented under the ADLs tab in the resident's POC. CNA F stated that she looked for redness, discoloration of urine and smell. CNA F stated that catheter care was provided daily and at least every shift or every time a resident's brief was changed. CNA F stated if any changes were noted she would have reported it to the nurse right away.</p> <p>During an interview on 05/14/2025 at 1:36 PM, LVN C stated that residents with catheters were checked twice a shift and that the nurse was aware to check because an order popped up on the MAR. LVN C stated that he checks catheters when he arrives for his shift and at the end of his shift. LVN C stated that he worked 12 hours shifts at the facility. LVN C stated that checking catheters included checking for drainage and that it was not backed up, asking for pain in the abdominal area, ensure that the tubing was clasped in the correct spot, the bag was hanging for proper flow and a privacy cover was on. LVN C stated that abnormal findings would be blood, clogging, white mucus (which indicated infection), and pain in abdomen. LVN C stated anything abnormal would be reported to the NP. LVN C stated that there was a batch order that was put in for any resident that admitted with a catheter. LVN C stated the batch orders included to check the catheter, drainage, monitor and check for any pain. LVN C stated order should have been put in upon admission as long as the NP or MD did not discontinue them. LVN C stated that the catheter care orders were only discontinued if the catheter had been removed. LVN C stated if a resident had a catheter but no orders there was a risk for infection, discomfort for the resident. LVN C stated normally the charge nurse put orders in but if it was missed then administration would check.</p> <p>During an interview on 05/14/2025 at 2:17 PM, the MD stated that she does provide orders when a resident admitted for catheter care and if a resident admitted with a catheter they should have had routine catheter care completed. The MD stated this included for staff to monitor for signs and symptoms of infection. The MD stated that she believed the catheter was changed every four weeks. The MD stated she thought the it would be common sense and that a staff would have noticed there were not orders. The MD stated the catheter was changed and monitored to reduce risk of infection.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/14/2025 at 3:00 PM, LVN A stated she was aware what orders a resident had in place on admission based on the resident's hospital orders. LVN A stated that if a resident came from another facility they usually arrived with orders. LVN A stated if a resident admitted with a peg or catheter there was usually a standing order that was put in. LVN A stated if there was not an order the nurse could have asked the MD or NP. LVN A stated that Resident #1 admitted with a catheter and she did not recall what orders were put in for his catheter. LVN A stated that the standing orders usually included to look that the catheter was intact, monitor for pain, and ensure the bag was in the right place (hanging below the bladder). LVN A stated Resident #1 came with orders from another facility but was unsure if he came with orders for his catheter. LVN A stated it was important to monitor a resident with a catheter because the resident could get an infection and staff needed to check how the urine was draining, color and if there was any sediment. LVN A stated any pain, fever, cloudy urine, foul smelling urine or swelling (depending on the placement) would be reported to the NP.</p> <p>During an interview on 05/14/2025 at 3:11 PM, LVN B stated that he was the unit manager for the facility. He stated he put in catheter care orders for Resident #1 because it was noticed during an order review that he had a foley but no orders for catheter care. LVN B stated that when a resident admitted with a catheter, ideally all orders would be included in the admission orders, but the facility had a batch order that was received from the physician that the charge nurse would use for catheter care. LVN B stated that the facility tried to review new admissions the following day and orders were generally reviewed every morning and all physician orders were reviewed from the previous day. LVN B stated that CNAs were trained on day-to-day care when they provided incontinent care, but the responsibility fell on the nurses. LVN B stated that nurses were aware to check or perform catheter care because of the initial head-to-toe admission assessment. LVN B stated it was important to monitor to ensure that the resident was not dealing with an infection and to ensure the resident was draining and observe the urine and ensure there were not renal issues or bleeding.</p> <p>During an interview on 05/14/2025 at 3:29 PM, CNA D stated that during catheter care she wore a gown, and gloves because the resident was on EBP. CNA D stated that she had to clean the catheter itself, clean the resident's private area, and look for signs of breakdown, discharge, discoloration in the tubing, redness. CNA D stated if she noticed any of the mentioned changes or concerns she would have notified the nurse right away.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/14/2025 at 4:35 PM, the DON stated that the charge nurse was responsible to ensure catheter care orders were entered at the time of admission. The DON stated within 24 hours the unit managers reviewed admissions. The DON stated that there were two unit managers that split the building. The DON stated that the 24 hour period did not include weekends. The DON stated that the facility had an RN supervisor over the weekend so she reviewed orders and stated nursing administration rotated on-call. The DON stated that she believed staff were in-serviced on admission orders and treatments on 05/12/2025. The DON stated that the facility had batch orders for catheter care orders and that included daily monitoring, daily monitoring of signs or symptoms of infection and tubing placement. The DON stated that if a resident's catheter was not being monitored or checked by the nurse they were at risk for infection. The DON stated if there was no order the charge nurse was still required to round multiple times a day. The DON stated that it was found Resident #1 did not have order but she was unsure why and stated she guessed it was something the facility missed. The DON stated it was found and a QAPI meeting was conducted and an audit on catheters was completed. The DON stated the audit was completed on 05/07/2025. The DON stated there were no additional residents found in the audit and going forward the unit managers were required to go lay eyes on the residents after the admission. The DON stated she was not aware that Resident #2 did not have catheter care orders until yesterday 05/13/2025.</p> <p>Review of facility in-service dated 05/12/2025 reflected purpose of training was PCC- ADT (Admit, Discharge, and Transfer) and Admit, Return, Discharge and Transfer Documentation. In-service reviewed documentation and charting guidelines and reflected catheter care should include, type of procedure and who performed it, date and time procedure was perform, type and size of catheter, changes in resident's condition, urine output and other pertinent data as necessary.</p> <p>Review of undated facility policy titled Catheter care, Indwelling Catheter Policy and Procedure reflected purpose of catheter care was to prevent infection and reduce irritation. Further review reflected catheter care should be provided daily or as needed.</p>		