STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675501	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy West Rehabilitation and Healthcare	3300 W 2nd Ave Corsicana, TX 75110

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 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** 41654 Based on interview and record review, the facility failed to ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 5 residents (Resident #19) reviewed for care plans. The facility failed to ensure Resident #19's care plan dated 05/31/2024 reflected the resident's recent left below knee amputation which had been updated/changed on 09/30/2024. This failure could place residents at risk of not receiving appropriate care to meet their current needs. Findings include: Record review of a facility face sheet for Resident #19 dated 11/21/24 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included peripheral vascular disease (also known as peripheral artery disease, is a condition that occurs when blood vessels narrow or become blocked, reducing blood flow to the body) (peripheral vascular disease can affect any blood vessel outside of the heart, but it most commonly affects the legs and feet), atrial fibrillation (irregular, often rapid heart that causes poor blood flow), osteoarthritis (a degenerative joint disease that causes the cartilage and bone in a joint to break down over time), cerebrovascular disease (a general term for conditions that affect the blood vessels in the brain and spinal cord, which can lead to serious complication), and white matter disease (a progressive disorder that occurs when the white matter in the brain is damaged.) Record review of Resident #19's Quarterly MDS assessment dated [DATE], reflected under Section C Cognitive Patterns, a BIMS score of 15 indicating Resident #15 was cognitively intact. Further review of the MDS assessment under Section K - Swallowing/Nutritional Status reflected resident required set-up or clean up assistance with eating, substantial/maximal assistance with toileting and showering, and partial/moderate assistance with personal hygiene. MDS reflected under Section I reflected Resident #19 had active diagnoses of peripheral vascular disease and acquired absence of left foot. Record review of Resident #19's Care Plan initiated 05/31/24 revealed a problem: Impaired physical Mobility r/t loss of balance and coordination Secondary to CVA; Muscle weakness Goal: Resident's needs will be met daily over the next 90 days. Interventions include: assist with mobility as needed daily, encourage ROM exercises as needed, may provide therapy as needed. (continued on next page)

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

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Problem: Has an ADL self-care performance deficit r/t pain, S/P Fracture, weakness. Resident chooses to sleep in recliner at times. Goal: Will demonstrate the appropriate use of adaptive device to increase ability in ADLS. Interventions include: MOBILITY: Requires moderate assist to ambulate x 1 staff, TRANSFER: Resident requires maximal assistance for all transfers. Record review of physician orders dated 11/08/24 for Resident #19 revealed an order for Float right heel when in bed every shift. In an interview on 11/19/24 at 11:07 AM, Resident #19 stated she was doing fine. She stated she recently had her left leg amputated below her knee. She stated staff took care of everything and all treated her well. She stated she used a call light and staff got to her quickly when she called for them. She stated she participated in therapy and had learned a lot from them. She stated she had no concerns. In an interview on 11/21/24 at 11:30 AM, the MDS stated the purpose of a care plan was to explain what they treated a resident for and informed staff of the residents plan of care. She stated she was responsible for completing and revising care plans. She stated the DON, or a corporate nurse were responsible for ensuring the accuracy of the care plans. She stated she had been trained on completing and revision of care plans. She stated if a resident had an amputation, it should have been included on their care plan and it could have affected the residents ADL's. She stated she was not aware that Resident #19's care plan did not include that Resident #19 had an amputation to her left leg below her knee. She stated Resident #19's amputated left leg below the knee should have been care planned. She stated if an amputation was not care planned it could have affected how the staff knew what to do for the resident or could have affected the care or transfer of a resident. In an interview on 11/21/24 11:40 AM, the DON stated the purpose of a care plan was to have known the plan of care for the residents. She stated the MDS nurse was responsible for completing and revising care plans. She stated they had care plan meetings and revised the care plans as needed and they also had care plan meetings and went over the care plans during the meetings and made changes as needed. She stated the corporate nurse was responsible for ensuring the accuracy of the care plans. She stated the MDS nurse was trained on completing and revision of care plans. She stated if a resident had an amputation, it should be included in the care plan. She stated she was not aware that Resident #19's left below knee amputation was not included in her care plan, but that it should have been in the care plan. She stated if an amputation was not included in a care plan, staff may not know a residents correct status, and it could have affected the safety awareness or transfers. In an interview on 11/21/24 11:55 AM, the ADM stated the purpose of a care plan was to inform nursing staff of how to properly care for the resident. She stated the MDS nurse was responsible for completing and revising the care plans and she had been trained on how to complete and revise the care plans accurately. She stated the IDT reviewed the care plans quarterly and initially the MDS nurse should ensure the care plans were done correctly. She stated any amputation should be care planned. She stated she was not aware that Resident #19's left below knee amputation was not care planned. She stated Resident #19 was one of their long-term residents and she had recently gone out to have the amputation done and then to a rehabilitation hospital. She stated Resident #19's amputation should have been care planned upon her re-admission. She stated if an amputation was not care planned it may have caused confusion for the staff and if the care plan had been done, it could have provided more direction for resident positioning. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled Comprehensive Care Plans dated 04/14/24 reflected the following documentation: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma informed. 2. The comprehensive care plan will be developed along with the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. d. The resident's goals for admission, desired outcomes, and preferences for future discharge. f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate. g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative. 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.