

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 06/07/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854</p> <p>Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 21 residents (Resident #94) reviewed for resident's rights.</p> <p>-CNA A was standing next to Resident #94's Geri-chair while feeding resident his lunch time meal.</p> <p>This failure could cause residents to feel humiliated and disrespected.</p> <p>Findings include:</p> <p>Record Review of Resident #94's clinical records revealed a [AGE] year-old male resident who was admitted to the facility on [DATE]. Resident #94 had the following diagnosis of personal history of transient ischemic attack (TIA), and cerebral infarction (stroke) without residual deficits, Hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs and facial muscles) and Hemiparesis (a nervous system disorder that causes a person to have a relatively mild loss of strength on one side of their body) following cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it) affecting right dominant side, Type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar (glucose) without complications, unspecified convulsions (seizures), post-traumatic stress disorder (disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), chronic, 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), unspecified, depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), unspecified, hemiplegia unspecified affecting right dominant side, generalized anxiety disorder, essential (primary) hypertension (a condition in which the force of the blood against the artery walls is too high), hypomagnesemia (low magnesium, acute kidney failure (sudden onset disease of the kidneys leading to kidney failure),, unspecified, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), unspecified, other specified disorders of brain.</p> <p>Record review of Resident #94's MDS, dated [DATE] revealed a BIMS score that was blank and had functionality of complete dependency upon staff with every ADL.</p> <p>Record review of Resident #94's care plan dated 05/03/2024, 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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Focus:</p> <p>[Resident #94] has ADL Self Care</p> <p>Performance Deficit r/t DX: CVA & encephalomalacia (the softening or loss of brain tissue after cerebral infarction, cerebral ischemia infection, craniocerebral trauma or other injury) of bilateral cerebrum (the principal and most anterior part or the brain) & cerebellum (the part of the brain at the back of the skull).</p> <p>Date Initiated: 05/03/2024 .</p> <p>.Interventions:</p> <p>o EATING: requires 1 person assistance to eat.</p> <p>Date Initiated: 05/03/2024</p> <p>Observation on 06/07/24 at 1:10 PM revealed CNA A standing next to Resident #94's Geri-chair feeding Resident #94 in the dining room of facility. Once CNA A spotted surveyor she promptly got a chair and sat down next to Resident #94 and continued to feed him his lunch.</p> <p>During an interview on 06/07/24 at 1:16 PM, CNA A stated that she did not sit down next to resident due to so many residents being in the dining room. CNA A stated that once the smokers went out to smoke she would be able to find a chair more easily. CNA A stated that a negative outcome for not sitting next to the resident to feed him was there just weren't any chairs available.</p> <p>Record review of facility provided admission pack revealed the following policy Federal Resident Rights undated, revealed the following:</p> <p>As a resident of this nursing facility, you have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31882</p> <p>Based on observation, interview and record review the facility failed to ensure residents had the right to and the facility promoted and facilitated resident self-determination through support of resident choice, which included but not limited to the right to make choices about aspects of his or her life in the facility that were significant to the resident for 1 of 25 residents (Resident #21) reviewed for self-determination.</p> <p>The facility failed to ensure Resident #21 was allowed to choose the type of foods he preferred when he expressed he would like all the foods the other residents were served.</p> <p>This failure could place residents at risk for being denied the opportunity to exercise his or her autonomy regarding things that were important in their life and a decrease in their quality of life.</p> <p>Findings include:</p> <p>Record review of Resident #21's face sheet revealed a [AGE] year-old-male admitted to the facility on [DATE] with diagnoses to include dementia (defective memory), dysphagia (difficulty swallowing), diabetes (a disease that results in too much sugar in the blood) and pain.</p> <p>Record review of comprehensive MDS assessment dated [DATE] revealed Resident #21 was usually understood. The MDS revealed Resident # 21 had a BIMS of 3 out of 15 which indicated the resident's cognition was severely impaired. Section K indicated Mechanically altered diet: Require change in texture of food or liquids.</p> <p>Record review of a care plan, dated 05/9/24 for Resident # 21 revealed the following:</p> <p>Category: Nutritional Status</p> <p>Resident has a potential for nutritional problem.</p> <p>Record review of Resident # 21's order summary report dated 6/7/24 revealed the following orders:</p> <p>Diet ordered 10/16/23: LCS, Pureed texture, nectar thick liquids consistency.</p> <p>Record review of Resident #21's diet card dated Wednesday 6/5/24 for the lunch meal revealed Resident # 21 should have received cream pie and sweet potato casserole with his meal.</p> <p>An observation was made on 6/5/24 at 12:03 pm of Resident #21's lunch tray revealed he got pudding instead of a cream pie. There was no sweet potato casserole on his plate.</p> <p>Record Review of the tray ticket for 6/6/24 for the lunch meal revealed Resident # 21 should have received a dessert empanada with his meal.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation was made on 6/6/24 at 12:00pm of Resident #21's lunch tray revealed he got pudding instead of a dessert empanada on the plate.</p> <p>Record Review of the tray ticket for 6/7/24 for the lunch meal revealed Resident # 21 should have received mixed berry cake with his meal.</p> <p>An observation was made on 6/7/24 at 12:00 pm of Resident #21's lunch tray revealed he got Jell-O, instead of a mixed berry cake.</p> <p>Record view of Resident # 21's weight log, March-May 2024, indicated there was no significant weight loss at the time of survey.</p> <p>During a confidential interview on 6/6/24 at 12:20 pm an employee stated Resident's #21 got pudding for the lunch meal on 6/5/24 instead of pie and pudding again for the supper dessert on 6/5/24 which listed a chocolate chip cookie. She stated most residents in the unit got a chocolate chip cookie on 6/5/24. The employee stated the residents with a pureed meal always got pudding instead of the listed dessert. The employee stated some of the other residents in the unit with a regular meal often get pudding instead of the scheduled dessert. The employee stated Resident # 21 was able to express his wants and he always asks for a dessert instead of pudding. The employee stated Resident #21 always looked sad when he did not get the same foods as other residents. The employee stated Residents # 21 will eat everything he was given and enjoyed eating different foods.</p> <p>During an interview on 6//7/24 at 11:00 am the RD stated she was not aware the menu for residents with purees were not being followed. She stated she expects residents to get what is listed on the menu in the correct form. She stated she trains the staff in policies and how to complete tasks in the kitchen. The Rd stated the consequences of not getting all menu items at meals could be a difference in the caloric intake and lost nutrients.</p> <p>During an interview on 6/7/24 at 12: 55 pm, Resident #21 stated loved the desserts and got tired of puddings all the time. He stated he was sad when he did not get the same foods as he saw on everyone else's plate.</p> <p>During an interview on 6/7/24 at 1:45 pm, the DM stated she was not aware residents on a pureed diet were not receiving pureed items as the menu listed. She stated the banana cream pie, the empananda and the chocolate chip cookie should have been pureed. The DM stated she was not aware residents with pureed diets were receiving pudding at multiple meals. She stated she could not say why residents received so much pudding for meals. She stated she had been short in the kitchen, and she only had one cook. She stated the sweet potatoes for the meal on Wednesday lunch was not pureed. The DM stated she did not have any polices for the kitchen. She stated she trains staff by telling employees how to do a task. She stated the consequences of not providing all the menu items for meals would be not getting enough nutrition.</p> <p>Record review of the facility's undated policy titled, Quality of Care with the subject Therapeutic Diets revealed:</p> <p>It is the policy of this facility that therapeutic diets shall be prescribed by the attending physician. A tray identification system is established to ensure each resident receives his diet as ordered.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39813</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice for 1 (Resident #5) of 21 residents reviewed for respiratory care.</p> <p>The facility failed to change Resident #5's nebulizer tubing and mask as per his physician orders.</p> <p>This failure could affect residents on respiratory therapy by placing them at risk for respiratory compromise and associated complications such as shortness of breath, confusion, respiratory failure, and exacerbation of their condition.</p> <p>Findings include:</p> <p>Record review of Resident #5's face sheet revealed a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include unspecified intracranial injury (brain dysfunction usually caused by an outside force, usually a violent blow to the head), chronic obstructive pulmonary disease (COPD refers to a group of diseases that cause airflow blockage and breathing-related problems), chronic pain (persistent pain that can last years), osteoarthritis (break down of joints causing pain related to age/wear and tear) or (degeneration of joint cartilage) malnutrition (lack of proper nutrition), coronary artery disease (damage or disease in the hearts major blood vessels), anxiety (a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), Type 2 diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), and cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it.</p> <p>Record review of Resident #5's clinical record revealed his last MDS was a quarterly completed 3-20-2024 listing him with a BIMS score of 12 indicating he was moderately cognitively impaired, and he had a functionality of requiring partial to moderate assistance with most of his activities of daily living.</p> <p>Record review of Resident #5's Order Summary Report with Active Orders as of: 6-5-2024 revealed the following order:</p> <p>- CHANGE NEBULIZER TUBING/MASK/MOUTHPIECE every night shift every</p> <p>Sun - Verbal Active 12/18/2023</p> <p>- Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 3 ml inhale orally four times a day . Verbal Active 07/18/2023</p> <p>Record review of Resident #5's clinical record revealed a care plan with the admitted [DATE], with the following:</p> <p>Focus-Resident has COPD (Chronic Obstructive Pulmonary Disease): med Ipratropium-Albuterol Inhalation Solution .</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Intervention-Give aerosol or bronchodilators as orders. (There was no intervention documented to address the nebulizer equipment care.)</p> <p>Focus-Resident has oxygen therapy r/t Dx of COPD: (date initiated 7-19-2023)</p> <p>Intervention-Change O2 tubing and humidifier bottle q week per physician orders. (Date initiated 7-19-2023) (There were no intervention documented to address the nebulizer equipment care.)</p> <p>During an interview on 06-05-2024 at 08:09 AM the Administrator reported that the previous DON resigned without notice and the new DON started last week and was currently at training and would be unavailable during the survey.</p> <p>During an observation and interview on 06-05-2024 at 09:27 AM Resident #5 was in his room sitting at the side of his bed eating his breakfast wearing his O2. Noted on Resident #5's bedside dresser was a nebulizer with his mask that was noted to have particles in the mask and the mask was noted to have been used frequently. Noted at the base of the mask was tubing that was dated 4-21-2024 with no date noted on the mask. Resident #5 reported that he receives his nebulizer treatments 3 times a day.</p> <p>During an observation on 06-06-2024 at 08:42 AM of Resident #5's nebulizer equipment revealed the mask continued to have particulates in it from continued use (the mask looked dirty). Noted was a second date of 6-2-2024 written over the original date of 4-21-2-24.</p> <p>During an interview on 06-06-2024 at 09:21 AM LVN A (the nurse responsible for Resident #5 this shift) reviewed a photo of Resident #5's nebulizer tubing (taken 6-5-2024) and verified that it was dated 4-21-2024 and that Resident #5's nebulizer mask looked a little dirty. LVN A reported that the nebulizer equipment is usually changed once a month. LVN A was asked to verify Resident #5's orders and LVN A noted that the nebulizer equipment to include tubing was to be changed weekly on Sunday per physician orders. LVN A reported that he would get the mask and tubing changed immediately. LVN A was asked to verify physically that the mask was marked 4-21-2024 and that the mask was dirty. LVN A noted that the nebulizer tubing was marked 6-2-2024 and stated, its marked 6-2-2024 but it looks liked its marked over the 4-21-2024 and that is just lazy. LVN A reported that if the equipment is not changed as it should then the resident could get an infection.</p> <p>During an interview on 06-06-2024 at 09:25 AM the CRN verified that Resident #5's nebulizer tubing was dated 4-21-2024 and that the mask did look dirty. The CRN was asked to physically observe the mask and tubing and upon inspection the CRN again verified that the mask did look dirty and that the tubing was marked 4-21-2024 and someone wrote over the date with 6-2-2024. The CRN reported that if the nebulizer equipment is not changed and maintained then a resident can get an infection.</p> <p>Record review of the facility provided policy titled Oxygen Equipment undated revealed the following:</p> <p>Policy: It is the policy of this facility to maintain all oxygen therapy equipment in a clean and sanitary manner for resident receiving oxygen.</p> <p>Procedures:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A. Pre-filled humidifier, when used, are to be dated and replaced every seven to ten days .</p> <ol style="list-style-type: none"> 1. Tubing should be replaced every week. 2. Masks should be replaced ever week. <p>C. Nebulizer Equipment Procedures</p> <ol style="list-style-type: none"> 2. Store, clean, and dry until next use.

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>47854</p> <p>Based on observation, interview, and record review; the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles for 2 of 3 medication carts (2C-1 and 100 Skilled medication carts) observed.</p> <p>-1 loose pill (Meloxicam) discovered in 2C-1 medication cart.</p> <p>-2 loose pills (Flexeril and unidentified pill) and a packet of 50 (Methadone) pills not double locked.</p> <p>These failures could result in residents' medications not being properly stored and maintained at their best therapeutic level.</p> <p>Findings include:</p> <p>Observation on 06/05/24 at 08:41 AM of Medication cart 2C-1, 1 loose pill was discovered, and MA D was able to identify medication as Meloxicam (an anti-inflammatory medication to help with arthritic pain).</p> <p>Interview on 06/05/24 at 08:49 MA D stated that a negative outcome for having loose pills in the medication cart. MA D stated that it could lead to a missed medication dose for the resident.</p> <p>Observation on 06/04/24 at 11:59 AM of medication cart for 100 skilled Hall revealed 2 pills and a small packet of 50 pills identified as methadone for Resident # 252. 1 lose pill was identified as Flexeril and the 2nd pill was unidentifiable by LVN B.</p> <p>During an interview on 06/05/24 at 12:03 PM LVN B revealed that the negative outcome for having lose pills in medication drawers could lead to the resident not getting the medication, because the medication didn't get into the cup. LVN B stated that the negative outcome for not double locking-controlled substances could lead to drug diversion, that is my fault so sorry.</p> <p>During an interview on 06/05/24 at 04:09 PM LVN B revealed that the previous ADON would package excess medications in small packages in counts of 50 to make narcotic counts easier on staff.</p> <p>During an interview on 06/06/24 at 08:26 AM ADON stated that the previous ADON would take medications from residents' stock and place in a pill crusher pouch and then either staple or tape shut to send medication home with residents.</p> <p>Record review on 06/06/24 at 09:02 AM revealed statements were received from ADON and LVN E along with in-service to reeducate the staff and facility policy regarding medication storage.</p> <p>Record review of facility policy titled, Medication Access and Storage, undated, revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Policy:</p> <p>It is the policy of this facility to store all drugs and biological in locked compartments. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications:</p> <p>Procedures:</p> <p>1. The provider pharmacy dispenses medications in containers that meet legal requirements. Medications are kept and stored in these containers.</p> <p>.4. Schedule II, III, IV, V controlled medications are stored in a separate area under double locked from other medications in a locked drawer or compartment designated for that purpose.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31882</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the menu was followed, for 2 out of 5 residents that received pureed food (Resident # 19 and 21), and one resident (#16) who had a mechanical soft diet in the Alzheimer's unit in that:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure Resident # 19 received a pureed pancake for breakfast on 6/5/24. 2. The facility failed to ensure Resident #16 received toast with her breakfast on 6/5/24. 3. Residents #16, 19 and # 21 received pudding for the lunch dessert instead of cream pie and pudding for the supper meal instead of the chocolate chip cookie the other residents received for 6/5/24. Residents #16, 19 and 21 did not receive sweet potato casserole for lunch. 4. Residents #16, 19 and #21 received pudding for the lunch meal on 6/6/24 instead of the dessert empanada. 5. Residents #16, 19 and #21 received jello for the lunch meal on 6/6/24 instead of the mixed berry cake. <p>These failures could place residents at risk for unwanted weight loss, hunger, unwanted weight gain, and metabolic imbalances.</p> <p>The findings include:</p> <p>Resident # 16</p> <p>Record review of Resident # 16's face sheet revealed an [AGE] year-old-female admitted to the facility on [DATE] with diagnoses to include dementia (defective memory), dysphagia (difficulty swallowing), diabetes (a disease that results in too much sugar in the blood) and anxiety.</p> <p>Record review of comprehensive MDS assessment dated [DATE] revealed Resident # 16 was rarely understood. The MDS revealed Resident # 16 had a BIMS of 3 out of 15 which indicated the resident's cognition was severely impaired. Section K indicated Mechanically altered diet: Require change in texture of food or liquids.</p> <p>Record review of a care plan, dated 5/12/24 for Resident # 16 revealed the following:</p> <p>Category: Nutritional Status</p> <p>Resident has a potential for nutritional problem.</p> <p>Record review of Resident #16's order summary report dated 6/7/24 revealed the following orders:</p> <p>Diet ordered 01/26/24: LCS diet, Mechanical Soft Pureed bread and cakes, thin liquids consistency.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #16's diet card dated Wednesday 6/5/24 revealed under Special Notes: House Shake Sugar Free, Diabetic Snack, 2 bowls of cereal and toast for breakfast every day, Bread and cakes puree.</p> <p>An observation was made on 16/5/24 at 8:25 am of Resident #16's breakfast tray revealed there was no toast.</p> <p>Record review of Resident # 16's diet card dated Wednesday 6/5/24 revealed she should have received toast with her cereal.</p> <p>Record Review of the tray ticket for 6/5/24 for the lunch meal revealed Resident # 16 should have received cream pie and sweet potato casserole with her meal.</p> <p>An observation was made on 6/5/24 at 12:00 pm of Resident #16's lunch tray revealed she got pudding instead of a cream pie and there was no pureed bread or sweet potato casserole on the plate.</p> <p>Record Review of the tray ticket for 6/6/24 for the lunch meal revealed Resident # 16 should have received a dessert empanada with her meal.</p> <p>An observation was made on 6/6/24 at 12:00 pm of Resident #16's lunch tray revealed she got pudding instead of a dessert empanada on the plate.</p> <p>Record Review of the tray ticket for 6/7/24 for the lunch meal revealed Resident # 16 should have received mixed berry cake with her meal.</p> <p>An observation was made on 6/7/24 at 12:00 pm of Resident #16's lunch tray revealed she got jello instead of a mixed berry cake.</p> <p>Resident # 19</p> <p>Record review of Resident #19's face sheet revealed a [AGE] year-old-female admitted to the facility on [DATE] with diagnoses to include Huntington's disease (a breakdown in the nerve cells in the brain), dysphagia (difficulty swallowing), and anxiety.</p> <p>Record review of comprehensive MDS assessment dated [DATE] revealed Resident #19 was rarely or never understood. The MDS revealed Resident # 19 had a BIMS of 0 out of 15 which indicated the resident's cognition was severely impaired. Section K indicated Mechanically altered diet: Require change in texture of food or liquids.</p> <p>Record review of a care plan, dated 05/31/24 for Resident # 19 revealed the following:</p> <p>Category: Nutritional Status</p> <p>Resident has a potential for nutritional problem.</p> <p>Record review of Resident # 19's order summary report dated 6/7/24 revealed the following orders:</p> <p>Diet ordered 02/07/24: Regular diet, Pureed texture, thin liquids consistency.</p> <p>(continued on next page)</p>		

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 06/07/2024
NAME OF PROVIDER OR SUPPLIER Legacy Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 4033 W 51st Ave Amarillo, TX 79109	

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #19's diet card dated Wednesday 6/5/24 revealed Resident #19 should have received a pancake, sausage and oatmeal for breakfast.</p> <p>An observation was made on 6/5/24 at 8:26 am of Resident #19's breakfast tray revealed there was no pancake.</p> <p>Record Review of the tray ticket for 6/5/24 for the lunch meal revealed Resident # 19 should have received cream pie and sweet potato casserole with her meal.</p> <p>An observation was made on 6/5/24 at 12:03 pm of Resident #19's lunch tray revealed she got pudding instead of a cream pie and there was no sweet potato casserole on the plate.</p> <p>Record Review of the tray ticket for 6/6/24 for the lunch meal revealed Resident # 19 should have received a dessert empanada with her meal.</p> <p>An observation was made on 6/6/24 at 12:00pm of Resident #19's lunch tray revealed she got pudding instead of a dessert empanada on the plate.</p> <p>Record Review of the tray ticket for 6/7/24 for the lunch meal revealed Resident # 19 should have received mixed berry cake with her meal.</p> <p>An observation was made on 6/7/24 at 12:00pm of Resident #19's lunch tray revealed she got Jell-O, instead of a mixed berry cake.</p> <p>Resident #21</p> <p>Record review of Resident #21's face sheet revealed a [AGE] year-old-male admitted to the facility on [DATE] with diagnoses to include dementia (defective memory), dysphagia (difficulty swallowing), diabetes (a disease that results in too much sugar in the blood) and pain.</p> <p>Record review of comprehensive MDS assessment dated [DATE] revealed Resident #21 was usually understood. The MDS revealed Resident # 21 had a BIMS of 3 out of 15 which indicated the resident's cognition was severely impaired. Section K indicated Mechanically altered diet: Require change in texture of food or liquids.</p> <p>Record review of a care plan, dated 05/9/24 for Resident # 21 revealed the following:</p> <p>Category: Nutritional Status</p> <p>Resident has a potential for nutritional problem.</p> <p>Record review of Resident # 21's order summary report dated 6/7/24 revealed the following orders:</p> <p>Diet ordered 10/16/23: LCS, Pureed texture, nectar thick liquids consistency.</p> <p>Record review of Resident #21's diet card dated Wednesday 6/5/24 for the lunch meal revealed Resident # 21 should have received cream pie and sweet potato casserole with his meal.</p> <p>(continued on next page)</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation was made on 6/5/24 at 12:03 pm of Resident #21's lunch tray revealed he got pudding instead of a cream pie and no sweet potato casserole.</p> <p>Record Review of the tray ticket for 6/6/24 for the lunch meal revealed Resident # 21 should have received a dessert empanada with his meal.</p> <p>An observation was made on 6/6/24 at 12:00pm of Resident #21's lunch tray revealed he got pudding instead of a dessert empanada on the plate.</p> <p>Record Review of the tray ticket for 6/7/24 for the lunch meal revealed Resident # 21 should have received mixed berry cake with his meal.</p> <p>An observation was made on 6/7/24 at 12:00 pm of Resident #21's lunch tray revealed he got Jell-O, instead of a mixed berry cake.</p> <p>During a confidential interview on 6/6/24 at 12:20 pm an employee stated Resident's #16 #19 and #21 got pudding for the lunch meal on 6/5/24 instead of pie and pudding again for the supper dessert on 6/5/24 which listed a chocolate chip cookie. She stated most residents in the unit got a chocolate chip cookie on 6/5/24. The employee stated the residents with a pureed meal always got pudding instead of the listed dessert. The employee stated some of the other residents in the unit with a regular meal often get pudding instead of the scheduled dessert. The employee stated Resident # 21 was able to express his wants and he always asks for a dessert instead of pudding. The employee stated Resident #21 always looked sad when he did not get the same foods as other residents. The employee stated Residents #16 , 19 and 21 will eat everything they are given and enjoy eating different foods.</p> <p>During an interview on 6/7/24 at 11:00 am the RD stated she was not aware the menu for residents with purees were not being followed. She stated she expects residents to get what is listed on the menu in the correct form. She stated she trains the staff in policies and how to complete tasks in the kitchen. The Rd stated the consequences of not getting all menu items at meals could be a difference in the caloric intake and lost nutrients.</p> <p>During an interview on 6/7/24 at 12: 55 pm, Resident #21 stated loved the desserts and got tired of puddings all the time. He stated he was sad when he did not get the same foods as he saw on everyone else's plate.</p> <p>During an interview on 6/7/24 at 1:45 pm, the DM stated she was not aware residents on a pureed diet were not receiving pureed items as the menu listed. She stated the banana cream pie, the empanada and the chocolate chip cookie should have been pureed. The DM stated she was not aware residents with pureed diets were receiving pudding at multiple meals. She stated she could not say why residents received so much pudding for meals. She stated she had been short staffed in the kitchen, and she only had one cook. She stated the sweet potatoes for the meal on Wednesday lunch were not pureed. The DM stated she did not have any polices for the kitchen. She stated she trains staff by telling employees how to do a task. She stated the consequences of not providing all the menu items for meals would be not getting enough nutrition.</p> <p>Record review of the facility's undated policy titled, Quality of Care with the subject Therapeutic Diets revealed:</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>It is the policy of this facility that therapeutic diets shall be prescribed by the attending physician. A tray identification system is established to ensure each resident receives his diet as ordered.</p>