

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676048	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2024
NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation Center G		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 Fm 2685 Gladewater, TX 75647	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401</p> <p>Based on observation, interview, and record review the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 2 of 3 residents reviewed for quality of care. (Resident #2 and Resident #1)</p> <p>Resident #2 and Resident #1 did not receive physician ordered wound care as ordered by the physician according to the manufacture's recommendations for treatment with Hydrofera Blue (a medicated foam dressing for wounds) that required moisture before use.</p> <p>The facility failed to ensure Resident #2's physician's plan of care for a boot that was an appropriate fit to prevent an increased risk for injury to his right foot as ordered by the physician.</p> <p>This failure could cause residents to not attain or maintain their highest physical well-being.</p> <p>Findings Included:</p> <p>1. Record review of Resident #2's Face Sheet indicated he was a [AGE] year-old male admitted to the facility on [DATE]. Some of his diagnoses were non pressure chronic ulcer of the right foot limited to the skin dated 4/16/22. Hemiplegia(paralysis on one side of the body)followed by a stroke, muscle weakness, foot drop of the right foot, and mild cognitive impairment.</p> <p>Record review of Resident #2's Quarterly MDS dated [DATE] indicated an intact cognitive status with a BIMs of 14. Resident #2's functional status was partial to maximum assistance with ADLs and sit up help with eating. Resident #2's skin condition did not indicate any pressure ulcers.</p> <p>Record review of Resident #2's Care Plan last revised 4/10/24 indicated a Focus area of wound to the right first and second toe. Some of the interventions were identify and document potential causative factors and eliminate or resolve where possible. Provide treatment as ordered, and wound care as ordered. A Focus area of Resident #2 reflected he had the potential for pressure ulcer development. Some of the interventions were to administer treatments as ordered and monitor effectiveness enhanced barrier precautions (infection conatal practices that can reduce the spread of germs).</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's computerized physician's orders indicated an order dated 6/1/14 indicated cleanse first and second toe with wound cleanser or normal saline , pat dry and apply methylene/Hydrofera blue and cover with dry dressing. An order dated 6/12/24 indicted to clean right fifth toe with wound cleanser or normal saline, pat dry , apply Medi honey and cover with dry dressing. An order dated 1/2/24 reflected to apply a boot to the right foot to assist in prevention of further injury to right toes due to dragging foot.</p> <p>Record review of Resident #2's the Wound Physician notes dated 6/4/24 indicated non pressure wound to the right second toe with full thickness with a duration of greater than 939 days. The wound size was 4.6 cm by 3 cm by 0.1 cm. with a surface are of 13.80 cm, moderate exudate(a watery fluid that can appear clear or pale yellow in color and is normally part of the healing process during the inflammatory stage of a wound) , 10 percent slough(dead tissue separating from living tissue and 90 percent granulation tissue(new connective tissue). The wound progress had improved as evidence by decreased surface area. A lymphatic wound(wound occurs when lymph nodes or vessels in lymphatic system are damaged or blocked) to the right first toe(Great toe or big toe) with full thickness duration greater than 127 days. The wound size was 2 cm by 1 cm by 0.1 cm with the surface are of 2/00 cm, moderate serous exudate, 100 percent granulation tissue, wound progress improved as evidenced by decreased drainage. The dressing treatment for both the wounds was methylene blue foam apply once daily for 23 days. A lymphedema wound of the right fifth toe(little toe) with duration of greater than 4 days. The wound measured 0.4cm by 0.3cm by 0.1 cm. the surface area was 0.12 cm with light serous drainage and 100 percent granulation(new healthy tissue) .</p> <p>During an interview on 6/19/24 at 9: 20 a.m. Resident #2 was in wheelchair with wheeling himself around using his hand and left foot. He is eating breakfast unassisted. His tray was on a table across the room. He was wheeling back and forth. He said he did not require assistance. He said that he had trauma to his toe because he had hit his foot on something. He had on socks.</p> <p>During an observation and interview on 6/19/24 at 11:41 a.m. revealed Resident #2's wound care was completed by LVN A and the ADON. Resident #2 was sitting up in his wheelchair. The ADON held his right foot while LVN A removed his sock. The resident had a bandage that covered all his toes. The LVN removed the bandage. Observation of his foot revealed the whole foot was swollen past the ankle and it was swollen more toward the toe area, and under the bottom of his foot. The first and second toes were deep purple, and the reddish color was on the top of the foot about half an inch high. The first toe had a wound on the inside appeared to be discoloration between that toe and the second toe. The first toe had an area with no skin and a black toenail. The second toe was completely discolored, purple in color, with the skin looking beefy, and the nail bed was white. There was a black spot on the outside of the fifth toe. LVN A cleansed the wounds with wounds cleanser to right foot 1st and 2nd toe, gently patted dry, applied 2 dry pieces of Hydrofera Blue between toes and draped over the toes and covered with a dry dressing. She applied Medi honey to fifth and covered with a dry dressing. The ADON said she was not sure if the treatment needed to be moisturized or not, she would find out if Hydrofera Blue was supposed to be moistened. Resident #1 had a Velcro half boot lying in the floor by his wheelchair. He said he did not wear it because it was too tight and hurt his toes. He said they were ordering him another boot. The ADON said they had ordered him another boot for his foot.</p> <p>During an interview on 6/19/2024 at 12:38 p.m. the DON said LVN A had just returned to the facility and was not aware of how to use the Hydrofera Blue. The DON said Hydrofera Blue should be moistened prior to applying to wound</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/19/24 at 4:44 p.m. a pre exit with the DON, acting administrator, the acting DON and Regional Nurse they were told LVN C did not know how to use the Hydrofera Blue. The DON said she was doing an in-service on the use of the Hydrofera Blue for her nursing staff.</p> <p>2. Record review of Resident #1's face sheet dated 6/19/24 indicated he was a [AGE] year-old male admitted to the facility on [DATE]. He had diagnoses of contracture((shortening and hardening of muscles often leading to deformity and rigidity of joints.) of the left upper arm, left elbow and left hand. Contracture of the right hand, colostomy status, (a new path for waste material to leave the body) neuromuscular dysfunctional of bladder9 the brain does not properly communicate with the bladder's nerves and muscles) , lack of coordination, quadriplegia (paralysis that affects all a person's limbs and body form the neck down), and pressure ulcer of the sacral(is a triangular bone at the base of the spine and center of the pelvis located between the lower back and tailbone) region.</p> <p>Record review of Resident #1's Annual MDS dated [DATE] indicated no cognitive impairment with a BIMS score of 15. Resident #1's functional abilities indicated he was dependent on staff for all ADLs including eating. The Skin Condition indicted the resident had a pressure ulcer and was at risk for developing pressure ulcers and he currently had 2 stage 4 pressure ulcers with 1 present on admission.</p> <p>Record review of Resident #1's care plan last revised on 4/3/24 indicate a Focus of Suprapubic Catheter and Urostomy(is a surgical procedure that creates a stoma for the urinary system, a urinary diversion) , some of the interventions were to monitor for pain and discomfort and report to physician any changes. A Focus area of a stage 4 to the sacrum related to immobility last revised on 7/28/23. Some of the interventions were to administer treatments as ordered and monitor effectiveness. A Focus area of a stage 4 pressure ulcer to the right ischium(the curved bone forming the base of each half of the pelvis) related to quadriplegia. The resident preferred to stay in bed most of the time. He had been attempting to get out of the bed more than usual since getting his new wheelchair with a revision date of 11/21/23. Some of the interventions were provide the resident with vitamins and supplement as order and the see wound care specialist weekly.</p> <p>Record review of Resident #1's computerized physician's order indicted an order dated 5/30/24 cleanse right ischium with wound cleanser, pat dry, apply methylene blue, cover with dressing. Cleanse Sacrum with wound cleanser, pat dry, apply methylene blue(foam wound care treatment), cover with dry dressing.</p> <p>Record review of Hydrofera Blue's instructions sheet dated 2020 indicated to moisten the dressing with sterile saline or sterile water prior to administration.</p> <p>During an interview and observation on 6/19/24 at 11:12 a.m. of Resident #1's wound care. Observation showed LVN A providing care to the right Ischium and Sacrum wound. She did not moisten the Hydrofera Blue prior to applying to wound bed. LVN A said the Hydrofera Blue softens up as the product sits on the wound.</p> <p>During a telephone interview on 6/19/2024 at 12:08 p.m. LVN B the Treatment Nurse. She said Hydrofera Blue should be moistened with normal saline or wound cleanser. She said the product was hard until it was dampened, it needed to be dampened before placing it on the wound. LVN B said the Hydrofera Blue helped to absorb more drainage.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility Care Planning Policy and Procedure last revised May 2007 indicated it was the policy of the facility that the interdisciplinary team shall develop a comprehensive care plan for each resident. The care plan was developed by professionals to include the attending physician.</p>

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<p>F 0925</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401</p> <p>Based on observation, interview, and record review the facility failed to ensure an effective pest control program so the facility was free of pests for 1 of 3 residents reviewed for pest control. (Resident #2)</p> <p>The facility had an outbreak of flies during the week of 5/23/24 through 6/5/24.</p> <p>On 6/1/24 a Resident #2 was noted with maggots in his wounds on his foot.</p> <p>This failure could cause the facility to become infested with pests.</p> <p>Findings included:</p> <p>Record review of Resident #2's Face Sheet indicated he was a [AGE] year-old male admitted to the facility on [DATE]. Some of his diagnoses were non pressure chronic ulcer of the right foot limited to the skin dated 4/16/22. Hemiplegia(paralysis on one side of the body)followed by a stroke muscle weakness, foot drop of the right foot, and mild cognitive impairment.</p> <p>Record review of Resident #2's Quarterly MDS dated [DATE] indicated intact cognitive status with a BIMs of 14. Resident #2's functional status was partial to maximum assistance with ADLs and sit up help with eating. Resident #2's skin condition did not indicate any pressure ulcers.</p> <p>Record review of Resident #2's Care Plan last revised 4/10/24 indicated a Focus area of wound to the right first and second toe. Some of the interventions were identify and document potential causative factors and eliminate or resolve where possible. Provide treatment as ordered, and wound care as ordered. A Focus area of Resident #2 reflected he had the potential for pressure ulcer development. Some of the interventions were to administer treatments as ordered and monitor effectiveness.</p> <p>Record review of Resident #2's computerized physician's orders indicated an order dated 6/1/14 indicated cleanse first and second toe with wound cleanser or normal saline , pat dry and apply methylene blue and cover with dry dressing. An order dated 6/12/24 indicted to clean right fifth toe with wound cleanser or normal saline, pat dry , apply Medi honey and cover with dry dressing.</p> <p>Record review of the facility last pest control log dated 5/23/24 indicated it was a monthly pest control visit and they targeted house flies, and ants.</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident #2's nursing notes dated 6/1/24 at 8:01 p.m. signed by LVN D. indicated upon wound care this shift, the nurse removed the dressing dated 5/31/24 from the wound care on previous day and maggots were noted inside the residents wound between the right toe and second toe. Wound care was performed as ordered by the physician, as well as cleaning between each of the resident's toes on the right foot. The resident stated his level of pain during wound care was 10/10. The wound itself was bright red and inflamed but not much drainage noted this shift. A clean dressing was applied the family member was at the bedside with the resident at this time of the occurrence and was aware. The DON, the Physician, and Wound Care Physician were notified with no new orders at this time. (Attempted to contact LVN D several times by phone and she would not answer or return calls or texts.)</p> <p>Record review of Resident #2's the Wound Physician notes dated 6/4/24 indicated non pressure wound to the right second toe with full thickness with a duration of greater than 939 days. The wound size was 4.6 cm by 3 cm by 0.1 cm. with a surface are of 13.80 cm, moderate exudate(a watery fluid that can appear clear or pale yellow in color and is normally part of the healing process during the inflammatory stage of a wound) , 10 percent slough(dead tissue separating from living tissue and 90 percent granulation tissue(new connective tissue). The wound progress had improved as evidence by decreased surface area. A lymphatic wound(wound occurs when lymph nodes or vessels in lymphatic system are damaged or blocked) to the right first toe(Great toe or big toe) with full thickness duration greater than 127 days. The wound size was 2 cm by 1 cm by 0.1 cm with the surface are of 2/00 cm, moderate serous exudate, 100 percent granulation tissue, wound progress improved as evidenced by decreased drainage. The dressing treatment for both the wounds was methylene blue foam apply once daily for 23 days. A lymphedema wound of the right fifth toe(little toe) with duration of greater than 4 days. The wound measured 0.4cm by 0.3cm by 0.1 cm. the surface area was 0.12 cm with light serous drainage and 100 percent granulation(new healthy tissue).</p> <p>Record review of a purchase order dated 6/5/24 indicated the facility purchased 6 wall sconce fly light traps for capturing flies, moths, gnats, mosquitos, and other flying insects.</p> <p>During an interview on 6/19/24 at 9:10 a.m. Resident #5 said they did have problems with flies a few weeks ago but they appear to all be gone now.</p> <p>During an interview on 6/19/24 at 9:12 a.m. Resident #6 said she saw a fly every now and then but had no issues with flies.</p> <p>During an interview on 6/19/24 at 9: 20 a.m. Resident #2 was in wheelchair with wheeling himself around using his hand and left foot. He is eating breakfast unassisted. His tray was on a table across the room. He was wheeling back and forth. He said he did not require assistance. He said that he had trauma to his toe because he had hit his foot on something. He had on socks. Observation of the room did not reveal any flies.</p> <p>During an interview on 6/19/24 at 9:35 a.m. Resident #7 said he was doing well and had no problems he was noted with a fly squatter on his side of the room. He said a few weeks ago they had quite a few flies, but now there was only and occasional fly here and there.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 6/19/24 at 10:30 a.m. CNA E said Resident #2's foot is always covered with a bandage. She said she had no idea what his wounds looked like. When they give him a shower, they put a plastic bag on the foot to keep it dry. CNA E said they did have a problem with flies a few weeks ago but they were better now.</p> <p>During observation on 6/19/24 at 10:45 a.m. a fly was observed in the conference room.</p> <p>During an observation and interview on 6/19/24 at 11:41 a.m. revealed Resident #2's wound care was completed by LVN A and the ADON. Resident #2 was sitting up in his wheelchair. The ADON held his right foot while LVN A removed his sock. The resident had a bandage that covered all his toes. The LVN removed the bandage. Observation of his foot revealed the whole foot was swollen past the ankle and it was swollen more toward the toe area, and under the bottom of his foot. The first and second toes were deep purple, and the reddish color was on the top of the foot about half an inch high. The first toe had a wound on the inside appeared to be discoloration between that toe and the second toe. The first toe had an area with no skin and a black toenail. The second toe was completely discolored, purple in color, with the skin looking beefy, and the nail bed was white. There was a black spot on the outside of the fifth toe. LVN A cleansed the wounds with wounds cleanser to right foot 1st and 2nd toe, gently patted dry, applied 2 dry pieces of Hyrofera Blue between toes and draped over the toes and covered with a dry dressing. She applied Medi honey to fifth and covered with a dry dressing.</p> <p>During a telephone interview on 6/19/2024 at 12:08 p.m. the Treatment Nurse/LVN B said LVN D had called her on a Saturday 6/1/24 a couple of weeks ago, to say she had found maggots in Resident #2's wound. The Treatment nurse said she told LVN D to call the DON and physician for orders. The Treatment Nurse said when she arrived at the facility on that Monday, she did not see any maggots and the resident had been seen by wound care on at least two occasions since and there were no problems noted.</p> <p>During an interview on 6/19/2024 at 12:38 p.m. the DON said she had been informed by LVN D that Resident #2 had maggots in his wound on 6/1/24. She said she had informed the LVN to write a factual note and not speculate about what may have occurred. She said she told LVN D to contact the physician and there were no new orders. She said on one day Resident #2 had maggots in his wound and the next day they were gone. They had problems with flies but had installed blue lights at the entrances of the facility and the flies were much better. She said the wound was covered and she had no idea how the maggots got in the wound. She said she had not seen any maggots in Resident #2's wound.</p> <p>During an observation on 6/19/24 at 3:00 p.m. a fly was noted flying around the nurse's station.</p> <p>During an interview on 6/19/24 at 5:24 p.m. the administrator there was an incident when Resident #2 was found with maggots. He said that they had quite a bit a rain and with that rain came the flies. They had put in 6 to 8 blue lights to prevent insects from coming in the building. They no longer had problems with flies just an occasional one here or there. He said he could only speculate about how Resident #2 got the maggots in his wound.</p> <p>During a telephone interview on 6/28/24 at 2:57 p.m. the Administrator said they had pest control out for the flies and they put in the blue lights to combat the fly problems. They ordered the lights, and they were installed and they had no farther issues with flies.</p> <p>(continued on next page)</p>		

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