

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/04/2025
NAME OF PROVIDER OR SUPPLIER  Legacy Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE  4033 W 51st Ave Amarillo, TX 79109	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39813</p> <p>Based on interview, record review, the facility failed to report an alleged violation of abuse/neglect immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation resulted in serious bodily injury, to officials in accordance with State law, including to the State Survey Agency for one (Resident #1) of 9 residents reviewed for abuse/neglect.</p> <p>The facility failed to report that Resident #1 alleged that she had been raped on 1-22-2025.</p> <p>The noncompliance was found to be Past Non-Compliance (PNC). The noncompliance began on 1-22-2024 and ended on 2-2-2024. The facility corrected the noncompliance before the investigation began.</p> <p>This failure could result in delayed identification of abuse or neglect and lack of timely follow-up on recommended interventions to prevent serious bodily harm, or lasting physical impairment.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet dated 2-4-2025 revealed a [AGE] year-old female resident admitted to the facility originally on 10-21-2022 and readmitted on [DATE] with diagnoses to include drug induced subacute dyskinesia (a movement disorder that can develop over days or weeks after exposure to certain medications), muscle weakness (a lack of muscle strength), difficulty walking, diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), paranoid schizophrenia (a disease that affects a person's ability to think, feel, and behave clearly), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), anxiety disorder (a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), mild intellectual disabilities (a condition that affects a person's intellectual functioning and adaptive skills), and alcohol dependence.</p> <p>Record review of Resident #1's last MDS was a quarterly completed 11-26-2024 with a BIMS of 11 indicating she was moderately cognitively impaired, and she had a functionality of requiring set-up/clean up to supervision/touching assistance with most activities.</p> <p>Record review of Resident #1's care plan with admitted [DATE] revealed the following:</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Focus: Resident is at risk for delusions or an acute confusional episode r/t paranoid schizophrenia. - Date Initiated: 02-09-2024.</p> <p>Focus: Resident is at risk for impaired cognitive function/dementia or impaired thought processes r/t DX: Cancer, PARANOID SCHIZOPHRENIA. - Date Initiated: 10-21-2022.</p> <p>Focus: Resident has potential for a psychosocial well-being problem r/t hallucination, delusions, paranoia all that occur intermittently due to DX: Paranoid Schizophrenia. - Date Initiated: 01-22-2025.</p> <p>Record review of Resident #1's Progress Notes revealed the following note completed by LVN A on 1-22-2025:</p> <p>Note Text: Late Entry. Resident stated to this nurse during medication pass, A man comes in my room and rapes me while I'm sleeping. He makes my roommate get out and he rapes me. This nurse told resident that I have been here all night and the aids have been here as well and there has not been a man in her room. This nurse asked resident if she was having hallucinations or delusions and if she could have dreamt this happening. Resident denied hallucinations, delusions or dreaming that she had been raped. Resident stated, It happens while I'm asleep. This nurse told resident that the only resident in the room was the roommate, and she had been in there the whole night. Also let resident know that this nurse has been at the nurses' station all night and that no one has been in her room other than the roommate and aide to help. Resident stated, That makes me feel better. Maybe I did dream it. Left resident in room with equal rise and fall in chest and call light in reach. No further needs. Plan of care continues.</p> <p>Record review of the Provider Investigation Report dated 1-31-2025 revealed the following:</p> <p>Incident Date: 1-22-2025</p> <p>Date Reported to HHSC: 1-26-2025.</p> <p>Description of Allegation: Resident stated to the nurse a man came into her room and raped her while she was asleep.</p> <p>During an interview on 2-4-2025 at 08:18 AM the ADM reported that the nurse who took the original report from Resident #1 when Resident #1 made her alleged rape on 1-22-2025 did not report this to management until 4 days later and then back dated her note. The ADM reported that LVN A had already been written up for the incident and reeducated.</p> <p>During an interview on 2-4-2025 at 10:23 AM PO B reported that he was early into the investigation with Resident #1 and was reluctant to give any opinion. PO B reported that he did not feel the allegation did occur, but he still needed to get records and interview staff before he would make an official finding. PO B was also waiting on records from another facility were apparently Resident #1 made similar allegations. PO B gave a case #25501238 for this incident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2-4-2025 at 10:32 AM LVN A reported that Resident #1 had reported to her on 1-22-2025 that a man was coming into her room every night while she was sleeping and raping her. LVN A reported that she waited 4 days to report the incident due to Resident #1's history of false allegation, that Resident #1 reported that night that the man involved made her roommate leave the room, and that he was the man from the couple that was always arguing across the hall. LVN A reported that only ladies lived across the hall, there were no males capable of assaulting Resident #1, that she (LVN A) was always up on the unit, and that at least one CNA was always working at the kiosk across from Resident #1's room. LVN A reported that they would have noticed a strange male on the unit, anyone entering or leaving the Resident #1's room to include Resident #1's roommate, so she (LVN A) did not feel the allegation was legitimate. LVN A stated, I didn't think it happened at all with all the false allegations Resident #1 makes. Resident #1's is always accusing someone of stealing or something of that nature. LVN A verified that she had been trained several times on ANE when the facility provides handouts and that she just finished her yearly computer training on 1-29-2025.</p> <p>During an interview on 2-4-2025 at 1:07 PM OM C reported that if an allegation of abuse or neglect was not reported immediately a resident could suffer and something could happen to that resident that we do not want them to have happen.</p> <p>During an interview on 2-4-2025 at 1:47 PM Per the ADM reported that he was aware that the facility was out of compliance with the reporting requirements and that he was aware that they would be cited for the noncompliance. He reported that was why he implemented their policy of a written reprimand for the employee involved and reeducation to include reeducation for all staff so that the noncompliance would not occur again, and resident safety would be maintained.</p> <p>Record review of the facility provided policy titled Nursing Administration revised 10-2013, revealed the following:</p> <p>Subject: Abuse Prevention</p> <p>Policy: It is the policy of this facility that each resident has the right to be free from abuse .</p> <p>D, Identification of Abuse</p> <p>All alleged violations, including injuries of unknow source and misappropriation of resident property are reported immediately to the administrator of the facility and to the officials in accordance with State law through established procedures.</p> <p>Record review of facility provided documents revealed a written warning given to LVN A Date of Notice - 1-27-2025 for failure to report abuse in a timely manner.</p> <p>Record review noted LVN A completed her required assigned retraining for Abuse: Preventing, Recognizing, and Reporting on 2-2-2025.</p> <p>Record review noted all staff completed a facility provided training for Abuse/Neglect and when to report Abuse/Neglect started 1-26-2025 with last date of staff signature 1-28-2025.</p>		