STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676048	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Center G	1201 Fm 2685 Gladewater, TX 75647

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, interviews, and record review, the facility failed to ensure residents reviewed received reasonable accommodation of needs for 3 of 20 residents (Resident#2, Resident #27, Resident #52) reviewed for resident rights. The facility failed to ensure Resident #2, Resident #27, and Resident #52 had a call light within reach. This failure could place residents at risk of injury that could lead to falls, major injuries, hospitalization , and unmet needs. Findings include: 1. Record review of the face sheet dated 1/15/2025 indicated Resident #2 was a [AGE] year old female and was readmitted on [DATE] with diagnoses including Hemiplegia and hemiparesis following Cerebral Infarction affecting the left non-dominant side (Hemiplegia is paralysis of one side of the body. Hemiparesis is weakness of one side of the body and is less severe than hemiplegia. Both are a common side effect of stroke or cerebrovascular accident), posterior subcapsular polar age-related cataract, bilateral (a fast-growing opacity in the rear of the natural lenses most commonly in people who take steroids or have diabetes), weakness (a quality or state of lacking strength), contracture of muscle, left upper arm (permanent shortening and tightening of muscle fibers). Record review of the quarterly MDS dated ,d+[DATE] indicated Resident #2 was usually understood and usually understood others. The MDS indicated a BIMS score of 06 indicating Resident #2 had sever cognitive impairment. Record review of a care plan revised on 11/7/2022 indicated Resident #2 was diagnosed with cerebral vascular accident (stroke) with hemiplegia with interventions to provide assistance turning and repositioning to keep body in good alignment and to prevent skin breakdown. The care plan revised on 11/7/2022 indicated she was incontinent related to activity intolerance, impaired mobility and was not a candidate for toileting program. The care plan indicated Resident #2 was to remain free from skin breakdown due to incontinence and brief use through the review date. During an interview and observation on 2/10/2025 at 9:35 AM, Resident # 2 said the staff answered her call light, but she never could find it. Resident #2's call light was observed hanging off her bedside table and out of reach. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of the face sheet dated 2/12/2025 indicated Resident #27 was an [AGE] year old male and was readmitted on [DATE] with diagnoses including seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movement, feelings, and consciousness) , hemiplegia and hemiparesis (severe or complete unilateral loss of strength or paralysis and weakness in one leg, arm or side of face) following a nontraumatic subarachnoid hemorrhage affecting left non-dominant side (a bleed within the subarachnoid space which is between the brain and the tissue covering the brain) , diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and muscle weakness (loss of muscle strength) . Record review of the quarterly MDS dated [DATE] indicated Resident #27 was able to make self-understood and usually understood others. The MDS indicated a BIMS score of 12 indicating Resident #27's cognition was moderately impaired. Record review of a care plan revised on 1/20/2022 indicated Resident #27 had ADL self-care performance deficits related to hospitalization for Coronary Artery Bypass Graft (CABG), Cerebrovascular accident (CVA), Congestive Heart Failure (CHF) and chest pains with interventions to assist with dressing, hygiene, toilet use, transfer, and bed mobility with one person assist. During an interview and observation on 2/10/2025 at 9:49 AM, revealed Resident #27 was observed to have deficits to his left side and was unable to lift left arm. Resident #27's call light was placed on the bedside table out of reach his reach. 3. Record review of the face sheet dated 2/12/2025 indicated Resident #52 was an [AGE] year old female and was readmitted on [DATE] with diagnoses including mild cognitive impairment (a stage between normal aging and dementia, with memory loss and trouble with language and judgement), pleural effusion (an excessive collection of fluid in the pleural cavity the fluid-filled space that surrounds the lungs) , chronic kidney disease (gradual loss of kidney function) and diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Record review of the quarterly MDS dated [DATE] indicated Resident #52 was able to make self-understood and usually understood others. The MDS indicated a BIMS score of 15 indicating Resident #52 was cognitively intact. Record review of a care plan revised on 1/2/2025 indicated Resident #52 had ADL self-care performance deficits related to weakness, impaired mobility, and cognitive deficits with interventions for one staff participation to reposition and turn in bed, one staff participation with bathing, dressing, and requires one person to assist with transfers. The care plan revised on 1/2/2025 indicated Resident # 52 was at risk for falls related to weakness, impaired balance, and psychotropic medication use. During an observation and interview on 2/10/2025 at 2:37 PM, revealed Resident #52 was sitting in her personal chair located on the left side of the bed with call light out of reach lying on her bed out of her reach. Resident #52 said she had a recent fall while attempting to obtain a crochet needle that was out of her reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/12/2025 at 10:15 AM, CNA F said anyone would be able to answer call lights. CNA F said the CNAs were responsible for ensuring call lights were within reach. She said she rounds on residents every 1-2 hours depending on the resident's needs. She said call lights should be clipped to the bed sheet or blanket within the resident's reach. CNA F said she checked the call lights when she made her rounds and would remind the residents what the call light is for. CNA F said it was important to make sure a resident's call light was within their reach so they can call for drinks, medications, report pain, to ensure they were clean and dry and to make sure the resident was not trying to get up by themselves which could result in a fall. CNA F said a resident's needs would not be met if they could not push their call light button. During an interview on 02/12/2025 at 10:29 AM CNA G said the staff should answer the call light quickly. She said a call light should be placed within resident's reach. CNA G said the staff would not know what they need if the resident was not able to reach call light. CNA G said the CNAs were responsible for ensuring call lights were within reach. CNA G said the facility had residents the staff checked on more frequently. During an interview on 02/12/2025 at 10:36 AM LVN H said call lights needed to be within reach. She said all staff are responsible for ensuring call lights were within reach. LVN H said the staff should make rounds at least every 2 hours if not more. LVN H said residents would yell if they needed help and they know to go check on them. LVN H said a resident would be at risk if they were unable to reach call light if they needed assistance. During an interview on 02/12/2025 at 10:49 AM, the ADON said anyone working the floor and providing care could answer the call lights. The ADON said the CNAs should hand the call light to the resident or clip the call light to a blanket to where the call light remains in place. The ADON said residents who have recliners and chairs in their room should still have access to call light and the CNA should make sure call light is within reach of the resident. The ADON said the resident could fall and not be able to get to their call light. During an interview on 02/12/2025 at 11:02 AM, the DON said call lights needed to be placed within a resident's reach. The DON said the call light needed to be clipped to an area easily accessible to the resident. The DON said if a resident was up in a chair, their call light needed to be accessible. She said everyone was responsible for ensuring the call lights were within reach. The DON said the resident could try to get up by themselves and not have access for assistance for someone to help them. During an interview on 02/12/25 at 11:12 AM, the OM said a resident should always have their call light clipped within reach. He said the staff should have contact every couple of hours even if they do not have contact with resident. The OM said the CNAs and medical staff were responsible for ensuring call lights were within reach to meet the needs of the residents. He said if a resident did not have ability to reach the call light, the staff would not be able to meet the needs, or answer questions the resident may have. Review of a facility policy titled Policy/Procedure-Nursing Clinical revised on 5/2007 indicated Routine procedures .Call Light/Bell . Policy.it is the policy of this facility to provide the resident a means of communication with nursing staff. Procedures: .5. Leave the resident comfortable. Place the call device within resident's reach before leaving the room. If the call light/bell is defective, immediately report this information to the unit supervisor.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46929 Based on observation, interview, and record review, the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals, and preferences for 1 of 1 resident (Resident #51) reviewed for respiratory care and services. The facility failed to ensure Resident #51's oxygen concentrator was clean and free of gray debris. This failure could place residents who receive oxygen at risk for developing respiratory complications. Findings included: Record review of Resident #51's face sheet, dated 02/11/25, indicated he was a [AGE] year-old male, admitted to the facility on [DATE], and readmitted on [DATE]. His diagnoses included cerebrovascular disease (a group of conditions that affect the blood vessels in the brain, leading to disruptions in blood flow and oxygen supply to the brain tissue), enterocolitis due to clostridium difficile (an infection of the colon caused by the bacterium Clostridium difficile), and pneumonia due to mycoplasma pneumoniae (a common respiratory infection caused by the bacterium Mycoplasma pneumoniae) (dated 02/05/25). Record review of Resident #51's quarterly MDS assessment, dated 01/27/25, indicated he had a BIMS score of 08, which indicated moderate cognitive impairment. He did not exhibit behaviors of rejection of care or wandering. He was dependent on staff for many of his activities of daily living, including oral hygiene, bathing, and lower body dressing. He required substantial assistance for other activities of daily living, including roll left and right, sit to lying, and chair/bed-to-chair transfers. The assessment further indicated Resident #51 received oxygen therapy while a resident at the facility. Record review of Resident #51's physician's orders, dated 02/11/25, indicated the following order: *o2 (oxygen) at 2-4 liters per minute continuous per nasal cannula. The start date was 02/05/25. Record review of Resident #51's care plan, dated 08/20/24, indicated a focus of Resident #51 was on oxygen therapy related to ineffective gas exchange. Interventions included oxygen via nasal prongs continuously as ordered by physician. During an observation on 02/10/25 at 09:37 AM, Resident #51 was sitting in a chair in his room watching TV. He had oxygen in place via a nasal cannula. The oxygen concentrator was set to 4 liters per minute. The oxygen concentrator filter was dirty with gray debris. During an observation on 02/10/25 at 02:55 PM, Resident #51 was in his room with oxygen in place via nasal cannula. The oxygen concentrator was set to 4 liters per minute. The oxygen concentrator was dirty with gray debris. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 02/11/25 at 08:27 AM, Resident #51 was in his room with oxygen in place via nasal cannula. The oxygen concentrator was set to 4 liters per minute. The oxygen concentrator was dirty with gray debris. During an interview on 02/12/25 at 01:09 PM, the ADON said Resident #51's dirty filter was likely missed while he was in the hospital. She said the filters should be pulled and cleaned at least once a week. She said she cleaned the filter on 02/11/25. She said the risk to the resident was a possible infection. During an interview on 02/12/25 at 01:17 PM, the DON said she expected the oxygen filters to be cleaned once a week. She said there was an increased risk for infection and poor oxygen flow. She said the nursing staff were responsible for cleaning the oxygen filters. During an interview on 02/12/25 at 01:22 PM, the Operations Manager said he expected the oxygen filters to be clean. He said the nursing staff was responsible for ensuring the filters were clean. He said the risk to the resident was possible harm. He said the contaminants from the air were not being filtered properly and potentially being passed to the resident. Record review of the facility's policy, Oxygen Equipment, last revised May 2007, stated: .It is the policy of this facility to maintain all oxygen therapy equipment in a clean and sanitary manner and to use disposable pre-filled humidifiers, tubing, masks and cannulas for residents receiving oxygen. This equipment is to be discarded after use. The facility will maintain clean tanks, connectors and concentrators . .4. Oxygen concentrator filters will be cleaned with water and detergent every week or according to manufacturers recommendations .

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019 Based on observation, record review and interview the facility failed to store all drugs and biologicals in locked compartments for 3 of 20 reviewed for medication storage. (Resident #2, Resident #27, Resident # 163) 1. The facility failed to securely store 3 packets of Thera calazinc barrier cream and a medication cup with a white substance located on Resident #2's beside table. 2. The facility failed to securely store over the counter medication Miconazole Nitrate 2% cream for Resident #27 which was located on the bedside table. 3. The facility failed to securely store prescribed medication Silvadene 400 gm and Adapt stoma powder for Resident #163 which was located on the bedside table. The failures could place residents at risk for health complications and not having received the intended therapeutic benefit of their medications and adverse reaction. Findings included: 1. Record review of the face sheet dated 1/15/2025 indicated Resident #2 was [AGE] years old and was readmitted on [DATE] with diagnoses including Hemiplegia and hemiparesis following Cerebral Infarction affecting the left non-dominant side (Hemiplegia is paralysis of one side of the body. Hemiparesis is weakness of one side of the body and is less severe than hemiplegia. Both are a common side effect of stroke or cerebrovascular accident), posterior subcapsular polar age-related cataract, bilateral (a fast-growing opacity in the rear of the natural lenses most commonly in people who take steroids or have diabetes), weakness (a quality or state of lacking strength), contracture of muscle, left upper arm (permanent shortening and tightening of muscle fibers). Record review of the quarterly MDS dated ,d+[DATE] indicated Resident #2 was usually understood and usually understood others. The MDS indicated a BIMS score of 06 indicating Resident #2 was moderately cognitively impaired. Record review of a care plan revised on 11/7/2022 indicated Resident #2 was diagnosed with cerebral vascular accident (Stroke) with hemiplegia with interventions to provide assistance turning and repositioning to keep body in good alignment and to prevent skin breakdown. The care plan revised on 11/7/2022 indicated she was incontinent related to activity intolerance, impaired mobility and was not a candidate for toileting program. The care plan indicated Resident #2's was to remain free from skin breakdown due to incontinence and brief use through the review date. During an observation and interview on 2/10/2025 at 9:35 AM, Resident #2 was observed to have 3 packets of thera calazinc body shield cream and a medication cup with her name written on the side with white substance in the medication cup located on the bedside table. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of order summary report dated 2/12/2025 for Resident #2 indicated an order for Nystatin Powder to be applied to underarms topically three times a day for yeast or rash under arms. 2. Record review of the face sheet dated 2/12/2025 indicated Resident #27 was [AGE] years old and was readmitted on [DATE] with diagnoses including seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movement, feelings, and consciousness) , hemiplegia and hemiparesis (severe or complete unilateral loss of strength or paralysis and weakness in one leg, arm or side of face) following a nontraumatic subarachnoid hemorrhage affecting left non-dominant side (a bleed within the subarachnoid space which is between the brain and the tissue covering the brain) , diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and muscle weakness (loss of muscle strength) . Record review of the quarterly MDS dated [DATE] indicated Resident #27 was able to make self-understood and usually understood others. The MDS indicated a BIMS score of 12 indicating Resident #27 was moderately impaired. Record review of a care plan revised on 11/8/2022 indicated Resident #27 was at risk for pressure ulcer development with goal to have intact skin, free of redness, blisters, or discoloration with intervention to monitor, document and report to MD PRN changes in skin status such as appearance, color, wound healing, signs and symptoms of infection, wound size, and stage. The care plan also indicated the nurse to be immediately of any new areas of skin breakdown such as redness, blisters, bruises, discoloration noted during bath or daily care. During an interview and observation on 2/10/2025 at 9:49 AM, Resident #27said the ointment on his bedside was for his jock itch. Resident # 27 said the nurses applied it to affected area when he needed it. Resident #27 had Miconazole Nitrate 2 % on his bedside table. During an observation on 2/11/2025 at 9:35 AM, revealed Resident #27 was sitting up in bed eating breakfast during morning rounds. Resident #27 was observed to have Miconazole Nitrate 2% cream on his bedside table. During an observation on 02/12/2025 at 08:33 AM, revealed Resident #27 was sitting up in bed eating breakfast during morning rounds. Resident #27 was observed to have Miconazole Nitrate 2% cream on his bedside table. Record review of order summary report dated 2/12/2025 for Resident #27 revealed the report did not indicate an order for Miconazole Nitrate 2 % ointment for jock itch. 3. Record review of the face sheet dated 2/11/2025 indicated Resident #163 was [AGE] years old and was admitted on [DATE] with diagnoses including Cellulitis of the abdominal wall (a bacterial infection of your skin and tissue beneath the skin), unspecified protein-calorie malnutrition (a lack of adequate calories, protein and other nutrients needed for tissue maintenance and repair), malignant neoplasm of bladder (a common type of cancer that begins in the cells of the bladder) and infection of incontinent external stoma of urinary tract (an infectious complication that affect the urinary tract and related to different types of urinary diversion). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a care plan revised on 2/10/2025 indicated Resident #163 had cellulitis to abdominal wall and pain related to wound to abdomen with interventions to administer antibiotics per MD orders, follow pain scale and medicate as ordered, monitor and report to nurse complaints of pain or request for pain treatment. The Care plan revised on 2/10/2025 also indicated Resident #163 had a urostomy (a surgical procedure that creates an artificial opening (stoma) for the urinary system)with interventions to monitor, record and report to MD signs and symptoms of urinary tract infection, ostomy (a prosthetic device that collects waste from surgically created opening in the abdomen) care as ordered, and enhanced barrier precautions. During an observation and interview on 2/11/2025 at 3:40 PM, revealed Resident #163 had urostomy powder and a blue jar of located on bedside table. Resident #163 said the powder was for his urostomy and the cream was for his abdomen wound and he said he applied as needed. During an observation on 2/11/2025 at 3:40 PM, Silvadene 1% labeled with Resident # 163's name, prescriber and direction to be applied to the area outside the stoma pouch twice daily and cover with a non-adherent dressing. Record review of order summary report dated 2/11/2025 for Resident # 163 revealed the report did not indicate an order for Silvadene or adapt stoma powder. During an interview on 2/11/2025 at 7:45 AM, RN J said she was not sure if Resident #163 could have stoma powder at bedside and she would have to check on that. RN J did not return with an answer by end of medication pass on the stoma powder identified. During an interview on 2/12/2025 at 10:15 AM CNA F said calamine should be kept on the their person. CNA F said she did not know if barrier cream packets could be kept at the bedside. CNA F said medications should not be stored in a resident room. CNA F said she would get the nurse, ADON or DON if a medication was identified. CNA F said no medications should be stored at the bedside. CNA F said it could be a high risk if a medication was not taken on time. She said a visitor, or another person could use the medication and it could be serious and make them sick. CNA F said the nurse was responsible for ensuring medications were stored properly. During an interview on 2/12/2025 at 10:29 AM, CNA G said medications should not be stored at the bedside. She said she would notify the nurse if a resident had medications at bedside. CNA G said it could be harmful if a visitor took the medication or used it incorrectly. CNA G said ointments and creams should not be stored at bedside. CNA G said the packets of barrier cream packets could be stored in a resident drawer and were mainly stored in drawer for residents who cannot get out of bed. CNA G said the nurses were responsible for ensuring medication were stored properly. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 2/12/2025 at 10:36 AM, revealed LVN H was walking down the 400-hall holding 2 tubes of ointments, Desitin and Miconazole Nitrate 2%. LVN H said she removed ointments from Resident #27's room. LVN H said Resident #27's resident representative visited in the evenings and must have brought the ointments with her. LVN H said the staff usually put it in the resident's drawer. LVN H said the ointments could not be accessible for the resident and the staff sometimes placed the ointments in the closet. LVN H said Resident #27 was incontinent, so he wanted to keep it handy. LVN H said Resident #27 had an order for barrier cream due to excoriation (damage or remove part of surface of (the skin) between his legs. LVN H said she would let the DON know if a new medication was identified. LVN H said the ointments were the same. LVN H said the antifungal was for the groin and the barrier cream was for the buttocks. During an interview on 02/12/2025 at 10:49 AM, the ADON said medications were not supposed to be stored in the room. The ADON said medication such as ointments, creams, eye drops were not to be stored in resident rooms. The ADON said the calazinc packets should not be stored in a resident's room. The ADON said she considered antifungal a medication. She said she would want the CNA to notify the nurse if medications were identified. The ADON said CNAs should not be storing medications and the medications such as creams and ointments should be stored out of accessibility to residents. The ADON said someone with dementia could apply or take the medication incorrectly or they could have an allergy to the medication. The ADON said Silvadene and adapt stoma powder should be stored on the treatment cart. The ADON said the nurse should make sure the nurses and staff completed an inventory of what medications were brought in from the hospital or home. During an interview on 02/12/2025 at 11:02 AM, the DON said medication and ointments should not be stored at a resident's bedside. The DON said the antifungal was considered a medication. The DON said she expected the facility to have an order for medications. The DON said a visitor or other resident could get the medication and have an adverse reaction. She said the medications should be stored on the nurse cart. The nurses were responsible for ensuring medications are stored properly. During an interview on 02/12/2025 at 11:12 AM, The OM (Operation Manager) said the medications such as creams, ointments and eye drops should be stored on the medication cart. The OM said he expected there to be an order for medication and properly store. He said the nurses do shift change and medications are accounted for. The OM said he expected the nurses and staff to report medications identified. The OM said there had been families who had brought in medications into the facility. He said the facility staff had attempted to educate residents and families on protocols and regulations, safety and need to review medications for proper diagnosis and treatments plans. The OM said he would expect antifungal cream to be removed from Resident # 27's bedside and stored on the locked medication cart. The OM said ointments and packets of ointment should be accounted for and no ointments or medication cups with medications should be stored on the resident's bedside table. The OM said there could be harmful effects if medication on resident or visitors. Review of a Medication Storage titled Medication Storage in the Facility policy undated indicated 1. Storage of medication. Policy .Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 35295 Based on interview, and record review the facility failed to employ sufficient staff with the appropriate competencies, skills set and accreditations to carry out the functions of the food and nutrition service department for 1 of 9 kitchen staff (Dietary Aide A) reviewed for qualified dietary staff. The facility failed to ensure the DA A met the requirements for food handling by obtaining a current and valid Food Handler's Certificate. This failure could place residents at risk of not having their nutritional needs met and placing them at risk for food born illnesses. Findings: During an interview and record review on 2/10/25 at 2:59 PM, the DM provided an undated Active Employee List for the kitchen staff. The list revealed DA A was hired 1/11/21. The DM provided his Food Handler's Certificate that was dated 11/6/22. The certificate indicated it was valid for 2 years. During an interview on 2/10/25 at 3:03 PM, the DM said she would check to see if DA A had a current, valid Food Handler's Certificate. She said his Food Handler's Certificate was not valid after 11/6/24. During an interview and record review on 2/10/25 at 3:53 PM, the DM brought a Food Handler's Certificate for DA A dated 2/10/25. She said he had just completed it. During an interview on 02/11/25 at 11:00 AM, the DM said she was responsible for making sure all staff had their current Food Handler's Certificate. She said she left it up to DA A to get his Food Handler's Certificate in a timely manner. She said she should have made sure he did it and reminded him. She said no one else verified the dietary staff's completion of the food handlers training. During an interview on 2/11/25 3:58 PM, the DON said the policy she provided, Infection Control Policy Food Service/Procedure was the only policy they had regarding Food Handler's Certificates. During a telephone interview on 2/12/25 at 10:03 AM, DA A said he was responsible for getting his Food Handler's Certificate updated as needed. He said he had a lot going on and it slipped his mind. He said he thought there would be a risk to residents, but he did not know what, and did not want to answer the question wrong. He said he updated his Food Handler's Certificate on 2/10/25. During an interview on 2/12/25 at 10:34 AM the DON said everyone that worked in the kitchen should have a current Food Handler's Certificate for safe food handling and to prevent germs and bacteria to the residents. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/12/25 at 11:01 AM, the OM said he expected all staff in the kitchen to follow the parameters and the rules for resident safety and it was unacceptable that DA A did not have a valid Food Handler's Certificate. He said it was the DM's responsibility to make sure DA A had a valid Food Handler's Certificate. Record review of an Infection Control Policy Food Service/Procedure with a revised date of 10/2022 indicated: Policy It is the policy of this facility to prevent contamination of food products and therefore prevent foodborne illness. Procedures 1.Director of food service responsibilities .C.Provide and document personnel education regarding personal hygiene and food handling sanitation . B.Education 1.Basic orientation and annual in-service education will include personal hygiene, hand washing techniques, and food handling sanitation and employee health .

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observation, interview, and record review, the facility failed to provide liquids consistent with the resident's needs, for 1 of 24 (Resident #21) residents reviewed for liquid inconsistency, in that: The facility failed to ensure CNA C did not serve ice water on 2/11/25 to Resident #21 who required nectar-thickened liquids. This failure could place residents who have dysphagia at risk for aspiration (breathing on foreign objects). Findings included: Record review of Resident #21' face sheet dated 2/11/25, indicated an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning) and dysphagia oropharyngeal phase (a condition where there is difficulty swallowing during the oropharyngeal phase, which involves the mouth throat and upper esophagus). Record review of Resident #21's quarterly MDS assessment dated [DATE], indicated Resident #21 was usually understood and sometimes understood others. The MDS assessment indicated Resident #21 had a BIMS of 1 and her cognition was severely impaired. The MDS assessment indicated Resident #21 required set-up assistance with eating. The MDS assessment indicated Resident #21 had a mechanically altered diet. Record review of Resident #21's comprehensive care plan revised on 10/30/24, indicated Resident #21 had a potential fluid deficit. The care plan interventions included to encourage the resident to drink fluids of choice, ensure the resident had fluids within reach, and ensure all beverages complied with the diet/fluid restrictions and consistency requirements. Resident #21 had a potential for swallowing problem related history of coughing or choking during meals or swallowing med, holding food in mouth/cheeks (pocketing). Record review of Resident #21's comprehensive care plan dated 12/08/23, indicated Resident #21 had an order for thickened fluids. The care plan intervention indicated all resident fluids should be thickened to nectar consistency. Diet to be followed as prescribe. o Honor resident rights to make personal dietary choices and provide dietary education as needed. o Monitor and report to physician as needed for any sign and symptoms of: decreased appetite, nausea and vomit, unexpected weight loss, complaint of stomach pain, etc. Monitor for shortness of breath, choking, labored respirations, lung congestion. Monitor/document/report to nurse/dietitian and MD PRN for difficulty swallowing, holding food in mouth, prolonged swallowing time, repeated swallows per bite, coughing, throat clearing, drooling, pocketing food in mouth. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #21's order summary report dated 2/11/25, indicated Resident #21 had the following order: *No added salt diet regular texture, nectar thick consistency, with an order start date of 8/23/24. During an observation on 2/11/24 at 12:05 p.m., revealed Resident #21's bedside table in her room had a pitcher filled with ice water. Resident #21 had a sign above the head of her bed and a sign on the wall facing the entrance door that reflected, Nectar Thicken Liquids. During an interview on 02/12/25 09:44 A.M., CNA C said the nurse put a nectar liquid sign in Resident #21's room. CNA C said she put the pitcher of ice water in Resident #21's room, but she had not drunk it. CNA C said she did not know Resident #21 was supposed to drink nectar thickened liquids only. She said she put the little nectar cups of juice in Resident #21's room for her to drink after she was informed of her to drink nectar thickened liquids. She said she had never seen Resident #21 drink the thin liquid water. She said she wondered why Resident #21 had not drank the water. She said if Resident #21 was supposed to drink nectar thickened liquids and she had water without thickening she could had choked. During an interview on 2/12/25 at 9:53 A.M., OT I said if a resident had a pitcher of ice water on their bedside table that was supposed to have nectar thicken liquids, that would not be good. She said most of the time the residents had a sign posted in their rooms. She said if the resident was coughing while drinking the staff would speak to the speech therapist about the resident. She said a negative effect of a resident having thin liquids available, while ordered to have nectar thicken liquids was aspiration, then pneumonia or choking. During an interview on 2/12/25 at 9:59 A.M., LVN J said all staff were responsible for ensuring that the residents have the correct diets and orders were followed. He said a resident on nectar thickened liquids should never have thin liquid water in their room. He said a negative effect of Resident #21 having ice water (thin liquid) was she could aspirate. During an interview on 2/12/25 at 10:05 A.M., CNA K said the aide should have asked the nurse if a resident was on nectar thickened liquids or thin liquids. She said a negative effect of a resident receiving thin liquids with a nectar thickened liquid restriction was the resident could aspirate or choke. During an interview on 2/12/25 at 10:15 A.M., ADON said when the residents come from the hospital, we check to see what type of orders the residents come with such as liquid diets. She usually staff did not put water pitchers in the resident's room that were on thickened liquids, to prevent this from happening. She said a negative effect of Resident #21 having thin liquids and she was on a nectar thicken liquid diet; she could get aspirate pneumonia. During an interview on 2/12/25 at 10:26 A.M., CNA L said the aides usually asked the nurse which residents were on thickened liquids, and they usually had signs in the resident's room if they were on thickened liquids. She said if Resident #21 was to drink a thin liquid and she was ordered to have nectar thick liquids she could aspirate. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25 at 11:32 A.M., the DON said the aides serve the residents' trays, so they should see the residents that were on thickened liquids on the resident's tray card. She said the nurse should had reported the thickened liquids to the aides. She said a negative effect of Resident #21 having ice water was she could aspirate. During an interview on 2/12/25 at 11:36 A.M., the Operations Manager said when the residents came from the hospital and once therapy has evaluated the resident, they communicate the orders needed for the resident. He said a resident on a nectar thickened liquid diet should not had a pitcher with ice water in their room. He said since Resident #21 had already been evaluated and it has been determined that she needed nectar thickened liquids, she should have never had a thin liquid such as ice water, because it could cause choking or aspiration to the resident. Record review of the facility's policy, Nutrition Status Management - Quality of Care, last revised in 12.2023, revealed: .It is the policy of this facility to assess each resident's nutritional status and needs, including medications and medical conditions to ensure that all residents maintain acceptable parameters of nutritional status, such as body weight and other available data, unless the resident's clinical condition demonstrates that this is not possible .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observation, interview and record review the facility failed to 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 for 3 of 24 residents (Residents #18, #46 and #51) reviewed for infection control practices. 1.The facility failed to ensure CNA G performed proper incontinent care. CNA G wiped from the top of Resident #18's buttocks down towards the perineal area during incontinent care. 2.The facility failed to ensure the proper disinfectant cleaner was used to clean Resident #51's isolation room. Resident #51 had Clostridium difficile (bacteria that causes infection in the large intestine). 3.LVN B did not change her gloves or sanitize her hands after performing catheter care for Resident #46. She touched clean items with her dirty gloves. These failures could place residents at risk for cross contamination and the spread of infection. Finding include: 1.Record review of Resident #18's face sheet, dated 2/11/25, indicated a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses which included other reduced mobility, weakness, need for assistance with personal care, muscle weakness, alcohol dependence with alcohol induced persisting dementia (a group of thinking and social symptoms that interferes with daily functioning) and Huntington's disease (an inherited condition in which nerve cells in the brain break down over time). Record review of Resident #18's quarterly MDS assessment, dated 12/2/24, indicated she was usually able to make herself understood and could usually understand others. Resident #18 had a BIMS score of 11, which indicated her cognition was moderately impaired. Resident #18 required maximal assistance with bed mobility and hygiene. Resident #18 was always incontinent of bowel and bladder. Record review of Resident #18's care plan dated 6/27/23 indicated bowel/ bladder incontinence related to confusion, dementia and weakness. Interventions include brief use, uses disposable briefs, change every 2 hours and prn. Chart bowel movement every shift. Incontinent: check as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes. Monitor/document for signs and symptoms of UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. During an observation on 02/11/25 at 2:34 P.M., revealed CNA F and CNA G performed incontinent care on Resident #18. While the CNAs performed incontinent care, CNA G wiped from the top of Resident #18's buttocks down towards the perineal area, then CNA F told her, I am going to need you to wipe up on the buttocks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/11/25 at 2:41 P.M., CNA F said she knew they messed up with incontinent care when CNA G wiped down on Resident #18's buttocks instead of wiping up and away from her perineal area. She said when performing incontinent care, when someone wiped down on the buttocks or intergluteal cleft (the formal term for the groove between the buttocks) that would wash everything toward the perineal area. She said improper incontinent care could cause UTIs. During an interview on 2/11/25 at 2:43 P.M., CNA G said she caught herself after she wiped down on the buttocks, then she wiped upward. She said that was not proper incontinent care and she caught herself after she did it. She said improper incontinent care could place the resident at risk for infections or UTIs. Record review of CNA G's: Clinical Proficiency-Incontinence Care sheet dated 10/21/24 indicated CNA G had met the requirements. The competency was signed by evaluator ADON. Record review of CNA F's: Clinical Proficiency-Incontinence Care sheet dated 1/14/25 indicated CNA F had met the requirements. The competency was signed by evaluator ADON. During an interview on 2/12/25 at 9:44 A.M., CNA C said during incontinent care staff were supposed to wipe the buttocks from front to back. She said improper incontinent care could cause a UTI or some type of infection. During an interview on 2/12/25 at 9:59 A.M., LVN J said improper incontinent care can cause UTIs and that came from E. coli getting in the urinary tract. He said staff should be wiping the residents from front to back during incontinent care. During an interview on 2/12/25 at 10:05 A.M., CNA K said during incontinent care the best practice was to go back not down when cleaning a resident's buttocks. She said a negative effect of improper incontinent care if the resident was a female by wiping down, something could get into her peri area and cause a UTI or sore. During an interview on 2/12/25 at 10:15 A.M., the ADON said she thought CNA F was nervous when she performed the incontinent care on Resident #18. She said when staff wiped down on the buttocks during incontinent care, they were pushing bacteria into the urethra. She said a negative effect of improper incontinent care was a potential for UTIs. During an interview on 2/12/25 at 10:26 A.M., CNA L said during incontinent care of the buttocks staff should wipe from front to back instead of down. She said improper incontinent care can cause UTIs and other infections, due to not cleaning correctly. During an interview on 2/12/25 11:32 A.M., the DON said she expected the aides to perform proper incontinent care. She said improper incontinent care could cause UTIs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #51's face sheet, dated 02/11/25, indicated he was a [AGE] year-old male, admitted to the facility on [DATE], and readmitted on [DATE]. His diagnoses included cerebrovascular disease (a group of conditions that affect the blood vessels in the brain, leading to disruptions in blood flow and oxygen supply to the brain tissue), enterocolitis due to clostridium difficile (an infection of the colon caused by the bacterium Clostridium difficile), and pneumonia due to mycoplasma pneumoniae (a common respiratory infection caused by the bacterium Mycoplasma pneumoniae) (dated 02/05/25). Record review of Resident #51's quarterly MDS assessment, dated 01/27/25, indicated he had a BIMS score of 08, which indicated moderate cognitive impairment. He did not exhibit behaviors of rejection of care or wandering. He was dependent on staff for many of his activities of daily living, including oral hygiene, bathing, and lower body dressing. He required substantial assistance for other activities of daily living, including roll left and right, sit to lying, and chair/bed-to-chair transfers. Record review of Resident #51's physician's orders, dated 02/11/25, indicated this order: *Room Placement: Single Room Isolation (all services be brought to the resident (e.g., rehabilitation, activities, dining, etc.) every shift for clostridium difficile, mycoplasma pneumonia. The start date was 02/06/25. Record review of Resident #51's care plan, dated 02/03/25, indicated a focus of has clostridium difficile. Interventions included: *Contact isolation: Wear gowns and masks when changing contaminated linens. Placed soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry. *Disinfect all equipment used before it leaves the room. *Educate resident/family/staff regarding preventative measures to contain the infection. During an observation on 02/10/25 at 09:37 AM, there was a red sign on Resident #51's door that stated STOP - Please see nurse before entering. There was an isolation cart outside of Resident #51's room that contained gowns, gloves, and masks. Resident #51 was inside his room sitting in a chair and watching TV. During an interview on 02/12/25 at 10:30 AM, Housekeeping Supervisor K said the housekeepers used the Betco pH7Q Dual disinfectant to clean and disinfect clostridium difficile rooms. He said he was going to look up and see if he could provide documentation that the cleaner killed clostridium difficile. During an interview on 02/12/25 at 10:49 AM, Housekeeper L said she was working on Resident #51's hall this day. She said she had not yet cleaned Resident #51's room, but she was going back to the hall. She said she used the Betco pH7Q dual cleaner to clean for clostridium difficile. She pointed to a bottle of the cleaner on the cart and showed it to this surveyor. During an observation on 02/12/25 at 11:10 AM, this surveyor observed Housekeeper L cleaning Resident #51's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/12/25 at 12:34 PM, Housekeeping Supervisor K said he was responsible for ensuring that the facility had a cleaner for killing clostridium difficile. He said the risk to the residents was that someone else could get infected with clostridium difficile. He said they would be getting another product that day. During an interview on 02/12/25 at 01:09 PM, the ADON said she expected the housekeeping staff to use the proper cleaner for clostridium difficile. She said the risk was possible spread of clostridium difficile to other residents. During an interview on 02/12/25 at 01:17 PM, the DON said she expected the housekeeping staff to use a cleaner that would kill clostridium difficile. She said housekeeping staff were responsible for using the proper cleaner. She said the risk was that clostridium difficile could potentially spread to other residents. During an interview on 02/12/25 at 01:22 PM, the Operations Manager said he expected the housekeeping staff to ensure the chemicals did kill clostridium difficile. He said the residents and employees could become sick with clostridium difficile or pass it on. He said the risk was increased for spreading clostridium difficile. He said the risk to the resident was that he could become reinfected. Record review of the following site was accessed on 02/12/25 at 12:00PM, and did not indicate the Betco pH7Q dual cleaner killed clostridium difficile bacteria: * List K: Antimicrobial Products Registered with EPA for Claims Against Clostridium difficile Spores | US EPA Record review of the following site was accessed on 02/12/25 at 12:15PM, and indicated the active ingredient in Betco pH7Q dual cleaner was registered under the name MAQUAT 256-NHQ. *Details for BETCO PH7Q DUAL | US EPA Record review of the following site was accessed on 02/12/25 at 12:15PM, and did not indicate the MAQUAT 256-NHQ cleaner killed clostridium difficile bacteria. *Details for MAQUAT 256-NHQ | US EPA 3.Record review of the undated face sheet indicated Resident #46 was an [AGE] year-old male that admitted [DATE]. Record review of the physician's orders dated 2/11/25 indicated Resident #46 had diagnoses that included: apraxia following cerebrovascular disease (a cognitive disorder that can occur after cerebrovascular disease, such as a stroke), Urinary Tract infection (bacteria gets in the tube through which urine leaves the body), and Extended Spectrum Beta Lactamase Resistance (enzymes that make bacteria resistant to many antibiotics). Record review of the quarterly MDS dated [DATE] indicated Resident #46 had unclear speech, was usually understood, and usually understood others. He had a BIMS of 14 indicating he was cognitively intact. Resident #46 was dependent on staff for toileting hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the undated care plan indicated Resident #46 had a CVA (Cerebrovascular Accident, a stroke, loss of blood flow to the brain) with aphasia (cannot communicate effectively). The care plan indicated he required the assistance of 1 staff for personal hygiene and had an indwelling catheter related to atonic bladder (bladder muscles are weakened and do not contract effectively), and neuromuscular dysfunction of the bladder (impaired bladder muscle activity due to the disrupted communication between the brain and the bladder itself). The care plan indicated he got a suprapubic catheter 10/13/21. During an observation on 2/11/25 at 3:00 PM, LVN B, CNA C, and the Treatment Nurse donned (put on) their PPE for EBP. Resident #46 was in bed, covered and positioned with pillows. LVN B provided catheter care for Resident #46's suprapubic catheter (a thin, flexible tube inserted through a small incision in the abdomen). LVN B did not change her gloves after completing the dirty procedure. She touched the clean towel with her dirty gloves to dry off his catheter. She touched a clean hospital gown that she covered him with. During an interview on 02/11/25 at 3:08 PM, LVN B said she should have changed her gloves and washed her hands before touching the clean towel to dry the catheter and the gown she laid over him. She said it was wrong of her to do that because she could have transferred bacteria to the resident which could cause infection. She said she was taught to change her gloves and wash her hands after a dirty procedure and before going to a clean one. Record review of a Suprapubic Cath Care Skills Checklist dated 5/22/24 indicated LVN B as proficient with catheter care. This was signed by the previous ADON. During an interview on 2/11/25 at 03:16 PM, CNA C said she noticed LVN B had not changed her gloves after performing catheter care on Resident #46 and had touched clean items with her dirty gloves. She said she did not know she could remind her to change her gloves with a surveyor in the room, so she did not say anything. She said there was a risk of infection to the resident and the staff from touching clean things with dirty gloves. CNA C said she was taught to always change her gloves after a dirty procedure before going to a clean one to prevent infection. During an interview and record review on 2/11/25 at 3:34 PM, the DON provided competencies for Suprapubic Catheter Care - Skills Checklist for LVN B, dated 5/22/24 and signed by the previous ADON. The skills checklist for LVN B indicated she was competent to provide catheter care. The DON said the previous ADON was no longer working at the facility. During an interview on 2/12/25 at 8:13 AM, LVN D said she would always change her gloves and wash her hands after a dirty procedure and before going to a clean procedure. She said if she had performed catheter care, she would immediately change her gloves and wash her hands before touching anything clean. She said touching clean items with dirty gloves was a risk of infection to residents and staff. During an interview 02/12/25 at 10:15 AM, RN E said she sometimes did Foley and incontinent care. She said staff must always change their gloves and wash their hands after a dirty procedure and before touching anything clean. She said touching clean items with gloves that were considered dirty was a risk of infection to staff and residents. RN E said female residents should always be wiped front to back to prevent urinary tract infections or vaginal infections. (continued on next page)

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Legend Oaks Healthcare and Rehabilitation Center G	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/25 at 10:34 AM, the DON said she expected all staff to change their gloves and wash their hands after a dirty procedure and before going to a clean procedure. She said using dirty gloves to touch something clean was a risk of transferring bacteria to the resident or staff. She said when wiping a woman, they must always wipe from front to back to prevent urinary tract or vaginal infections. During an interview on 02/12/25 at 11:01 AM, the OM said all staff should change their gloves and wash their hands after a dirty procedure and before going to a clean area to keep from transmitting infection to the residents and staff. He said when wiping a woman during incontinent care, she should be wiped from front to back to prevent urinary and vaginal infections. He said he expected all staff to be accountable when they have done something they should not have, and to learn the correct way for the benefit of the residents. All staff must follow the parameters and the rules. Record review of a Policy/Procedure - Nursing Clinical with a revised date of 5/2007 indicated: Procedures .2. Assist resident to turn on side with back toward you. Expose buttocks area. Wash, using front-to-back strokes, rinse, and dry exposed skin surfaces . Record review of an Environmental Services - Housekeeping Policy with a revised date of 2022 indicated: Policy .Housekeeping and Maintenance services include the cleaning, sanitization, and care for rooms and common areas of the facility to ensure that the facility is a safe for all who reside, work, and visit. 1 .g.Use the proper disinfectant and cleaners when working. These products are labeled and mixed for the intended use. If any questions arise, MDS [MSDS-Material Safety Data Sheets] and product information is available upon request. Record review of an Indwelling Urinary Catheter Care policy with a revised date of 12/2023 indicated: Policy .It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed (PRN) to promote hygiene, comfort, and decrease the risk of infection. 46929 35295