STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455351	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation	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)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 Based on observation, interview, and record review, the facility failed to develop a baseline care plan that included instructions needed to provide effective and person-centered care of the resident, for one of four residents (Resident #150) reviewed for baseline care plans. The facility failed to ensure a baseline care plan was completed within 48 hours of admission that addressed the care needs of newly admitted Resident #150. This failure could place residents at risk of not receiving necessary care and services. The findings included: Review of Resident #150 face sheet dated 05/06/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses chronic pain syndrome, and other specified disorder of bone density and structure, multiple sites. Review of Resident #150 EMR reflected the only MDS completed was her entry MDS dated [DATE]. Review of her nursing admission assessment dated [DATE] completed by LVN E reflected she was assessed for pain on admission with the pain level of 4/10. Review of LVN E's documented note reflected Pt. was medicated prior to leaving last facility . Review of Resident #150 physician orders reflected an order dated 05/02/2025 Monitor for pain every shift; Fentanyl patch 75mcg/hr . replace every 72 hours; Baclofen 5mg two times daily and oxycodone HCL 5mg one tablet every 4 hours as needed for severe pain related to chronic pain syndrome. In an interview and observation on 05/06/2025 at 11:22 AM Resident #150 stated she was in pain that her neck was hurting, and she needed her pain medication. Resident #150 stated it had been an hour since she asked for pain medication and still had not gotten it and it was an hour late. Resident #150 began crying stating she was really hurting. Review of Resident #150's base line care plan reflected no entries related to pain or pain management . (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow up interview on 05/06/2025 at 12:10 PM Resident #150 stated she got her pain medication at 12:00 noon. She stated she had neck pain that was severe which came from a fused vertebra in her neck. She stated they took off her Fentanyl patch on 05/05/2025 and did not put another one on because they did not have any and it needed to be ordered. She stated she wanted her oxycodone to be put routine instead of PRN because they take too long to bring it when it is PRN. Resident #150 further stated she will refuse to take her Baclofen sometimes because it makes her to sleepy and stated she has told them she only wants to take it at night, but they keep trying to give it to her during the day. In an interview on 05/07/2025 at 3:36 PM MDS Coordinator B stated Resident #150 should have a base line plan of care within 48 hours of admission. She further stated Resident #150 should have had a plan of care for her pain. She stated Resident #150 not having one could lead to staff not knowing what to do for the resident to manage her pain. In an interview on 05/08/2025 at 12:05 PM the DON stated the base line care plan should be completed within 48 hours and should cover the residents' immediate needs. She stated with Resident #150's pain which was a big issue with her and should have been on her base line care. She stated failure of the staff not putting all the residents care needs on the base line care plan could lead to staff not knowing what care to provide the resident . Review of the facility's undated policy Care planning policy and procedure reflected Purpose: To provide a comprehensive plan of care addressing resident's needs, strengths, goals, and approaches. Policy: Each resident's care plan will remain current and inform staff of resident's needs, strengths, goals, and approaches . The provided facility policy did not address base line care plans.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 32452 Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive care plan that describes the services that are to be furnished to maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 18 residents (Resident #48), in that: The facility failed to ensure Resident #48's comprehensive care plan reflected a plan of care for his left hand and neck contractures (A permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen and a decrease in ROM). This failure could place residents at risk for not having care needs identified and a plan to address those needs developed. Findings included: Review of Resident #48's face sheet dated 05/06/2025 reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses intracranial injury (head injury), spastic hemiplegia affecting dominant side (Hemiplegia is a symptom that involves one-sided paralysis.), contracture of left hand (A permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen and a decrease in range of motion.) Review of Resident #48's quarterly MDS assessment dated [DATE] reflected he was assessed to have a BIMS score of 8 indicating moderate cognitive impairment. Resident #48 was assessed to have functional limitations in range of motion on both upper and lower extremities. Review of Resident #48's comprehensive care plan reflected a problem dated 07/11/2023 revised on 03/24/2025 I require staff assistance for all ADL's related to spastic hemiplegia affecting right side; contracture of left hand. Interventions included .I require assistance with bed mobility, transfers and assist with feeding . Interventions did not include interventions for contracture management of his right hand and the care plan did not address his neck contracture. Observation and interview on 05/05/2025 at 7:30 AM revealed Resident #48 up in his Geri-chair in the dining room. Resident #48 was observed to have a contracture to his right hand with his fingers curling toward his palm, no splint, hand roll or other device was observed. Resident #48 was further observed to have a neck contracture with Resident #48's neck bent toward his left should (touching his shoulder). Resident #48 was asked if he could open his hand and he stated no, he was further asked if he could move his head and he stated, No it is stuck that way. No pillow or positioning device was observed. Observation on 05/05/2025 at 3:50 AM revealed Resident #48 remained up in his Geri-chair no positioning devices or pillow was observed for his neck and no device or splint was observed in his right hand. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/06/2025 at 1:40 PM revealed Resident #48 in room in bed. His head was on his shoulder with no positioning device in place, and no device or splint was noted in his right hand. In an interview on 05/07/2025 at 11:30 AM the COTA/ OTA stated therapy was not currently working with Resident #48. She stated he was last seen for therapy in 03/2023 and had not had any changes in his contractures . Review of Resident #48's OT discharge summary dated 03/31/2023 reflected Patient will safely wear a palmar guard on right hand for up to greater than 8 hours w/ minimal signs and symptoms of redness, swelling, discomfort or pain. In an interview on 05/07/2025 at 1:30 PM CNA J stated Resident #48 used to have a pillow for his neck, but it got dirty, and it got thrown away. She stated he used to have a splint or hand roll for his left hand but has not had one for a long time. CNA J stated the last time she trimmed Resident #48's nails she put a rolled-up wash cloth in his hand so his nails would not dig into his right hand. CNA J stated she did not know if she should put the rolled-up wash cloth in his hand since there was not an order for it. CNA J stated Resident #48's hand was contracted and needed something in it. She stated she put a pillow under his neck today (05/07/2025) to assist in positioning his head. In an interview on 05/07/2025 at 2:00 PM MDS Coordinator A stated she did the care plan for Resident #48. She stated after reviewing his care plan that his interventions on the care plan were just the basic ones they put in. MDS Coordinator A stated there were not any individualized interventions for his right-hand contracture and there was no plan of care for his neck contracture. She stated Resident #48 should have a plan of care for his contractures and interventions to instruct staff on how to care for Residents #48's contractures to prevent complications or increased contractures. In a follow up interview on 05/07/2025 with MDS Coordinator A at 2:30 PM she stated she really did not consider his neck a contracture and that was why it was not care planned . Review of definition of contracture in the [NAME] dictionary reflected a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to restricted joint mobility. Observation on 05/08/2025 at 9:25 AM revealed Resident #48 up in his Geri-Chair. Resident #48 had a pillow positioned under his head between his shoulder and neck and [NAME] guard was noted in his right hand. In an interview with the DON on 05/08/2025 at 12:05 PM the DON stated she expected staff to identify contractures and develop an individualized plan of care for the contractures. She stated that Resident #48's neck was contracted, and he need a plan of care for contractures, so staff know how to manage them. The DON stated the staff failure to do so could lead to residents having worsening contractures, pain, or pressure sores . Review of the facility's undated policy Care planning policy and procedure reflected Purpose: To provide a comprehensive plan of care addressing resident's needs, strengths, goals, and approaches. Policy: Each resident's care plan will remain current and inform staff of resident's needs, strengths, goals, and approaches .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51511 Based on observation, interview, and record review the facility failed to review and update care plan for one of twelve residents (Resident #84) reviewed for care plans timing and revision. The facility failed to ensure that care plan was updated and revised with safety interventions appropriate to resident's cognitive status for Resident #84 after falls on 4/28/2025 and 5/3/2025. These failures could place residents at risk of not having their medical, nursing, and mental needs met, and of not having their safety needs addressed. Finding included: Review of clinical records for Resident #84 reflected an [AGE] year-old female admitted on [DATE], with diagnosis of Fracture to Left Humerus (left upper arm fracture), Multiple rib fractures, Dementia, Diabetes (a condition that affects the way the body processes blood sugar), and Hypertension (high blood pressure). Review of Resident #84's MDS dated [DATE] reflected a BIMS score of 3 (severe cognitive impairment). Health conditions show one fall since admission with major injury. Review of Resident #84's comprehensive care plan on 05/07/2025 at 08:38 AM reflected that there were no interventions for fall mats or low bed. Falls recorded on plan of care 2/8/25, unwitnessed fall, hip fx (fracture) and, 4/28/25, unwitnessed fall no injury. Revision on 5/05/25. There was one revision after February, which is dated 5/5/2025: Educate and encourage me to call for assistance when needing toileting Date Initiated: 04/29/2025. Review of physician orders for Resident #84 reflected no orders for fall precautions, fall mat, increased monitoring, or low bed. There was an order for PT to eval and treat dated 05/06/2025. There were orders for Skilled Physical therapy started on 02/13/2025 and 05/06/2025. Review of Resident #84's Physician Progress dated 04/28/2025 reflect History of Present Illness: ADMISSION HISTORY [AGE] year-old female transferred from another facility for LTC. She has a history of hypertension, GERD, depression and anxiety, diabetes. Patient had a fall and broke her hip. She was discharged . Note for 4-28-2025 reflected, She is somewhat confused today and asking questions that make no sense. Review of Resident #84's Progress Notes reflected an unwitnessed fall on 02/08/2025 in which resident was transferred emergently to the hospital. Resident returned from the hospital on 02/12/2025 with hip/femur fracture. Progress notes dated 04/28/2025 reflected an unwitnessed fall out of bed without injury. Progress note dated 05/03/2025 reflected a witnessed fall out of the resident's bed without injury. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Incident Log related to falls for the facility reflected Resident #84 had an unwitnessed fall on 02/08/2025 and 04/28/2025, and there is a witnessed fall listed on 05/03/2025. There are no outcomes or details listed for residents in this log. Review of Resident #84's Physical Therapy screening assessments were completed for Resident #84 on 02/12/2025 for fall on 02/08/2025, 04/29/2025 for fall on 04/28/2025, and on 05/05/2025 for fall on 05/03/2025. No fall recommendations noted in screening assessments. All indicate resident has difficulty with transfers. Review of Resident #84's Physical Therapy evaluation and plan of treatment with Start of Care dated 02/13/2025 reflected a history of falls, Precautions/Contraindications are listed as: high fall risk, dementia, and unclear WB (ability to bear weight on a limb) precautions. There are no recommended fall precautions listed in this evaluation. Review of Physical Therapy evaluation and plan of treatment with Start of Care dated 05/06/2025 reflected a diagnosis of Repeated Falls. Prior living section reflected, Prior Cognitive Assistance = Constant SUP (24 hr/day supervision needed) Prior Living Description: Patient admitted to this facility 1-28-25 and was modified independent with bed mobility and transfers and sba with ambulation. Since hip fx patient has required min assist with bed mobility, mod assist with transfers and cga with wc mobility up to 100'. She has been no ambulatory. There are no fall precaution recommendations listed on this evaluation. Observation on 05/05/2025 1:50 PM of Resident #84 revealed resident lying in bed in her room, very confused. No fall mat in room. Bed is not in the low position. Observation on 05/06/2025 at 10:00 AM of Resident #84 sitting in wheelchair at bedside. She is talking to herself and the television. She is pressing the call light like a remote control. No fall mat in the room. Observation on 05/07/2025 at 11:41 AM of Resident #84's room reflected no fall mats at the bedside with the bed not in the low position. (Resident was not in room). Observation on 05/07/2025 at 1:34 PM revealed Resident #84 lying in bed. Bed is not in low position. Resident is awake and alert, talking to herself in bed. Interview on 05/07/2025 2:18 PM with DON stated that Resident #84 had a fall with hip fracture in February 2025. Stated she has had two falls since then. Stated that she initiated some interventions for the resident after the fall in February, including encouraging her to use her call light, a sign in the room to remind her to call, and education on the call light. Stated she believes she was able to retain some education . Stated there were no interventions on Resident #84's care plan for low bed, fall mat, or more frequent rounding. Stated that since she has had a third fall recently, We should maybe move to a fall mat. Stated she has physical therapy screen residents after falls to determine appropriate interventions for the resident so as not to restrain her mobility. Stated that if the resident were to fall from a raised bed without a fall mat, she could injure herself. Stated that any fall could potentially result in a fracture. In an interview on 05/07/2025 at 02:35 PM MDS coordinator A stated that the DON updated the care plans related to falls as part of risk management responsibilities. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/08/2025 at 01:49PM with CNA O stated that prior to the fall mat started yesterday, Resident #84's care orders for fall prevention were to keep her call light in reach and encourage her to use it. CNA stated that knowing her fall history, she would keep the bed low. Stated that was on shift for a recent fall where the resident slid out of bed and told the CNA that she was praying. Stated that fall mats are an appropriate intervention to prevent injury with her specific types of fall history. Interview on 05/08/2025 at 02:15PM with RN R stated that prior to the addition for fall mats the previous day, the fall interventions for Resident #84 were to monitor her every two hours and encourage the call light use. Stated that she does not believe that the resident is capable of being educated on the call light and she has not seen the resident use the call light appropriately at all during her shifts. She stated that fall mats are an appropriate intervention to prevent injuries with the specific types of falls that the resident has had. Stated that there were no fall mats prior to yesterday. Stated that if the resident were to fall from a raised bed without a fall mat, she could fracture her hip again or have a head injury. Review of the facility's undated policy Care planning policy and procedure reflected Purpose: To provide a comprehensive plan of care addressing resident's needs, strengths, goals, and approaches. Policy: Each resident's care plan will remain current and inform staff of resident's needs, strengths, goals, and approaches .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 1 of 3 residents (Resident #48) reviewed for ADL's. The facility failed to ensure assistance was provided for repositioning and incontinent care every 2 hours for Resident #48 when he was observed to be left in his Geri-chair on 05/05/2025 from 7:00 AM until 4:00 PM. (9 hours). This failure could place residents at risk of not being provided care and assistance when needed. Findings Included: Review of Resident #48's face sheet dated 05/06/2025 reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses intracranial injury (head injury), spastic hemiplegia affecting dominant side (Hemiplegia is a symptom that involves one-sided paralysis.), contracture of left hand (A permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen and a decrease in range of motion.) Review of Resident #48's quarterly MDS assessment dated [DATE] reflected he was assessed to have a BIMS score of 8 indicating moderate cognitive impairment. Resident #48 was assessed to not have behaviors or refuse care. Resident #48 was further assessed to be dependent on staff for transferring, bed mobility and toileting and was assessed to be incontinent of bowel and bladder. Review of Resident #48's comprehensive care plan reflected a problem dated 07/11/2023 I am at risk for skin break down related to impaired and/or decreased mobility; psoriasis and seborrheic dermatitis. Interventions included .I may need pillow or other supportive/ protective devices to assist with positioning . Keep my skin clean and dry and avoid shearing/friction .Reposition me as appropriate . Further review of Resident #48's comprehensive care plan reflected a problem dated 07/11/2024 I am incontinent of urine. Interventions included Assist me with perineal cleansing as needed. Observe my skin daily for irritation and redness . Observation on 05/05/2025 at 7:00 AM revealed Resident #48 up in Geri-chair sitting outside the dining room in the TV area. Observation on 05/05/2025 at 7:30 AM revealed Resident #48 up in Geri-chair eating breakfast with assist in the dining room. Observation on 05/05/2025 at 11:50 AM revealed Resident #48 up in Geri-chair sitting outside the dining room in the TV area. Resident #48 was observed to be in the same pants and shirt since breakfast. Both his pants and shirt had eggs on them. Observation on 05/05/2025 at 2:51 PM revealed Resident #48 up in Geri-chair sitting outside the dining room in the TV area. Resident #48 was observed to be in the same pants and shirt with clothing more soiled since lunch. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/05/2025 at 3:50 PM Resident #48 was asked if he had been up all day. Resident #48 stated yes. Resident #48 was asked by surveyor if he would mind lying down in the bed so the surveyor could check his skin. Resident #48 stated he did not mind and stated his bottom was sore. Observation on 05/05/2025 at 3:55 PM revealed CNA F and CNA G mechanical lifting Resident #48 into bed. CNA F removed Resident #48's brief in the front to reveal a saturated brief and strong urine odor. Resident #48 was observed with slight redness to his front peri area. CNA F and CNA G then turned Resident #48 onto his side to reveal the saturated brief also contained BM. Resident #48's skin was slightly red and blanchable . In an interview on 05/05/2025 at 4:10 PM the CNA staffer stated CNA H worked Resident #48's hall from 6:00 AM until 2:00 PM then was replaced by CNA G. In an interview on 05/05/2025 at 4:12 PM CNA G stated he had not gotten to Resident #48 yet that when he came in at 2:00 PM he started his rounds at the front of the hall and had not made it to Resident #48 who was at the end of the hall. In an interview on 05/05/2025 at 4:15 PM LVN C stated she was the nurse assigned to Resident #48's hall. LVN C stated she was supposed to round on her residents every 2 hours. LVN C stated she did not today (05/05/2025) because she got distracted. She stated that sometimes Resident #48 will refuse to go to bed. LVN C she stated no one came to her today and told her that Resident #48 refused care and if he had refused care the CNA should have let her know if a resident was refusing care so they could intervene. LVN C stated she was supposed to monitor the CNAs to ensure resident care was being performed; she stated she just got distracted and did not round. In an interview on 05/05/2025 at 5:17 PM CNA H stated she did not put Resident #48 to bed or perform incontinent care for him because he refused to go to bed. She stated she did not report to his nurse LVN C that he refused care. She stated she did not report his behaviors and should have. She stated she should have repositioned him throughout the day and did not. When asked why she did not provide Resident #48 care through out the day she did not answer. CNA H stated they usually put a pillow under his neck because the way it is contracted. She stated they had three CNAs on the hall, so she had help for a two person mechanical lift transfer. CNA H stated she is supposed to make rounds and perform incontinent care every two hours. In an interview on 05/08/2025 at 12:05 PM the DON stated it was her expectation that nurses make rounds every 2 hours to ensure CNAs are making rounds every two hours and that residents are provided incontinent care every two hours. The DON stated even if the resident does not want to go to bed, she stated they still needed incontinent care and to be repositioned every 2 hours. The DON stated if resident refuses care the CNA should tell the nurse and the care plan should reflect the behavior and the behavior should be monitored by the nurses. She stated Resident #48 to her knowledge did not usually refuse care. Review of the facility's undated policy Incontinence Care reflected Purpose: 1. To keep skin clean, dry, free of irritation and odor. 2. To identify skin problems as soon as possible so treatment can be started. 3. To prevent skin breakdown. 4. To prevent infection . The facility policy did not address how often incontinent care should be provided. No other policies related to resident rounds or repositioning of residents requested on 05/07/2025 and 05/08/2025 were provided.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 Based on observation, interview, and record review the facility failed to ensure 1of 4 residents reviewed with limited range of motion (Resident 48), received appropriate treatment and services to prevent a decrease in range of motion. The facility failed to ensure Resident #48 had interventions in place for his right- hand contracture and neck contracture (A permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen and a decrease in ROM) to prevent further decline of the range of motion in his right hand and neck. This deficient practice placed residents with contractures at risk for decrease in mobility, range of motion, and could contribute to worsening of contractures. Findings Include: Review of Resident #48's face sheet dated 05/06/2025 reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses intracranial injury (head injury), spastic hemiplegia affecting dominant side (Hemiplegia is a symptom that involves one-sided paralysis.), contracture of left hand (A permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen and a decrease in range of motion.) Review of Resident #48's quarterly MDS assessment dated [DATE] reflected he was assessed to have a BIMS score of 8 indicating moderate cognitive impairment. Resident #48 was assessed to have functional limitations in range of motion on both upper and lower extremities. Review of Resident #48's comprehensive care plan reflected a problem dated 07/11/2023 revised on 03/24/2025 I require staff assistance for all ADL's related to spastic hemiplegia affecting right side; contracture of left hand. Interventions included .I require assistance with bed mobility, transfers and assist with feeding . Interventions did not include interventions for contracture management of his right hand and the care plan did not address his neck contracture. Observation and interview on 05/05/2025 at 7:30 AM revealed Resident #48 up in his Geri-chair in the dining room. Resident #48 was observed to have a contracture to his right hand with his fingers curling toward his palm, no splint, hand roll or other device was observed. Resident #48 was further observed to have a neck contracture with Resident #48's neck bent toward his left should (touching his shoulder). Resident #48 was asked if he could open his hand and he stated no, he was further asked if he could move his head and he stated, No it is stuck that way. No pillow or positioning device was observed. Observation on 05/05/2025 at 3:50 AM revealed Resident #48 remained up in his Geri-chair no positioning devices or pillow was observed for his neck and no device or splint was observed in his right hand. (continued on next page)

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Legacy Nursing and Rehabilitation	2817 Kent Street Bryan, TX 77802

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/06/2025 at 1:40 PM revealed Resident #48 in room in bed. His head was on his shoulder with no positioning device in place, and no device or splint was noted in his right hand. In an interview on 05/07/2025 at 11:30 AM the COTA/ OTA stated therapy was not currently working with Resident #48. She stated he was last seen for therapy in 03/2023 and had not had any changes in his contractures . Review of Resident #48's OT discharge summary dated 03/31/2023 reflected Patient will safely wear a palmar guard on right hand for up to greater than 8 hours w/ minimal signs and symptoms of redness, swelling, discomfort or pain. In an interview on 05/07/2025 at 1:30 PM CNA J stated Resident #48 used to have a pillow for his neck, but it got dirty, and it got thrown away. She stated he used to have a splint or hand roll for his left hand but has not had one for a long time . CNA J stated the last time she trimmed Resident #48's nails she put a rolled-up wash cloth in his hand so his nails would not dig into his right hand. CNA J stated she did not know if she should put the rolled-up wash cloth in his hand since there was not an order for it. CNA J stated Resident #48's hand was contracted and needed something in it. She stated she put a pillow under his neck today (05/07/2025) to assist in positioning his head. In an interview on 05/07/2025 at 2:00 PM MDS Coordinator A stated she did the care plan for Resident #48. She stated after reviewing his care plan that his interventions on the care plan were just the basic ones they put in. MDS Coordinator A stated there were not any individualized interventions for his right-hand contracture and there was no plan of care for his neck contracture. She stated Resident #48 should have a plan of care for his contractures and interventions to instruct staff on how to care for Residents #48's contractures to prevent complications or increased contractures. In a follow up interview on 05/07/2025 with MDS Coordinator A at 2:30 PM she stated she really did not consider his neck a contracture and that was why it was not care planned . Review of definition of contracture in the [NAME] dictionary reflected a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to restricted joint mobility. Observation on 05/08/2025 at 9:25 AM revealed Resident #48 up in his Geri-Chair. Resident #48 had a pillow positioned under his head between his shoulder and neck and [NAME] guard was noted in his right hand. In an interview with the DON on 05/08/2025 at 12:05 PM the DON stated she expected staff to identify contractures and develop an individualized plan of care for the contractures. She stated that Resident #48's neck was contracted, and he needed a plan of care for contractures, so staff know how to manage them. The DON stated the staff failure to do so could lead to residents having worsening contractures, pain, or pressure sores. Review of the facility's undated policy Range of motion exercises policy and procedure reflected .To improve or maintain joint mobility and muscle strength . To prevent complications of immobility . Neck . Loss of voluntary movement and limitation in range of motion of the head and neck should be assessed and appropriate treatment ordered by a physician .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51511 Based on observation, interview, and record review the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for one (Resident #84) of twelve residents reviewed for fall interventions. The facility failed to ensure adequate supervision and assistance devices to prevent accidents and develop effective interventions to prevent accidents for Resident #84 after falls on 2/8/2025, 4/28/2025, and 5/3/2025. These failures could place residents at risk of repeated falls with major injury and/or fracture. Findings include: Review of clinical records for Resident #84 reflected an [AGE] year-old female admitted on [DATE], with diagnosis of Fracture to Left Humerus (left upper arm fracture), Multiple rib fractures, Dementia, Diabetes (a condition that affects the way the body processes blood sugar), and Hypertension (high blood pressure). Review of Resident #84's MDS dated [DATE] reflected a BIMS score of 3 (severe cognitive impairment). Review of Resident #84's comprehensive care plan on 05/07/2025 at 08:38 AM reflected that there were no interventions for fall mats or low bed. Falls recorded on plan of care 2/8/25, unwitnessed fall, hip fx (fracture) and, 4/28/25, unwitnessed fall no injury. Revision on 5/05/25. There is one revision after February, which is dated 5/5/2025: Educate and encourage me to call for assistance when needing toileting Date Initiated: 04/29/2025. Review of physician orders for Resident #84 reflected no orders for fall precautions, fall mat, increased monitoring, or low bed. There is an order for PT to eval and treat dated 05/06/2025. There are orders for Skilled Physical therapy started on 02/13/2025 and 05/06/2025. Review of Resident #84's Physician Progress dated 04/28/2025 reflect History of Present Illness: ADMISSION HISTORY [AGE] year-old female transferred from another facility for LTC. She has a history of hypertension, GERD, depression and anxiety, diabetes. Patient had a fall and broke her hip. She is somewhat confused today and asking questions that make no sense. Review of Resident #84's Progress Notes reflected an unwitnessed fall on 02/08/2025 in which resident was transferred emergently to the hospital. Resident returned from the hospital on 02/12/2025 with hip/femur fracture. Progress notes dated 04/28/2025 reflected an unwitnessed fall out of bed without injury. Progress note dated 05/03/2025 reflected a witnessed fall out of the resident's bed without injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Incident Log related to falls for the facility reflected an unwitnessed fall on 02/08/2025 and 04/28/2025; there is a witnessed fall listed on 05/03/2025. There are no outcomes or details listed for residents in this log. Review of Resident #84's Physical Therapy screening assessments were completed for Resident #84 on 02/12/2025 for fall on 02/08/2025, 04/29/2025 for fall on 04/28/2025, and on 05/05/2025 for fall on 05/03/2025. No fall recommendations noted in screening assessments. All indicate resident has difficulty with transfers. Review of Resident #84's Physical Therapy evaluation and plan of treatment with Start of Care dated 02/13/2025 reflected a history of falls, Precautions/Contraindications are listed as: high fall risk, dementia, and unclear WB (ability to bear weight on a limb) precautions. There are no recommended fall precautions listed in this evaluation. Observation on 05/05/2025 1:50 PM of Resident #84 revealed resident lying in bed in her room, very confused. No fall mat in room. Bed is not in the low position. Observation on 05/06/2025 at 10:00 AM of Resident #84 sitting in wheelchair at bedside. She is talking to herself and the television. She is pressing the call light like a remote control. She is unable to operate the television remote without frequent assistance from staff. No fall mat in the room. Observation on 05/07/2025 at 11:41 AM of Resident #84's room reflected no fall mats at the bedside with the bed not in the low position. (Resident was not in room). Observation on 05/07/2025 at 1:34 PM revealed Resident #84 lying in bed. Bed is not in low position. Resident is awake and alert, talking to herself in bed. Interview on 05/07/2025 2:18 PM with DON stated that Resident #84 had a fall with hip fracture in February 2025. Stated she has had two falls since then. Stated that she initiated some interventions for the resident after the fall in February, including encouraging her to use her call light, a sign in the room to remind her to call, and education on the call light. Stated she believes she was able to retain some education. Stated there were no interventions on Resident #84's care plan for low bed, fall mat, or more frequent rounding. Stated that since she has had a third fall recently, We should maybe move to a fall mat. Stated she has physical therapy screen residents after falls to determine appropriate interventions for the resident so as not to restrain her mobility. Stated that if the resident were to fall from a raised bed without a fall mat, she could injure herself. Stated that any fall could potentially result in a fracture. Stated she was made aware of all falls for the resident. Review of Physical Therapy evaluation and plan of treatment with Start of Care dated 05/06/2025 reflected a diagnosis of Repeated Falls. Prior living section reflected, Prior Cognitive Assistance = Constant SUP (24 hr/day supervision needed) Prior Living Description: Patient admitted to this facility 1-28-25 and was modified independent with bed mobility and transfers and sba with ambulation. Since hip fx patient has required min assist with bed mobility, mod assist with transfers and cga with wc mobility up to 100'. She has been no ambulatory. There are no fall precaution recommendations listed on this evaluation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/07/2025 at 02:35 PM MDS coordinator A stated that the DON updated the care plans related to falls as part of risk management responsibilities. Interview on 05/08/2025 at 01:49PM with CNA O stated that prior to the fall mat started yesterday, Resident #84's care orders for fall prevention were to keep her call light in reach and encourage her to use it. Stated that knowing her fall history, she would keep the bed low. Stated that was on shift for a recent fall where the resident slid out of bed and told the CNA that she was praying. Stated that fall mats are an appropriate intervention to prevent injury with her specific types of fall history. Interview on 05/08/2025 at 02:15PM with RN R stated that prior to the addition for fall mats the previous day, the fall interventions for Resident #84 were to monitor her every two hours and encourage the call light use. Stated that she does not believe that the resident is capable of being educated on the call light and she has not seen the resident use the call light appropriately at all during her shifts. She stated that fall mats are an appropriate intervention to prevent injuries with the specific types of falls that the resident has had. Stated that there were no fall mats prior to yesterday. Stated that if the resident were to fall from a raised bed without a fall mat, she could fracture her hip again or have a head injury. Review of facility policy on Fall Prevention Program and Procedure reflected, 1. All residents will be placed on the Fall Prevention Program as decided by the Interdisciplinary Team upon admit and evaluated for continuation at quarterly assessment. 2. All residents will be re-evaluated at quarterly assessment and as needed for high risk based on fall assessment, history of falls and overall status. 6. All residents on the program will have care plan addressing goals and approaches.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 Based on observations, interviews, and record review the facility failed to ensure pain management was provided to residents who required such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 2 of 3 (Resident #150, and Residents #85) residents reviewed for pain management. A) The facility failed to ensure Resident #150 effective pain management by not evaluating effectiveness of current pain medications and not having her current pain medications available for administration. B) The facility failed to ensure that Resident #85 received at least daily assessments of pain for 34 of 49 days. This failure could place resident at risk for increased pain causing undo suffering. Findings included: A) Review of Resident #150 face sheet dated 05/06/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses chronic pain syndrome, and other specified disorder of bone density and structure, multiple sites. Review of Resident #150 EMR reflected the only MDS completed was her entry MDS dated [DATE]. Review of her nursing admission assessment dated [DATE] completed by LVN E reflected she was assessed for pain on admission with the pain level of 4/10. Review of LVN E's documented note reflected Pt. was medicated prior to leaving last facility . Review of Resident #150 physician orders reflected an order dated 05/02/2025 Monitor for pain every shift; Fentanyl patch 75mcg /hr. replace every 72 hours; Baclofen 5mg two times daily and oxycodone HCL 5mg one tablet every 4 hours as needed for severe pain related to chronic pain syndrome. In an interview on 05/05/2025 at 9:10 AM Resident #150's FM stated she was concerned about Resident #150's pain medication. She stated the facility has not gotten it right since her admission on 05/02/2025. The FM stated Resident #150's oxycodone should be routine instead of PRN. She stated Resident #150 was having too much breakthrough pain. In an interview and observation on 05/06/2025 at 11:22 AM Resident #150 stated she was in pain that her neck was hurting, and she needed her pain medication. Resident #150 stated it had been an hour since she asked for pain medication and still had not gotten it and it was an hour late. Resident #150 began crying stating she was really hurting. Review of Resident #150's base line care plan reflected no entries related to pain or pain management. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow up interview on 05/06/2025 at 12:10 PM Resident #150 stated she got her pain medication at 12:00 noon. She stated she had neck pain that was severe which came from a fused vertebra in her neck. She stated they took off her Fentanyl patch on 05/05/2025 and did not put another one on because they did not have any and it needed to be ordered. She stated she wanted her oxycodone to be put routine instead of PRN because they take too long to bring it when it is PRN . Resident #150 further stated she will refuse to take her Baclofen sometimes because it makes her to sleepy and stated she has told them she only wants to take it at night, but they keep trying to give it to her during the day. In an interview on 05/06/2025 at 1:30 PM LVN D stated Resident #150 MD had to reorder her Fentanyl patch due to the triplicate needed. He stated the admitting nurse should have reached out to Resident #150's MD to order the Fentanyl on admission. LVN D stated the medication would be delivered this evening. LVN D stated if the medication had been ordered on the day of her admission she would not have run out. LVN D further stated he was told earlier today right before lunch that she needed pain medication. LVN D further stated he took the medication right to Resident #150 . Review of Resident #150's MAR reflected she was administered her oxycodone HCL 5mg on 05/06/2025 at 7:02 AM and 11:56 AM. (4 hours and 56 min apart) Further review of Resident #150 MAR reflected her pain level was documented at an 8 out 10 at 11:56 AM. In an interview on 05/06/2025 at 5:30 PM LVN E stated when Resident #150 was admitted she had a Fentanyl patch on. LVN E stated she ordered all her medication from the pharmacy but called the NP regarding the fentanyl patch since she could not order it. LVN E further stated the order had to come from the doctor and the NP told her she would call Resident #150's MD to get the order for the Fentanyl. Review of Resident #150's MAR dated May 2025 reflected an entry that Resident #150's Fentanyl patch was removed at 4:34 PM on 05/05/2025. Review of Resident #150's nursing progress note reflected an entry dated 05/05/2025 at 4:34 PM related to order to apply Fentanyl patch documented awaiting drug arrival. Further review reflected an entry dated 05/06/2025 at 2:08 PM This nurse spoke with pharmacist to have fentanyl patch and oxycodone mediation STAT delivered at this time. Pending delivery from pharmacy. Review of nursing progress notes reflected an entry on 05/06/2025 at 5:53 PM Fentanyl patch 75mcg/hr. dose administered at 5:45 PM to right chest. In an interview on 05/07/2025 at 9:35 AM Resident #150 stated her pain was ok this morning she stated she just got her oxycodone and they put her pain patch (Fentanyl) on last night. In an interview on 05/07/2025 at 12:05 PM Resident #150's NP stated she could not order Fentanyl from the pharmacy that the medication had to be ordered by Resident #150's MD. Resident #150's MS stated she has told the nurses in the past and has been reiterating with them that they need to call the MD when they have orders for Fentanyl and to follow up as needed if the medication is not delivered. She stated Residents should have their pain medications on hand to ensure their pain was under control to prevent mood changes and increased anxiety. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/07/2025 at 3:36 PM MDS Coordinator B stated Resident #150 should have a base line plan of care within 48 hours of admission. She further stated Resident #150 should have had a plan of care for her pain. She stated Resident #150 not having one could lead to staff not knowing what to do for the resident to manage her pain. In an interview on 05/08/2025 at 12:05 PM the DON stated the base line care plan should be completed within 48 hours and should cover the residents' immediate needs. She stated with Resident #150's pain which was a big issue with her and should have been on her base line care. She stated failure of the staff not putting all the residents care needs on the base line care plan could lead to staff not knowing what care to provide the resident. In an interview on 05/08/2025 at 12:05 PM the DON stated it was the admitting nurse's job to ensure medications were ordered on admission. She stated with Resident #150, LVN E was new and did not know that she was supposed to follow up with the MD. She stated it was a training issue and she was going to provide training to her to ensure she understood it was not the NP responsibility to follow up with the MD but her responsibility to follow and make sure the medications are ordered ensure the residents care needs are met and residents do not experience pain. B) Review of face sheet dated 05/06/2025 for Resident #85 reflected a [AGE] year-old male, admitted on [DATE], with diagnoses including Metabolic encephalopathy (a group of conditions that cause brain dysfunction), Dementia, Pain, Primary osteoarthritis of the right shoulder (a joint disease that causes breakdown of cartilage and bone), Depression. Review of MDS for Resident #85 dated 02/20/2025 reflected a BIMS score of 11 (moderate cognitive impairment). Review of Physician progress note dated 02/27/2025 reflected a history of Right shoulder surgery. Review of Physician Orders for Resident #85 on 05/06/2025 reflected that there was no order for pain monitoring. Review of Care plan for Resident #85 reflected a focus area dated 02/19/2025 of I am experiencing the presence of pain (Rt Shoulder) with interventions including to Evaluate my pain using a 1-10 scale and Watch me for worsening of my pain symptoms and report to my physician. There are no interventions stating how often to check for pain. Assessments for pain reflected there were no entries for 03/20/2025, 03/25/2025, 03/28/2025, 03/29/2025, 03/30/2025, 03/31/2025, 4/2/2025, 04/03/2025, 04/04/2025, 04/05/2025, 04/06/2025, 04/07/2025, 04/08/2025, 04/09/2025, 04/10/2025, 04/11/2025, 04/12/2025, 04/13/2025, 04/14/2025, 04/15/2025, 04/16/2025, 04/17/2025, 04/18/2025, 04/19/2025, 04/20/2025, 04/21/2025, 04/22/2025, 04/23/2025, 04/24/2025, 04/25/2025, 04/26/2025, 04/27/2025, 04/28/2025, 04/29/2025, 04/30/2025, 05/01/2025, 05/02/2025, 05/03/2025, 05/04/2025, 05/05/2025, 05/06/2025. This is 34 of the last 49 days where pain was not assessed for this resident. Review of Progress notes for Resident #85 reflected there were no progress notes documenting pain on a 1-10 scale for the days not listed between 04/01/2025 to 05/06/2025. There are no narrative style progress notes with assessments of pain levels from 1-10 for the dates not documented on in the pain assessments. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/05/25 at 9:13 AM revealed Resident #85 in room. Resident was standing in front of a chest of drawers, leaning on his elbows with his head in his hands. Resident cannot recall the words for the location of the pain, but indicated he had pain to his back on the right side, under his right shoulder blade. Stated that he asks the nurses for medication and his is given what he can take. Stated the pain medications do not help enough. Resident knows where he is but was unable to recall the details of the conversation for more than a few moments. Interview with RN on 05/07/2025 at 10:30 AM stated that Resident #85 had been to orthopedic surgeon twice for steroid injections related to pain. Stated that recent medication added for the resident's pain have been ineffective. State he has an appointment in June for another steroid injection and the facility is going to consult pain management. RN states she was knowledgeable of his unresolved pain condition. Stated there are times that he does not complain of pain. Surveyor requested that RN show where pain is charted. She indicated that her documentation would be in the TAR. RN confirmed that there is no order for pain monitoring. Stated that if there is not a place to document in the TAR, she had not been documenting pain for this resident. She stated that a resident with chronic pain should have orders to monitor for pain at least once a shift. She stated that she does monitor for pain with rounds for her patients. Stated she would add the order to monitor for pain. Stated that unresolved pain can lead to depression, anxiety, agitation, increase in behaviors, and high blood pressure. Interview on 05/07/2025 at 10:38AM with NP stated that the nurses should be monitoring pain every day for Resident #85. Stated it should be recorded with vital signs or in progress notes. Observation on 05/07/2025 at 11:42 AM revealed Resident #85 sitting at the table in the dining room, leaning on his elbows with his head in his hands. Stated he was having pain. Stated his pain was 5/10 to the right side of his back under his right shoulder blade. Stated he asked for pain medications today. Stated he does not recall who he told about the pain. In an interview on 05/8/2025 at 01:52 PM DON stated they should be monitoring pain every day for Resident #85. Stated that her expectation for monitoring pain in residents with chronic or unresolved pain is that they bed assessed every shift, prior to PRN medications, and after medications to assess for effectiveness. Stated that resident #85 should have orders to monitor for pain. Stated his pain should be documented at least daily. Stated that if we do not monitor for pain and document the pain levels they will not know if he has had any pain. Review of facility undated Pain Management Policy and Procedure reflected: Purpose: To maintain the resident as pain free as possible with the least amount of medication required. Policy: Resident pain is to be assessed and addressed to meet individual needs. Procedure: 1. Resident is to be assessed for pain every shift and as needed. a) Pain scale 0-10 utilized for verbal and facial. 2. Nurse to be notified of any resident having pain. Pain medication is to be utilized as ordered by the physician and as indicated. 4. PRN pain medication is to be administered as applicable. 5. The nurse is to document effectiveness of pain medications administered. 6. A non-pharmacological pain intervention is to be provided to assist in pain management . 51511

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation	2817 Kent Street Bryan, TX 77802

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 Based on interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drug and biological) to meet the needs of each resident for 1of 5 residents (Resident #150) reviewed for medications and pharmacy services, in that: The facility failed to ensure Resident #150 physician ordered medication Fentanyl was available for administration. These deficient practices could place residents at risk of not receiving therapeutic dosage of medications and symptomatic changes in vital signs. Findings include: Review of Resident #150 face sheet dated 05/06/2025 reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses chronic pain syndrome, and other specified disorder of bone density and structure, multiple sites. Review of Resident #150 EMR reflected the only MDS completed was her entry MDS dated [DATE]. Review of her nursing admission assessment dated [DATE] completed by LVN E reflected she was assessed for pain on admission with the pain level of 4/10. Review of LVN E's documented note reflected Pt. was medicated prior to leaving last facility . Review of Resident #150 physician orders reflected an order dated 05/02/2025 Monitor for pain every shift; Fentanyl patch 75mcg /hr. replace every 72 hours; Baclofen 5mg two times daily and oxycodone HCL 5mg one tablet every 4 hours as needed for severe pain related to chronic pain syndrome . In an interview on 05/06/2025 at 12:10 PM Resident #150. She stated she had neck pain that was severe which came from a fused vertebra in her neck. She stated they took off her Fentanyl patch on 05/05/2025 and did not put another one on because they did not have any and it needed to be ordered. In an interview on 05/06/2025 at 1:30 PM LVN D stated Resident #150 MD had to reorder her Fentanyl patch due to the triplicate needed. He stated the admitting nurse should have reached out to Resident #150's MD to order the Fentanyl on admission. LVN D stated the mediation would be delivered this evening. LVN D stated if the medication had been ordered on the day of her admission she would not have run out. In an interview on 05/06/2025 at 5:30 PM LVN E stated when Resident #150 was admitted she had a Fentanyl patch on. LVN E stated she ordered all her medication from the pharmacy but called the NP regarding the fentanyl patch since she could not order it. LVN E further stated the order had to come from the doctor and the NP told her she would call Resident #150's MD to get the order for the Fentanyl. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #150 MAR dated May 2025 reflected an entry Resident #150's Fentanyl patch was removed at 4:34 PM on 05/05/2025. Review of Resident #150's nursing progress note reflected an entry dated 05/05/2025 at 4:34 PM related to order to apply Fentanyl patch documented awaiting drug arrival. Further review reflected an entry dated 05/06/2025 at 2:08 PM This nurse spoke with pharmacist to have fentanyl patch and oxycodone mediation STAT delivered at this time. Pending delivery from pharmacy. Review of nursing progress notes reflected an entry on 05/06/2025 at 5:53 PM Fentanyl patch 75mcg/hr. dose administered at 5:45 PM to right chest. In an interview on 05/07/2025 at 9:35 AM Resident #150 stated her pain was ok this morning she stated she just got her oxycodone and they put her pain patch (Fentanyl) on last night. In an interview on 05/07/2025 at 12:05 PM Resident #150's NP stated she could not order Fentanyl form the pharmacy that the medication had to be ordered by Resident #150's MD. Resident #150's MS stated she has told the nurses in the past and has been reaerating with them that they need to call the MD when they have orders for Fentanyl and to follow up as needed if the medication is not delivered. She stated Residents should have their pain medications on hand to ensure their pain was under control to prevent mood changes and increased anxiety. In an interview on 05/08/2025 at 12:05 PM the DON stated it was the admitting nurse's job to ensure medications were ordered on admission. She stated with Resident #150 LVN E was new and did not know that she was supposed to follow up with the MD. She stated it was a training issue and she was going to provide training to her to ensure she understood it was not the NP responsibility to follow up with the MD but her responsibility to follow and make sure the medications are ordered ensure the residents care needs are met and residents do not experience pain. Review of the facility's undated policy Medications orders processing reflected The purpose of this procedure is to provide guidelines for ordering medications from pharmacy. Medication orders shall, except when the Pharmacy is closed, be processed, and dispensed only after being reviewed and checked by a Pharmacist . The facility's policy did not address medication ordering timelines or the procedure for ordering narcotics.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51511 Based on observation, interview, and record review the facility failed to ensure it was free of a medication error rate of 5% or greater. There were four (4) medication errors in 35 opportunities for an error rate of 11. 43% by 1 of 3 staff members observed (LVN C) administering medications to 1 of 7 residents. (Resident #35). Resident #35 was administered 325 mg Aspirin, crushed via PEG tube. Order stated 81 mg Chewable Aspirin, administered by mouth. Medication was administered with the incorrect dose and route of administration. Resident #35 failed to receive adequate physical assessment per the accepted standards and principles which apply to professionals, including vital signs for blood pressure and pulse, prior to receiving medications for lowering blood pressure. This failure could place residents at risk of not receiving medications as ordered and not receiving therapeutic benefits. Findings include: Review of Face sheet for Resident #35 reflected a [AGE] year-old male, admitted on [DATE], with diagnoses including Cerebral Infarction (interruption of blood flow to the brain), Dysphagia (difficulty swallowing), Aphasia (difficulty using or understanding language), and Essential Hypertension (high blood pressure). Review of MDS for Resident #35 dated 05/06/2025 reflected a BIMS score of 3 (severely cognitively impaired). Review of current Care Plan for Resident #35 reflected a Focus area stating, I have a diagnosis of hypertension. Interventions listed for the Focus area included Administer my antihypertensive medications as ordered and Obtain and evaluate my blood pressure as appropriate. Focus areas also include: I have difficulty swallowing r/t Dysphagia (NPO DIET) and I have difficulty with communicating r/t aphasia. Review of current orders for Resident #35 on 05/07/2025 at 0851AM reflected: Metoprolol Tartrate Oral Tablet 50 MG (Metoprolol Tartrate) Give 1 tablet via PEG-Tube two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION, Aspirin 81 Oral Tablet Chewable (Aspirin) Give 1 tablet by mouth in the morning related to OTHER SEQUELAE OF CEREBRAL INFARCTION (I69.398), Lisinopril Oral Tablet 20 MG (Lisinopril) Give 1 tablet via PEG-Tube in the morning for htn, Norvasc Oral Tablet 10 MG (Amlodipine Besylate) Give 1 tablet via G-Tube in the morning for htn, NPO diet related to Aphasia (indicates nothing should be taken by mouth for resident), and Vitals Q month. Review of blood pressure records on 05/07/2025 at 08:47AM for Resident #35 reflected his last recorded blood pressure on 04/12/2025 at 05:43PM was recorded as 114/69. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of pulse records on 05/07/2025 at 08:47AM for Resident #35 reflected his last recorded pulse on 04/12/2025 at 0543 PM was 82 bpm . Observation of medication administration for Resident #35 on 05/06/2025 0728 with LVN C revealed LVN C administered 325 MG Aspirin, crushed via PEG tube (a tube inserted into the stomach) administration. LVN C administered metoprolol 50 MG 1 tablet, crushed via PEG tube, lisinopril 20 MG tablet, crushed via PEG tube, and amlodipine 10 MG tablet, crushed via PEG tube without taking any vital signs prior to medication administration. Interview on 05/07/2025 at 09:15 AM the DON was informed of a medication error rate greater than five percent, including failure to provide blood pressure monitoring before administering Metoprolol, Lisinopril, and Amlodipine; and incorrect dose and route for aspirin 81 mg PO for Resident #35. She stated she was not aware of a lack of parameters regarding blood pressure medications for Resident #35. Stated that she doesn't believe that pharmacy has made any recommendations regarding the parameters or route of administration. Stated she would have the order for Chewable Aspirin 81 mg by mouth updated with the correct route of administration today. Stated they do not require parameters for all blood pressure medications. Asked if it was a regulatory requirement to have blood pressure parameters with blood pressure medications. Observation on 05/17/2025 at 0924AM revealed LVN E in resident room with Resident #35. LVN E is wearing gloves and holding the resident's PEG tube while she is pouring in a bottle of tube feeding liquid. Stated that she was just finishing the administration of his morning medications and tube feeding. Interview on 05/07/2025 at 09:32 LVN E stated I always check when asked if she took a blood pressure prior to administration of AM doses of Metoprolol, Lisinopril, and Amlodipine. Stated that if I do not check and record vital signs, the resident's blood pressure could be abnormally low or high and she would not know. Stated the care team would not be able to track blood pressure trends if readings were not documented. Stated that in her experience most places do have parameters for blood pressure medications. Stated that as a nurse she is accustomed to taking blood pressure and sometimes pulse before giving blood pressure medications. Stated she did not give the aspirin 81mg by mouth for Resident #35. Stated she gave it crushed through the resident's PEG tube. Stated that shel did not notice the order was for oral administration when she reviewed it while preparing his medications. Stated she just assumed that he has all his medications through his g-tube . Stated she should have called the doctor and gotten new orders for the correct route of administration. She stated that if a resident who is unable to communicate his symptoms or refuse medications is given blood pressure medications without first checking blood their blood pressure, it could result in a drop in blood pressure and the resident could possibly die. In a phone interview with 5/7/2025 at 0952 AM with LVN C stated that she did give 325 mg Aspirin via PEG tube, not the 81 mg Aspirin ordered for the resident. Stated that aspirin 81 mg PO was not an appropriate way to administer a medication for Resident #35. Stated she did not see that in the order. Stated she should have reviewed the order, talked to the NP, and unit manager to let them know that the order is wrong. Stated that she should get a new order. Stated that she did not take a blood pressure or pulse before giving his blood pressure medications. Stated that she did not take the blood pressure or pulse because the medication did not have parameters. Stated that giving blood pressure medications without monitoring the blood pressure for a resident could lead to a drop in blood pressure or pulse, causing hypotension. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Phone interview on 05/07/2025 10:00 AM with Pharmacist, stated Is this a regulatory requirement? I don't do this for blood pressure medications at home. Unable to complete interview. Call disconnected. Interview on 05/07/2025 at 10:38AM NP stated that chewable aspirin by mouth is not an appropriate order for Resident #35. Stated the nurses should have clarified the order with a provider. Stated that blood pressure medications should have parameters for blood pressure and sometimes pulse. Stated that the staff should be checking blood pressure before giving blood pressure medications to a resident who cannot communicate their symptoms. Stated there used to be standing parameters for the facility with blood pressure medications. Stated that having parameters for blood pressure medications is a standard of care. Stated that if staff are administering blood pressure medications without checking a blood pressure prior to administration, residents could have hypotension (low blood pressure), including dizziness and lethargy. Stated that pharmacy should be reviewing medications for correct route of administration and appropriate parameters. Stated that there have been no recent recommendations regarding parameters with blood pressure medications. In a phone interview on 05/08/2025 at 0939AM with DP of the facility pharmacy consultant group stated that he would question an order for an oral medication for a resident with all PEG tube medications. That is it is sometimes hard to catch, but yes orders should be reviewed for incorrect route of administration. Stated that the standard of practice for the level of monitoring required for a patient is individualized for the patient. Stated that if a resident was unable to communicate symptoms or refuse a medication and may have a lack of cognitive skills to inform staff of changes and was receiving several daily or more than daily blood pressure medications that he would discuss the appropriate level of medication monitoring for that resident with the Medical Director, who has the final say. Informed that there were no noted recommendations from Pharmacy regarding this resident for the month of April. Stated that Standards of Practice would apply to medication administration. Interview on 5/8/2025 at 1:52 PM with DON stated that it is a standard of practice to monitor blood pressure when residents are receiving multiple blood pressure medications and are unable to communicate their symptoms to staff or refuse the medication. Sstated that if we do not monitor residents blood pressure with administration of medications intended to lower blood pressure, especially those without the ability to report their symptoms or refuse the medications, it could lead to the resident becoming worse and the facility would not know. This could include a hypotensive or hypertensive crisis (an emergency situation where blood pressure is abnormally high or low). Stated that if the resident was given an oral medication as it was with the current order, it could have led to the resident choking. Stated that the increased dose of aspirin given related to the medication error could have caused and adverse medication reaction or stomach pain. She stated that her expectation was that staff review the orders before giving medications and call the physician or nurse practitioner to update the orders if there is a concern and to also inform unit managers if there is a medication concern that is not resolved by physician. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/8/2025 at 2:25 PM with Administrator stated that it was his expectation that the pharmacist consultants and medical director create safe parameters for medications for the residents in the facility. Stated that it is his expectation that staff follow standards of practice for their discipline. Stated he would refer to his team for information on details regarding standards of practice for their discipline. Stated that for residents with daily or more than daily medications meant to lower blood pressure, especially those without the ability to communicate their symptoms or refuse a medication, not monitoring blood pressure prior to giving medications could result in an unhealthy drop in blood pressure. Stated that it is his expectation that nursing contact the physician regarding any inappropriate orders for a resident. Stated that a failure to update inappropriate orders could result in a variety of negative outcomes for a resident. Stated that regarding the order for aspirin by mouth for Resident #35, if it had been given by mouth he could have choked. Review of facility policy Medication Administration Policy and Procedure reflected: 6. Medication Administration Record shall be compared with the resident's medical record prior to preparation of any medication. 7. The individual administering the medication shall verify the medication selected for administration is the correct medication based on the medication order and the medication product label. 8. The individual administering a medication shall be aware of the following information concerning each medication before administration: a. Therapeutic action b. Untoward actions or side effects . g. Signs of medication deterioration h. Precautions i. Any contraindications that would preclude the administration of the medication. 10. The individual administering a medication shall discuss any unanswered, significant concerns about the medication with the resident's physician or prescriber of the medication and/or healthcare staff providing care, treatment, and services to the resident. a. The discussion shall be documented in the resident's medical record. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	18. The medication nurse shall assure that the correct medication is administered by checking the physician's order and the medication label.

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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. 51511 Based on observation and interview the facility failed to ensure expired and/or discontinued medications were removed from use for one of two medication storage rooms in the facility. The facility failed to ensure expired and/or discontinued medications were removed from use for one medication storage room. This failure could place residents at risk of not receiving the intended therapeutic benefits of their medications. Findings include: Observation and interview on 05/07/2025 at 11:25 AM of medication storage review for Medication Storage closet on Hall 100 revealed six bottles of Multivitamins with an expiration date of 01/2024 and one box of Nicotine Patches with an expiration date of 04/2024. The ADON present at the time of the review observed and removed the expired packages from the room. The ADON stated that medications would be disposed of per facility policy. Interview on 5/8/2025 at 1:52 PM with DON stated that her expectation is that the supply person monitor the expiration dates when supplies are restocked. She stated a Unit Manager/ADON will be assigned to review this weekly going forward. Stated that expired medications can potentially cause adverse medication reactions with residents or not be effective for their intended purpose. Interview on 5/8/2025 at 2:25 PM with Administrator stated that expired products should be disposed of. Stated the responsibility for monitoring for expired products would ultimately fall on the DON but could be delegated to another staff if appropriate. Stated that use of expired medications could result in potential negative outcomes for a resident, including decreased effectiveness of the medication. Review of facility policy for Medication Administration Policy and Procedure reflected 8. The individual administering a medication shall be aware of the following information concerning each medication before administration: a. Therapeutic action b. Untoward actions or side effects c. Antidote (if applicable) and its location d. Route and frequency of administration e. Appropriate timing of medication administration (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Normal dosage and maximum safe dosage g. Signs of medication deterioration h. Precautions i. Any contraindications that would preclude the administration of the medication. j. That the expiration date has not been exceeded.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 51470 Based on observations, record review and interviews, the facility failed to prepare food by methods that conserve nutritive value for 1 of 1 kitchen reviewed for food and nutrition services. 1. The facility failed to ensure Dietary [NAME] K refrained from adding an unmeasured amount of liquid from cooked carrots to pureed carrots during meal service on 5/6/2025. 2. The facility failed to ensure Dietary [NAME] K refrained from adding an unmeasured amount of pan juices to pureed roast during meal service on 5/6/2025. This failure had the potential to affect all residents who received pureed diets prepared in the facility's kitchen, placing those residents at risk for diminished or altered nutritional status and potential weight loss. Findings included: Observation on 5/6/2025 at 10:24 AM revealed Dietary [NAME] K placed cooked carrots into the puree blender. She began to add unmeasured liquid from the cooked carrots to the puree blender. Dietary [NAME] K added unmeasured liquid twice to the puree blender with cooked carrots. Dietary [NAME] K proceeded to prepare the pureed roast by adding unmeasured pan juices to the puree blender. Interview on 5/6/2025 at 10:40AM, Dietary [NAME] K was asked how many servings of pureed carrots and roast she had prepared. She stated that she did not know the exact number but made enough to cover all the pureed diets. When asked how many residents were on pureed diets, Dietary [NAME] K stated there were 20. Dietary [NAME] K asked what instructions she followed for measuring the liquid added to the puree. She responded that she just guessed the amount. When asked if she had ever been trained on how much liquid to add, she stated no; she stated that she had not and that she just eyeballs it. In an interview on 5/6/2025 at 10:45AM, with Dietary Supervisor, she was asked if there was a recipe book available for the dietary cooks to follow for pureed and other diet textures. Dietary Supervisor presented the recipe book. Dietary [NAME] K was called over to review the recipe book. Dietary Supervisor explained to Dietary [NAME] K the recipes for pureed food items were in the recipe book. The recipe for pureed carrots and roast were reviewed. Dietary [NAME] K stated she understands the recipe will need to be adjusted for the 20 pureed diets. Policy/protocol for pureeing food was requested from Dietary Supervisor, she stated she is not aware of one and she will check the files. The policy /protocol for pureeing food was not provided at the time of exit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51470 Based on observations, interviews, and record reviews the facility failed to properly store, prepare, distribute food in accordance with professional standards for food service safety for 1 of 1 kitchen. 1. The facility failed to label and date all food items located in the walk-in refrigerator and in the dry food pantry area on [DATE], [DATE], and [DATE]. 2. The facility failed to discard expired food items located in the walk-in refrigerator and in the dry food pantry area. 3. The facility failed to clean and sanitize its cooking equipment, including the deep fryer and two ovens. 4. The facility failed to ensure that dietary staff wore hair restraints (e.g. beard restraints) to prevent hair from contacting food, per current Food Code. These failures could place residents who received meals from the kitchen at risk of foodborne illnesses. The findings included: Observation during the initial tour of the kitchen on [DATE] beginning at 07:17 AM, the following was observed: Walk-in refrigerator: o Bag of coleslaw-not dated, not labeled, expiration date-[DATE]. o Carton of scrambled egg mix, not labeled, not dated. o Tray of 19 dessert cups(cheesecake),not labeled, not dated. Dry Food Pantry area: o 1 loaf of bread, not labeled, not dated. o 2 packages of rolls, not labeled, not dated. o Large plastic container of rice, not labeled, not dated. o 2 -1-gallon containers of corn syrup, expiration date-[DATE] o ,d+[DATE]-gallon containers of Reduced Italian dressing-expiration date-[DATE] (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o ,d+[DATE]-gallon containers, 1 opened-expiration date-[DATE] Dietary Aide M with beard was noted not to be wearing a beard restraint. During a follow up tour of kitchen on [DATE] beginning at 9:20AM, the following was observed: Expired food items remained: 1 bag of coleslaw, 2 -1-gallon containers of corn syrup, ,d+[DATE]-gallon containers of Reduced Italian dressing, and ,d+[DATE]-gallon containers of Reduced Italian dressing. The unlabeled, undated scrambled egg mix remained in refrigerator. The deep fryer was observed with excessive buildup of grease and food debris on both interior and exterior surface; the ovens were observed to be soiled with black smut and charred residue inside indicating kitchen equipment had not been cleaned in accordance with food safety standards. [DATE] at 9:54AM, kitchen policy and procedure were requested from Administrator. In an interview on [DATE] at 11:54AM, with Dietary Supervisor, the surveyor requested copies of the facility's cleaning schedule. Dietary Supervisor provided copies. The Dietary Supervisor was asked how often the deep fryer was cleaned. She stated that it is cleaned every other Friday if fish is served. She noted that fish is usually served on Fridays. She also stated that the fryer is cleaned on Saturday nights but added it had just been cleaned after surveyor left earlier. When asked how often the stove is cleaned, the Dietary Supervisor stated that it is cleaned every two weeks. The surveyor then asked what potential harm could occur if kitchen equipment is not cleaned as scheduled. The dietary supervisor stated that unclean equipment could cause a fire hazard and cooking food in unclean equipment could cause residents to become ill. Dietary Supervisor was asked how new employees are trained on kitchen policies and protocols, she stated new staff are trained by tenured employees for 3 days, and additional training time is provided if needed. Record review of the facility's Food Safety and Sanitation Policy and Procedure, not dated revealed: Policy: All local, state, and federal standards and regulations are followed to assure a safe and sanitary food service department. Procedure: 4.Hair restraints are required and should cover all hair on the head. Food Storage: 9. All time and temperature control for safety (TCS) leftovers are labeled, covered, and dated when stored. a. They are used within 72 hours (or discarded). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation	2817 Kent Street Bryan, TX 77802

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Foods with expiration dates are used prior to the use by date on the package. 11. Canned and dry foods without expiration dates are used within six months of delivery or according to the manufacturer's guidelines. Record review of facility's kitchen weekly cleaning schedule revealed: Wednesday-clean on top of stove top & clean ovens (top and bottom) Thursday-Check all leftovers in refrigerator & clean deep fryer. During a final visit to kitchen on [DATE] at 2:08 PM, the following was observed: Dietary [NAME] L noted with about a 1 to 1 ,d+[DATE]-inch beard was not wearing a beard restraint. Dietary Aide M noted with about a 2-inch beard was not wearing a beard restraint. Dietary Aide N noted with about a 2 ,d+[DATE]-inch beard was not wearing a beard restraint. During an interview on [DATE] at 2:10 PM, Dietary Aide M stated he has been employed at the facility for one year. He stated he received training on hair restraints but stated he had not been trained on beard restraints and he had never been instructed to wear one. When asked about potential issues that could arise from hair falling into food, he stated a resident could choke and that staff could get fired. During an interview on [DATE] at 2:13 PM, Dietary Aide M stated he has been employed at the facility for two months. He stated he received training on hair restraints and beard restraints. Dietary Aide M stated he does not wear a beard restraint because the facility has not provided beard restraint. During an interview on [DATE] at 2:16 PM, Dietary [NAME] L stated he has been employed at the facility for 9 months. He stated he was first a dietary aide and now he was a cook. He stated he was trained on hair restraints and beard restraints. Dietary [NAME] L stated his understanding was that beard restraints are only required if your beard is longer than one inch. Dietary [NAME] L also stated that all dietary staff are responsible for labeling and dating food items, as well as discarding expired foods. He stated the potential risk for not discarding expired food, could cause the residents to become ill. During Interview on [DATE] at 2:34 PM with Dietary Supervisor, she was asked the protocol for hair and beard restraints. Dietary Supervisor stated all individuals entering the kitchen are required to wear a hair restraint at all times. She explained that this is the reason that hair nets are placed outside the entry door for kitchen staff. When asked about beard restraints, the Dietary Supervisor stated she was not aware that employees were required to wear beard restraints. She stated she thought staff only needed to be clean cut. Dietary Supervisor stated she will order some beard restraints. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dietary Supervisor was asked about food labeling and discarding procedures . Dietary Supervisor stated all staff are responsible for labeling food items with date received, the name of the item if it's a new item. She stated prepared items are labeled with the date they were cooked and discard date, which is 3 days later. Dietary Supervisor stated all kitchen staff are expected to check food items dates daily and discard expired items when found. She stated she has monthly in-service on labeling. When asked about the potential harm of serving expired foods to residents, the Dietary Supervisor stated that it could result in residents becoming ill or experiencing food poisoning.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 51511 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections and follow accepted national standards for two of three residents reviewed for infection control practices. (Resident #5 and Resident #35). The facility failed to ensure that LVN C, LVN E, and Hospice RN P followed Enhanced Barrier Precautions when providing care and use of invasive lines for Resident #5 with medication administration through a PEG tube and for Resident #35 during urinary catheter bag change. These failures could place the residents at risk for developing infection. Findings included: Review of Face sheet for Resident #35 reflected a [AGE] year-old male, admitted on [DATE], with diagnoses including Cerebral Infarction (interruption of blood flow to the brain), Dysphagia (difficulty swallowing), Aphasia (difficulty using or understanding language), and Essential Hypertension (high blood pressure). Review of MDS for Resident #35 dated 05/06/2025 reflected a BIMS score of 3 (severely cognitively impaired). Review of Physician orders for Resident #35 reflected orders for Enhanced Barrier Precautions dated 01/06/2025, NPO diet related to Aphasia (indicates nothing should be taken by mouth for resident) dated 05/28/2024, Enteral feed: two times a day (indicating the resident should receive tube feeding formula twice a day through direct line to stomach) dated 05/30/2024. Review of Care plan for Resident #35 reflected a focus area of, I require Enhanced Barrier Precautions related to peg. Date initiated: 05/28/2024 and intervention including, Staff will wear PPE during caring for an indwelling medical device dated 05/28/2024. Review of Face sheet for Resident #5 reflected a [AGE] year-old male, admitted on [DATE], with diagnoses including Malignant neoplasm of the prostate (prostate cancer), cardiomegaly (enlarged heart), metabolic encephalopathy (a group of conditions that cause brain dysfunction), and personal history of radiation. Review of MDS for Resident #5 dated 02/07/2025 shows BIMS of 3 (severe cognitive impairment). Review of Physician orders for Resident #5 reflected orders for Enhanced barrier precautions dated 04/26/2024, Suprapubic catheter = (18) French with (30) CC bulb dated 04/24/2025, and Admit to Hospice dated 11/24/2023. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Care plan for Resident #5 reflected a focus area indicating I am at risk for urinary tract infection r/t suprapubic catheter, dated 04/03/2024. Focus area indicating I use a suprapubic catheter with a goal of I will experience no infections from catheter use. Focus area indicating I require Enhance barrier precautions related to catheter. Interventions listed included Staff will wear PPE during Caring for an indwelling medical device. Date initiated 04/03/2024. Focus area indicating I have chosen to receive Hospice Care- dated 08/17/2024, with intervention to Coordinate my care with my Hospice Team date initiated 08/17/2024. Observation of medication administration on 5/6/2025 at 0728AM revealed that LVN C did not wear a gown during administration of medication and tube feeding formula for Resident #35 through his PEG tube (a tube inserted into the stomach). There was a sign on the door for Enhanced Barrier Precautions, indicating that a gown and gloves should be worn with all direct care for Resident #35. Observation on 05/07/2025 at 9:24 AM revealed LVN E administered medications and tube feeding formula to Resident #35 through PEG tube with gloves on. LVN E was not wearing a gown. There is a sign on the door for Enhanced Barrier Precautions. Interview on 05/07/2025 at 10:19 AM LVN E stated she did not wear a gown when she administered medications and tube feeding formula to Resident #35. Stated that she should wear a gown and gloves any time she is handling the PEG tube. Stated that if Enhanced Barrier Precautions are not followed, the resident could get an infection. Observation on 05/06/2025 at 10:10 AM revealed Hospice RN P walking to the bathroom in the room with Resident #5. She had a pair of gloves on and was carrying a urinary catheter bag in her hand. She was not wearing a gown. Interview on 05/06/25 at 10:10 AM with Hospice RN P stated she was changing out the urinary catheter bag for Resident #5. Stated she did not use a gown to provide care for the urinary catheter. Surveyor pointed to the sign on the door for Enhanced Barrier Precautions. Hospice RN P stated that, it may be a facility policy, but that is not how hospice does things. Stated she would not wear a gown changing a catheter bag in someone's home. Interview on 05/06/2025 at 1:40 PM with Hospice Nurse RN Q stated if hospice is working in the building, we honor the facility policies infection control. Stated that if proper PPE is not worn when caring for residents on Enhanced Barrier Precautions including urinary catheter bag care, the resident is at an increased risk for infection. Interview on 5/8/2025 at 1:52 PM with DON stated that staff have ready access to PPE for EBP in the linen rooms and on the treatment cart for wound care. Stated her expectation was for staff to wear a gown and gloves for any care regarding urinary catheters and PEG tubes (tube inserted into the stomach). Stated that the Hospice agency is responsible for education with their own staff. Stated that the hospice staff are responsible for following the infection control policies of the facility when working with residents in the facility . Stated she would in-service the hospice staff on EBP and inform the hospice agency regarding the lack of required PPE used in care of the Resident #35. Stated that not wearing required PPE with resident care could lead to infection for the resident and contribute to the spread of infection in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/8/2025 at 2:25 PM with Administrator stated that it is his expectation that the hospice staff follow the infection control policies of the facility when they work with residents in the facility. Stated the potential impact to the resident could be a transfer of infection to the resident or others. Record review of Hospice contract reflected the agency shall provide services to the Residents who are under Hospice's care at the same level and to the same extent as those services would be provided if the Resident was at home (facility), indicating that while a resident is being cared for in the facility, that care provided by the hospice agency should be of the same extent as that provided by the facility. Review of facility policy for infection control reflected Place identified residents in required Isolation Precautions per CDC or Office of Public Health Guidelines. Review of Facility Enhanced Barrier Precautions policy reflected: 1. EBP are indicated for residents with any of the following: a. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or b. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. ii. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. 4. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: a. Dressing b. Bathing/Showering c. Transferring d. Providing Hygiene e. Changing Linens f. Changing briefs or assisting with toileting g. Device care or use (Central line, urinary catheter, feeding tube, tracheostomy) 5. PPE is to be applied prior to performing the high-contact resident activity according to below and before moving on to another resident. a. Perform hand hygiene. (continued on next page)

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