

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676113	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation Center -		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 W Hutchins Place San Antonio, TX 78224	

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 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41095</p> <p>45857</p> <p>Based on interview and record review, the facility failed to ensure residents' right to formulate an advance directive for 1 of 6 residents (Resident #320) reviewed for advanced directives, in that:</p> <p>The facility failed to ensure Resident #320's Out-of-Hospital Do Not Resuscitate (OOH DNR) was included in the medical record and correctly completed.</p> <p>This failure could place residents at-risk of having their end of life wishes dishonored, and of having CPR performed against their wishes.</p> <p>The findings included:</p> <p>Record review of Resident #320's face sheet, dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia (a group of symptoms that affects memory, thinking, and interferes with daily life), Parkinson's disease (a movement disorder that affects the nervous system and worsens over time) without dyskinesia (uncontrolled, involuntary movements of the face, arms, and legs) without mention of fluctuations, and adult failure to thrive.</p> <p>Record review of Resident #320's initial admission record, dated [DATE] revealed the resident was sometimes understood and sometimes understood others.</p> <p>Record review of Resident #2's comprehensive care plan, initiated on [DATE] revealed the resident was a DNR.</p> <p>Record review of Resident #320's Order Summary Report, dated [DATE] revealed an order for DNR, with a start date of [DATE], and no end date.</p> <p>Record review Resident #320's DNR, dated [DATE], revealed it contained Resident #320's RP's signature and name in section C. The DNR was signed by two witnesses and two physicians. There were two physicians' signatures at the bottom of the document but no witness or RP signature at the bottom where any person who had signed above must sign below.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 2:20 p.m. the SW stated he was unsure if there were any pending DNR's and had just started at the facility. The SW was unsure if Resident #320 had a DNR or where the DNR was.</p> <p>During an interview on [DATE] at 2:59 p.m. the DON stated clinical staff was helping the SW with DNR paperwork since he was new and in training. The DON stated it took them a while to find the DNR and if Resident #320 had coded, he would have received CPR in the event of an emergency if they had taken that long to locate the DNR. The DON stated the RP's signature was not necessary on the document because they had two provider signatures.</p> <p>During an interview on [DATE] at 11:27 a.m. Resident #320's RP stated they did not complete a DNR form. The RP was shown the DNR form. The RP stated that was not their signature or print and was concerned someone would be forging their name on documents. The RP stated they did wish to execute a DNR but was not asked to fill out paperwork by the facility. The RP stated they only discussed the DNR with hospital staff prior to being admitted to the facility.</p> <p>Record review of the facility policy titled Advanced Directives and Associated Documentation, dated , d+[DATE], reflected . Procedure: 1. Prior to, upon, or immediately after admission, a facility staff member shall: a. Provide the resident/family or responsible agent written information regarding the right to accept or refuse medical treatment and the right to formulate Advance Directives b. Document in the resident health record that, at the time of admission, the resident/family has been provided with written information regarding advance directives. c. Inquire whether he/she has completed an Advance Directive. 2. If the resident is incapacitated at the time of admission and is unable to receive information or indicate whether or not he/she has executed an advance directive, the facility may give advance directive information to the resident's representative in accordance with existing State law. a. If the resident becomes able to receive information at a later point during his/her admission, the facility will follow its policy relative to the provision of advance directive information to extent permitted by the resident's condition. b. Information will be provided directly to the resident by a member of the care plan team, in a timely manner . 4. If the resident is incapacitated and not-capable of independent decision-making at the time of admission: a. Inform the surrogate decision maker to document his/her desire to initiate an advance directive and his/her knowledge that this decision is in the resident's best interest or is to comply with resident's known desires, when this need arises. b. If the surrogate decision-maker is a family member who is not the attorney-in-fact, conservator or guardian with health care decision power, all members of the immediate family with equal relationship to the resident will need to agree and sign the document. i. In the event opinions differ among family members, the Advance Directives will not be implemented until a resolution is achieved. c. If there is no surrogate decision maker who can act on behalf of an incapacitated resident, an Advance Directive order may be issued when the attending physician determines it is medically appropriate and concurrence is evident in the resident health record by the Interdisciplinary Team. 5. When an Advance Directive is completed: a. Review the Advance Directive to validate the document reflects the resident choices and that the document is signed and dated by the resident or responsible agent . d. Obtain copy of the Advance Directive and conservatorship/guardianship documents and place in the resident health record. 6. Obtain copy of the Advance Directive and conservatorship/guardianship documents and place in the resident health record. a. It should be noted that a Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form is not an advance directive. b. Once the advance directive or information regarding resident preferences regarding treatment options is received by the facility, it will be confirmed in the resident medical record and communicated to members of the care plan team .</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857</p> <p>Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 3 residents (Resident #226, Resident #221 and Resident #320) reviewed for comprehensive care plans in that:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure Resident #226's use of bed rails was care planned. 2. The facility failed to ensure Resident #221's use of bed rails was care planned. 3. The facility failed to ensure Resident #320's use of bed rails was care planned. <p>This deficient practice could place residents at risk of not being provided with the necessary care or services and having personalized plans developed to address their specific needs.</p> <p>The findings included:</p> <p>1. Record review of Resident #226's face sheet, dated 9/26/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included legal blindness (severe vision impairment), and hemiplegia (total paralysis of one side of the body) and hemiparesis (weakness or partial paralysis on one side of the body) following cerebral infarction (also known as a stroke; occurs when blood flow to a part of the brain is blocked) affecting unspecified side.</p> <p>Record review of Resident #226's most recent MDS assessment, dated 9/14/24 revealed the resident was moderately cognitively impaired for daily decision-making skills.</p> <p>Record review of Resident #226's baseline care plan, dated 9/12/24 revealed the use of bed rails was not included in the care plan.</p> <p>Record review of Resident #226's Enabling Device/Safety Device/Restraint Informed Consent, dated 9/12/24 revealed the resident's representative signed the document and was fully informed of the potential dangers in the usage of handrails and bed side rails.</p> <p>During an observation and interview on 09/25/24 8:12 a.m., Resident #226 stated he was completely blind, could not walk and needed help with transfers. Resident #226 was observed in the bed with quarter bed rails up on both sides of the bed. Resident #226 stated he had never tried to use the quarter rails.</p> <p>Observation on 09/26/24 at 2:08 p.m. revealed Resident #226 sleeping in bed and the quarter bed rails were up on both sides of the bed.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of Resident #221's face sheet, dated 9/26/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy and lack of coordination.</p> <p>Record review of Resident #221's baseline care plan, dated 9/13/24 revealed the resident was at risk for impaired cognitive function/dementia or impaired thought processes and did not have the use of bed rails included in the baseline care plan.</p> <p>Record review of Resident #221's Enabling Device/Safety Device/Restraint Informed Consent, dated 9/13/24 revealed the resident signed the document and was fully informed of the potential dangers in the usage of handrails and bed side rails.</p> <p>During an observation on 9/24/24 at 10:26 a.m., Resident #221 was sitting up in bed with quarter rails on both sides of the bed in the up position.</p> <p>During an observation and interview on 9/26/24 at 8:30 a.m., Resident #221 was sitting up in bed with quarter rails on both sides of the bed in the up position. Resident #221 stated the bed rails were always up and did not know how to put them down. Resident #221 stated she used the bed rails to reposition herself.</p> <p>3. Record review of Resident #320's face sheet, dated 9/26/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia (a group of symptoms that affects memory, thinking, and interferes with daily life), Parkinson's disease (a movement disorder that affects the nervous system and worsens over time) without dyskinesia without mention of fluctuations, and adult failure to thrive.</p> <p>Record review of Resident #320's initial admission record, dated 9/19/24 revealed the resident was sometimes understood and sometimes understood others.</p> <p>Record review of Resident #320's Enabling Device/Safety Device/Restraint Informed Consent, dated 9/19/24 revealed the resident representative signed the document and was fully informed of the potential dangers in the usage of hand rails and bed side rails.</p> <p>Record review of Resident #320's assessments, on 9/26/24, revealed they did not contain a Restraint/Enabling Device /Safety Device Evaluation.</p> <p>Record review of Resident #320's Order Summary Report, dated 9/26/24 revealed an order for bolsters placed on bed with a start date of 9/20/24, and no end date. Another order for MAY USE MOBILITY BARS TO AIDE IN EASY TURNING &REPOSITIONING WHILE IN BED every evening and night shift, with a start date of 9/19/24, and no end date.</p> <p>Record review of Resident #320's baseline care plan, dated 9/20/24 revealed the resident was at risk for impaired cognitive function/dementia or impaired thought processes and did not have the use of bed rails included in the baseline care plan.</p> <p>During an observation on 9/27/24 at 11:25 a.m. revealed Resident #320 was sitting in his bed with 1/8th rails in the upright position on either side of the bed.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/26/24 at 4:29 p.m., the DON revealed Resident #226, Resident #221, and Resident #320 had bed rails used as enablers and were affixed to the bed. The DON stated to have the bed rails it was required to have physician orders, a consent and the bed rails needed to be care planned. The DON stated, the use of bed rails should be care planned to make sure the staff are aware the bed rails are used as mobility bars to enhance mobility and not as a restraint.</p> <p>A careplan policy was requested and provided for comprehensive care plans, no baseline care plan policy was provided.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 of 3 residents (Resident #77, and #312) reviewed for indwelling urinary catheter care.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure Resident #77's indwelling urinary catheter drainage bag was emptied and draining to gravity when provided with urinary catheter care. 2. The facility failed to ensure CNA C cleansed Resident #312 from the meatus (the opening of the urethra where urine exits the penis) outwards and washed the resident's scrotum, inner thighs, and thoroughly cleaned between his buttocks. <p>These failures could place the residents with indwelling urinary catheter devices at risk for the development of new or worsening urinary tract infections.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Record review of Resident #77's face sheet, dated 9/27/24 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included need for assistance with personal care, benign prostatic hyperplasia with lower urinary tract symptoms (a benign condition in which the prostate gland is larger than normal causing slow or block the flow of urine from the bladder), and cystitis (inflammation of the bladder or a lower urinary tract infection). <p>Record review of Resident #77's most recent significant change MDS assessment, dated 7/29/24 revealed the resident was severely cognitively impaired for daily decision-making skills and utilized an indwelling urinary catheter.</p> <p>Record Review of Resident #77's comprehensive care plan with revision date 3/13/24 revealed the resident had an indwelling urinary catheter related to obstructive uropathy (urine flow blocked or slowed related to obstruction in any part of the urinary tract) with interventions that included to position the catheter bag and tubing below the level of the bladder and away from entrance room door, provide catheter care every shift and as needed, and a goal for the resident to remain free from catheter related trauma.</p> <p>Observation on 9/26/24 beginning at 5:09 p.m., revealed Resident #77's indwelling urinary catheter bag was filled with approximately 1,200 ml of urine and draining to gravity on the right side of the bed rail. Observation during catheter care revealed, CNA A took the indwelling urinary catheter bag and tubing and placed it on the foot of the bed next to Resident #77's right foot. Observations of the indwelling urinary catheter bag and tubing revealed they remained on Resident #77's bed throughout the catheter care until 5:47 p.m.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/26/24 at 5:57 p.m., CNA A stated she realized Resident #77's indwelling urinary catheter bag was filled with urine and should have emptied the bag prior to catheter care. CNA A further stated, the indwelling urinary catheter bag filled with urine could backflow and could give the resident a urinary tract infection or the catheter could dislodge. CNA A stated she was nervous.</p> <p>During an interview on 9/26/24 at 6:18 p.m., the DON stated, Resident #77's indwelling urinary catheter bag should have been emptied of urine prior to catheter care as it could dislodge and you don't want to push it and the urine could back flow causing an infection.</p> <p>Record review of CNA A's Comprehensive Clinical Competency Review Skills Checklist dated 5/25/24 revealed CNA A had satisfied the requirements for performing catheter care.</p> <p>2. Record review of Resident #312's face sheet, dated 9/27/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included encounter for orthopedic aftercare following surgical amputation and benign prostatic hyperplasia (a condition in which the prostate gland grows larger than normal, but the growth is not caused by cancer) without lower urinary tract infection.</p> <p>Record review of Resident #312's admission MDS revealed it was not complete because he was a new admit.</p> <p>Record Review of Resident #312's comprehensive care plan with revision date 9/26/24 revealed the resident had an indwelling urinary catheter with interventions to provide catheter care every shift and as needed.</p> <p>During an observation on 9/27/24 at 11:28 a.m. revealed CNA C and CNA D provided catheter and incontinent care to resident #312. Resident #312 had purulent (thick, milky discharge) continuously dripping from his urethra (urethra is a tube that connects the urinary bladder to the urinary meatus for the removal of urine from the body). CNA C held Resident #312's penis and wiped in the wrong direction from the base to the tip of the penis. The purulent drainage was on the resident's scrotum and had dripped from the resident's penis onto his scrotum. CNA C did not clean the resident's scrotum or under the scrotum. CNA C then turned the resident to his side and cleaned his buttocks. CNA C did not fully sperate the resident's gluteus folds to reach the intergluteal cleft (the groove between the buttocks that runs from just below the sacrum to the perineum).</p> <p>During an interview on 9/27/24 at 11:59 a.m. CNA C stated he thought he wiped the right direction when he cleaned the resident's penis. CNA C stated if he wiped towards to meatus it could cause infection. CNA C stated he forgot to clean the resident's scrotum and under the scrotum because he focused on the catheter care and forgot. CNA C stated he thought he separated the resident's buttocks enough to clean between the folds because he observed fecal matter on the wipe. CNA C stated he had received training for catheter and peri care but did not have any male residents on his assigned hallway who received catheter care. CNA C stated he was asked to help with the catheter care for Resident #312 but was not familiar with the resident.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/27/24 at 12:09 p.m. the DON stated if staff did not clean the resident's penis the right direction or provide full peri care to include cleaning the scrotum and buttocks the resident could get an infection. The DON stated the resident was sent to the hospital the day prior and returned with a diagnosis of a UTI. The DON stated the resident was having a PICC line inserted to receive IV antibiotics. The DON stated they had no hospital paperwork but had requested it.</p> <p>Record review of CNA C's skills check list, dated 2/27/24, showed CNA C was trained and met standards for catheter care and perineal care. The check off stated with warm water and soap to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return foreskin to normal position .Wash and rinse the tip of penis using circular motion beginning at urethra. Continue washing down the penis to the scrotum and inner thighs .Clean the rectal area, wiping in strokes from the base of the scrotum and over the buttocks.</p> <p>Record review of the facility policy and procedure titled, Infection Control Policy/Procedure, Section: Quality of Care, Subject: Catheter Care, Indwelling, review date 12/2019 revealed in part. .It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and PRN for soiling . Purpose: to Promote hygiene, comfort and decrease risk of infection for catheterized residents .Keep tubing below level of bladder .</p> <p>41095</p> <p>45857</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075</p> <p>Based on observation, interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for 2 of 2 residents (Resident #226, and Resident #75) reviewed for dialysis in that:</p> <p>The facility did not maintain communication, coordination, and collaboration with the dialysis facility for Resident #226 and Resident #75.</p> <p>This deficient practice could affect residents who received dialysis treatments and place them at risk for complications and not receiving proper care and treatment to meet their needs.</p> <p>The findings were:</p> <p>1. Record review of Resident #226's face sheet, dated 9/26/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included displacement of vascular dialysis catheter (a medical device used to access the bloodstream for dialysis treatment), end stage renal disease (condition in which the kidneys cease functioning on a permanent basis) and dependence on renal dialysis (process of removing excess water, solutes and toxins from the blood in people whose kidneys can no longer perform these functions naturally).</p> <p>Record review of Resident #226's most recent MDS assessment, dated 9/14/24 revealed the resident was moderately cognitively impaired for daily decision-making skills and was dependent on renal dialysis.</p> <p>Record review of Resident #226's comprehensive care plan, revision date 9/24/24 revealed the resident was at risk for impaired cognitive function/dementia or impaired thought processes related to confusion, end stage renal disease and dialysis.</p> <p>Record review of Resident #226's Order Summary Report, dated 9/26/24 revealed the following:</p> <ul style="list-style-type: none"> - DIALYSIS COMMUNICATION FORM TO BE COMPLETED AND FILED/SCANNED IN CHART ON DIALYSIS DAYS, with order date 9/20/24 and no stop date - HEMODIALYSIS 3 X /WEEK EVERY TTTHS AT DIALYSIS CLINIC 7:00 AM, with order date 9/24/24 and no stop date - RESIDENT HAS PERMACATH TO RU MONITOR SITE Q SHIFT FOR BLEEDING, PAIN, REDNESS, TENDERNESS, SWELLING, AND DISLODGE MENT every shift and as needed with order date 9/22/24 and no stop date <p>Record review of Resident #226's Renal Dialysis Communication Form revealed the form dated 9/23/24 was missing the dialysis staff's signature and the form dated 9/26/24 revealed the Dialysis Center Information section requested the following information: Please send VS and BP regimen times given BP meds please. Patient's BP reading high today.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/25/24 at 8:17 a.m., Resident #226 stated he had been receiving dialysis treatments for 4 years and the dialysis port was on the upper left chest.</p> <p>During an interview on 9/26/24 at 3:46 p.m., the ADON stated she was responsible for making sure the Renal Dialysis Communication Forms were completed before being filed away. The ADON stated the nurses should check the form for completeness at the time it was received, and she checked the forms weekly for completeness before it was filed. The ADON stated the Renal Dialysis Communication Form for Resident #226, dated 9/23/24 was missing the dialysis staff's signature and the form dated 9/26/24 had information the dialysis clinic requested regarding the resident's blood pressure reading being elevated. The ADON could not confirm if the dialysis clinic had received the information requested on 9/26/24 by the dialysis clinic.</p> <p>During an interview on 9/26/24 at 4:12 p.m., the DON stated, Resident #226's Renal Dialysis Communication Form dated 9/23/24 was missing the dialysis clinic 's signature and the section for recommendations communications was unclear. The DON further stated, the communication form dated 9/26/24 had a note from dialysis about the resident's blood pressure that should have been clarified the day received today. The DON stated, the floor staff are supposed check these when they return, it's like an appointment, they should be checking like for orders and should be addressed as soon as possible. That is my expectation. The DON stated the ADON was supposed to be checking behind the nurses to ensure this does not happen, because of missing documentation and (missing) sheets in the past.</p> <p>2. Record review of Resident #75's face sheet, dated 9/26/24 revealed a [AGE] year-old male readmitted to the facility on [DATE] and initially admitted on [DATE] with diagnoses that included type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), chronic kidney disease (a gradual loss of kidney function), and dependence on renal dialysis (process of removing excess water, solutes and toxins from the blood in people whose kidneys can no longer perform these functions naturally).</p> <p>Record review of Resident #75's most recent MDS assessment, dated 9/13/24 revealed the resident's cognition was intact for daily decision-making skills and was dependent on renal dialysis.</p> <p>Record review of Resident #75's comprehensive care plan, revision date 8/12/24 revealed the resident needed dialysis related to renal failure with interventions to check arteriovenous fistula (connection or passageway between an artery and a vein) every day for bruit (abnormal sound generated by turbulent flow of blood in an artery due to either an area of partial obstruction or a localized high rate of blood flow through an unobstructed artery) and thrill (A vibratory sensation felt on the skin overlying an area of turbulence, often indicating a loud heart murmur caused by an incompetent heart valve.), obtain vital signs and weight, report significant changes in pulse, respirations, and blood pressure immediately.</p> <p>Record review of Resident #75's Order Summary Report, dated 9/26/24 revealed the following:</p> <ul style="list-style-type: none"> - DIALYSIS COMMUNICATION FORM TO BE COMPLETED AND FILED/SCANNED IN CHART ON DIALYSIS DAYS, with order date 9/11/24 and no stop date. - Hemodialysis 3 times a week every Tuesday, Thursday, and Saturday at dialysis clinic at 9:15 a.m. transport, chair time 10:15 a.m., with order date 9/24/24 and no stop date. <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Monitor and record every shift AV (arteriovenous) permacath (is a catheter, a special IV device, that medical professionals insert into a blood vessel) [NAME] (left upper chest or clavicle) for bleeding, redness, swelling, pain, signs and symptoms of infection, document (-) absent or if (+) present notify MD and dialysis, with an order date of 9/25/24, and no end date.</p> <p>-Monitor and record every shift AV shunt/fistula for bruit and thrill. Document (+) present or if (-). Absent notify MD and dialysis center, with an order date of 9/11/24, and no end date.</p> <p>Record review of Resident #75's nursing progress notes, dated 9/26/24, revealed a note written on 9/17/24 by LVN E that reflected, .Receiving dialysis. Dialysis type: Hemodialysis Resident response to dialysis is Resident denies pain, and s/s of discomfort to dialysis site. Resident tolerating dialysis treatment well at this time. Other observations and interventions include Resident noted to miss dialysis days at times. No s/s of discomfort noted .</p> <p>Record review of Resident #75's Renal Dialysis Communication Forms revealed there was no form for 9/17/24. The form for 9/24/24 was not completed upon return by facility staff, and the form for 9/26/24 was not completed upon return by staff.</p> <p>During an interview on 9/26/24 at 4:13 p.m. LVN E stated he wrote in a skilled nursing note that the resident missed dialysis on 9/17/24 and he documneted it in a note as miss dialysis at times.</p> <p>During an interview on 9/26/24 at 3:43 p.m. the ADON stated she oversaw reviewing the dialysis communication forms to ensure they were completed. The ADON stated the forms dated 9/24/24 and 9/26/24 were missing the information for the assessment done by their facility staff upon return. The ADON stated they still had time to complete the form for 9/26/24. The ADON stated the resident did not go to dialysis on 9/17/24.</p> <p>Record review of the facility policy and procedure titled, Dialysis (Renal), Pre- and Post-Care, dated 3/2009 revealed in part, .It is the policy of this facility to .Participate in ongoing communication and collaboration with the dialysis facility regarding dialysis care and services .The care of the resident receiving dialysis services will reflect ongoing communication, coordination and collaboration between the nursing home and dialysis staff .Staff will immediately contact and communicate with .designated dialysis staff .regarding any significant changes in the resident's status related to clinical complications or emergent situations .</p> <p>45857</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075</p> <p>Based on observation, interview and record review, the facility failed to assess the resident for risk of entrapment from bed rails prior to installation and review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for 3 residents of 9 residents (Resident #226, Resident #221, and Resident #320) reviewed for use of side or bed rails in that:</p> <ol style="list-style-type: none"> 1. The facility failed to attempt to use appropriate alternatives prior to installing a side or bed rail for Resident #226 and failed to assess Resident #226 for risk of entrapment from bed rails before they were installed. 2. The facility failed to attempt to use appropriate alternatives prior to installing a side or bed rail for Resident #221 and failed to assess Resident #221 for risk of entrapment from bed rails before they were installed. 3. The facility failed to attempt to use appropriate alternatives prior to installing a side or bed rail for Resident #320 and failed to assess Resident #320 for risk of entrapment from bed rails before they were installed. <p>This failure could affect residents who use bed or side rails as enablers and could result in entrapment.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Record review of Resident #226's face sheet, dated 9/26/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included legal blindness (severe vision impairment), and hemiplegia (total paralysis of one side of the body) and hemiparesis (weakness or partial paralysis on one side of the body) following cerebral infarction (also known as a stroke; occurs when blood flow to a part of the brain is blocked) affecting unspecified side. <p>Record review of Resident #226's most recent MDS assessment, dated 9/14/24 revealed the resident was moderately cognitively impaired for daily decision-making skills.</p> <p>Record review of Resident #226's Enabling Device/Safety Device/Restraint Informed Consent, dated 9/12/24 revealed the resident's representative signed the document and was fully informed of the potential dangers in the usage of hand rails and bed side rails.</p> <p>Record review of Resident #226's Restraint/Enabling Device /Safety Device Evaluation, dated 9/22/24 revealed the resident had Associated Health issues/diagnoses which contribute to potential for falls or need for Safety/Enabling Devices related to weakness. Further review of the document revealed, Indicate below, ALL measures you have tried Before Implementing Recommended Device. Check ALL that Apply was left blank.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 09/25/24 8:12 a.m., Resident #226 stated he was completely blind, could not walk and needed help with transfers. Resident #226 was observed in the bed with quarter bed rails up on both sides of the bed. Resident #226 stated he had never tried to use the quarter rails.</p> <p>Observation on 09/26/24 at 2:08 p.m. revealed Resident #226 sleeping in bed and the quarter bed rails were up on both sides of the bed.</p> <p>2. Record review of Resident #221's face sheet, dated 9/26/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy and lack of coordination.</p> <p>Record review of Resident #221's baseline care plan, dated 9/13/24 revealed the resident was at risk for impaired cognitive function/dementia or impaired thought processes.</p> <p>Record review of Resident #221's Enabling Device/Safety Device/Restraint Informed Consent, dated 9/13/24 revealed the resident signed the document and was fully informed of the potential dangers in the usage of hand rails and bed side rails.</p> <p>Record review of Resident #221's Restraint/Enabling Device /Safety Device Evaluation dated 9/14/24 revealed the resident had Associated Health issues/diagnoses which contribute to potential for falls or need for Safety/Enabling Devices related to weakness. Further review of the document revealed, Indicate below, ALL measures you have tried Before Implementing Recommended Device. Check ALL that Apply was marked 1/4 side rails right and 1/4 side rails left.</p> <p>During an observation on 9/24/24 at 10:26 a.m., Resident #221 was sitting up in bed with quarter rails on both sides of the bed in the up position.</p> <p>During an observation and interview on 9/26/24 at 8:30 a.m., Resident #221 was sitting up in bed with quarter rails on both sides of the bed in the up position. Resident #221 stated the bed rails were always up and did not know how to put them down. Resident #221 stated she used the bed rails to reposition herself.</p> <p>During an interview on 9/26/24 at 4:29 p.m., the DON revealed Resident #226 and Resident #221 had bed rails used as enablers and were affixed to the bed. The DON stated the facility obtained a consent at the time of admission for the use of enablers. The DON stated to have the bed rails it was required to have physician orders, a consent and the bed rails needed to be care planned. The DON further stated, we do an assessment to make sure they are able to use it, and it is not a restraint. The DON stated, the use of bed rails should be care planned to make sure the staff are aware the bed rails are used as mobility bars to enhance mobility and not as a restraint.</p> <p>3. Record review of Resident #320's face sheet, dated 9/26/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia (a group of symptoms that affects memory, thinking, and interferes with daily life), Parkinson's disease (a movement disorder that affects the nervous system and worsens over time) without dyskinesia without mention of fluctuations, and adult failure to thrive.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #320's initial admission record, dated 9/19/24 revealed the resident was sometimes understood and sometimes understood others.</p> <p>Record review of Resident #320's Enabling Device/Safety Device/Restraint Informed Consent, dated 9/19/24 revealed the resident representative signed the document and was fully informed of the potential dangers in the usage of hand rails and bed side rails.</p> <p>Record review of Resident #320's assessments, on 9/26/24, revealed they did not contain a Restraint/Enabling Device /Safety Device Evaluation.</p> <p>Record review of Resident #320's Order Summary Report, dated 9/26/24 revealed an order for bolsters placed on bed with a start date of 9/20/24, and no end date. Another order for MAY USE MOBILITY BARS TO AIDE IN EASY TURNING &REPOSITIONING WHILE IN BED every evening and night shift, with a start date of 9/19/24, and no end date.</p> <p>Record review of Resident #320's baseline care plan, dated 9/20/24 revealed the resident was at risk for impaired cognitive function/dementia or impaired thought processes and did not have the use of bed rails included in the baseline care plan.</p> <p>During an observation on 9/27/24 at 11:25 a.m. revealed Resident #320 was sitting in his bed with 1/8th rails in the upright position on either side of the bed. The resident was not able to answer questions when asked. The resident also appeared to have a mattress with side bolsters.</p> <p>Record review of the facility policy and procedure titled, Mobility Bars, with revision date 5/2007 revealed in part, .It is the policy of this facility to use mobility bars .1. Based on resident's assessed medical needs .2. Used for treatment of medical symptoms or condition .3. Used for resident's mobility and/or transfer . Informed Consent .</p> <p>45857</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>36232</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen, in that:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure an opened bag of shredded cheese was stored in a sealed container in the reach-in cooler. 2. The facility failed to ensure a storage bag of cooked pork was sealed and labeled with a use-by date in the reach in cooler. 3. The facility failed to store a mop in the equipment storage closet in a position that allowed air drying. <p>These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observation on 09/24/2024 at 9:26 AM revealed there was a 5-lb. bag of shredded cheddar cheese in the reach-in cooler. The cheese was in its original package and placed in a clear, gallon-sized storage bag with a zipper-seal. The package of cheese had been opened and the zipper-sealed bag was also open. <p>During an interview on 09/24/2024 at 9:27 AM the DS stated the zipper-sealed bag should have been closed. The DS further stated any staff member who stored food in the cooler was responsible for ensuring all foods were properly labeled, dated, and stored in sealed containers or bags to prevent cross contamination and spoilage.</p> <ol style="list-style-type: none"> 2. Observation on 09/24/2024 at 9:29 AM revealed leftover cooked pork in a gallon-sized storage bag with a zipper-seal. The bag was unsealed, and there was no prepared or use-by date on the bag. <p>During an interview on 09/24/2024 at 9:30 AM the DS stated the storage bag of pork should have been sealed and labeled with a use-by date, and it was facility policy to use leftover food within seven days. The DS further stated all dietary staff knew they were supposed to store all leftover food sealed bags or containers and label and date the bags and containers with a use-by date to prevent cross contamination and spoilage. Staff was trained upon hire and all dietary staff had valid and current food handler certificates.</p> <ol style="list-style-type: none"> 3. Observation on 09/26/2024 at 11:50 AM in the equipment storage closet revealed a mop stored with the mop head on the ground in a manner that did not allow for air drying. Further observation revealed the mop head was not completely dry to the touch. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/26/2024 at 11:50 AM, the DS stated the mop head was damp, the mop should have been stored on a hook in the closet, and dietary staff knew how it was supposed to be stored.</p> <p>When asked on 09/24/2024 at 9:45 AM for the facility's dietary policies, the DS stated the facility used the Texas Food Establishment Rules (TFER) as their policy manual.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 3-305.11, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination.</p> <p>Record review of the of the Texas Food Establishment Rules (TFER), October 2015, S228.69(a)(1)(A) & (B) revealed it was the same verbiage as the U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, 3-305.11(A)(1) and (2), Food Storage.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (A) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.</p> <p>Record review of the Texas Food Establishment Rules (TFER), October 2015, S228.75 (g) (1) revealed it was the same verbiage as the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, 3-501.17(A), Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 6-501.16 Drying Mops. After use, mops shall be placed in a position that allows them to air-dry without soiling walls, equipment or supplies.</p> <p>Record review of the Texas Food Establishment Rules (TFER), October 2015, S228.186(f) revealed it was the same verbiage the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, 501.16, Drying Mops.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857</p> <p>Based on interview, and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 4 residents (Resident #320) reviewed for hospice services, in that:</p> <p>The facility failed to ensure Resident #138's most recent plan of care (POC), DNR, and hospice physician orders were available and at the facility.</p> <p>This deficient practice could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs.</p> <p>The findings were:</p> <p>Record review of Resident #320's face sheet, dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia (a group of symptoms that affects memory, thinking, and interferes with daily life), Parkinson's disease (a movement disorder that affects the nervous system and worsens over time) without dyskinesia without mention of fluctuations, and adult failure to thrive.</p> <p>Record review of Resident #320's initial admission record, dated [DATE] revealed the resident was sometimes understood and sometimes understands others and did not mention hospice.</p> <p>Record review of Resident #2's comprehensive care plan, initiated on [DATE] revealed the resident was a DNR and did not mention hospice.</p> <p>Record review of Resident #320's Order Summary Report, dated [DATE] revealed an order for DNR, with a start date of [DATE], and no end date.</p> <p>Record review of Resident #320's hospice binder on [DATE] at 11:27 a.m. Resident #320's hospice binder and EMR did not have the hospice plan of care or hospice physician orders.</p> <p>During an interview on [DATE] at 2:20 p.m. the SW stated he was unsure if there were any pending DNRs and had just started at the facility. The SW was unsure if resident #320 had a DNR or where the DNR was.</p> <p>During an interview on [DATE] at 2:59 p.m. the DON stated they had checked all the hospice residents documents the day prior and thought they were all in the binder. The DON stated they did find the DNR in the ADONs office, but it took them a while to find the DNR, and if the resident had coded, he would have received CPR in the event of an emergency, if they had taken that long to locate the DNR. The DON stated the DNR should have been in the binder along with the POC.</p> <p>(continued on next page)</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy titled Nursing Clinical, Quality of Care, Administration, End of Life Care, Hospice, dated ,d+[DATE], stated POLICY: It is the policy of this facility to provide end of life care for dying residents . Through continuing interdisciplinary assessment, individualized plans will be developed and implemented . 2. A care plan will be developed based on the individualized assessments, the desires of the resident/surrogate decision-maker, and the physician's orders . 4. Hospice services will be offered as appropriate and as ordered by the physician. These services will be integrated into the overall individualized, interdisciplinary care plan. Collaboration with Hospice will include processes for orienting staff to facility policies and procedures which may include: residents rights, documentation and record keeping requirements .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075</p> <p>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 disease and infection for 2 of 3 residents (Residents #77 and #312) reviewed for infection control, in that:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure CNA B used appropriate hand hygiene when removing her gloves after assisting Resident #77 with indwelling urinary catheter care. 2. The facility failed to ensure staff did not let Resident #312's catheter tubing touch the floor and used enhanced barrier precautions (EBP) when caring for the catheter and the resident. <p>These deficient practices could place residents at-risk for infection due to improper care practices.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Record review of Resident #77's face sheet, dated 9/27/24 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included need for assistance with personal care, benign prostatic hyperplasia with lower urinary tract symptoms (a benign condition in which the prostate gland is larger than normal causing slow or block the flow of urine from the bladder), and cystitis (inflammation of the bladder or a lower urinary tract infection). <p>Record review of Resident #77's most recent significant change MDS assessment, dated 7/29/24 revealed the resident was severely cognitively impaired for daily decision-making skills and utilized an indwelling urinary catheter.</p> <p>Record Review of Resident #77's comprehensive care plan with revision date 3/13/24 revealed the resident had an indwelling urinary catheter related to obstructive uropathy (condition where urine flow is blocked or slowed, often related to an obstruction in any part of the urinary tract) with interventions that included to provide catheter care every shift and as needed, and a goal for the resident to remain free from catheter related trauma.</p> <p>Observation on 9/26/24 at 5:09 p.m., during indwelling urinary catheter care, CNA B helped CNA A pull back Resident #77's blanket, unfastened his disposable brief, and then repositioned Resident #77 from his back to his left side. After CNA A completed care, both CNA A and CNA B repositioned the resident onto his back. CNA B realized she had forgotten to get a clean pad to place underneath the resident's buttock area, removed her gloves, did not use appropriate hand hygiene, and opened the resident's bedroom door to retrieve a clean pad. CNA B returned to the bedside, continued to assist CNA A, took a clean brief and as she positioned the brief under the resident's buttocks, tore the disposable brief. CNA B then removed her gloves, did not use appropriate hand hygiene, and opened the resident's bedroom door to retrieve a clean disposable brief. CNA B then returned to the bedside with a clean brief and continued to assist CNA A with catheter care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676113	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation Center -		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 W Hutchins Place San Antonio, TX 78224	

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

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/26/24 at 5:57 p.m., CNA B stated she realized she had not washed or sanitized her hands after taking off her gloves after leaving the bedside which could result in cross contamination. CNA B stated cross contamination from not using appropriate hand hygiene could result in the resident developing an infection.</p> <p>During an interview on 9/26/24 at 6:18 p.m., the DON stated it was her expectation for the staff, when removing gloves, should be sanitizing, or washing their hands because it was proper infection control practice and failure to do so could result in a risk of infection.</p> <p>2. Record review of Resident #312's face sheet, dated 9/27/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included encounter for orthopedic aftercare following surgical amputation and benign prostatic hyperplasia (a condition in which the prostate gland grows larger than normal, but the growth is not caused by cancer) without lower urinary tract infection.</p> <p>Record review of Resident #312's admission MDS revealed it was not complete because he was a new admit.</p> <p>Record Review of Resident #312's comprehensive care plan with revision date 9/26/24 revealed the resident had an indwelling urinary catheter with interventions to provide catheter care every shift and as needed.</p> <p>Record Review of Resident #312's physician's orders, dated 9/27/24, revealed:</p> <ul style="list-style-type: none"> - catheter type Fr#16 ml 10 to closed urinary drainage system, diagnosis use for BPH, with an order date of 9/23/24 and no end date. - catheter care every shift. Monitor for urethral site for signs and symptoms of skin break down, pain/discomfort, unusual odors, urine characteristics or secretions, catheter pulling causing tension every shift, with a start date of 9/22/24, and no end date. <p>During an observation on 9/24/24 at 10:07 a.m. revealed Resident #312 was noted to have his name outside the door with a pink label.</p> <p>During an observation and interview on 9/24/24 at 10:59 a.m. revealed Resident #312 was lying in bed. The resident was lying in the same position during the attempted interview and only moved his arms. The resident's bed was low to the floor and a catheter bag was in a dignity bag wedged under the bed and off the floor. About 1 foot of the catheter bag tubing was touching the floor. The resident stated he was thirsty and wanted to move up in the bed.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/24/24 at 11:00 a.m. Resident #312 kept pressing his call light over and over after staff entered the room. The resident then stated he wanted to sit up or move. LVN F entered the room and stated the catheter was normally not touching the floor. LVN F stated the resident would fidget and that caused the tube to touch the floor. LVN G then adjusted the catheter so the tube was not touching the floor. LVN F and LVN G then put on gloves only and adjusted the resident in bed to sit him up more. LVN F and LVN G were positioned on either side of the bed and their clothing was touching the residents bed and sheets as they repositioned the resident in the bed. Upon exiting the room LVN F stated the pink names on the resident's door meant he was on enhanced barrier precautions. When asked if they should have had on PPE for EBP, LVN F stated she was just notified he was on enhanced barrier precautions. LVN F then turned to other staff in the hallway and told them to make sure they were wearing gowns when providing care to Resident #312.</p> <p>During an interview on 9/27/24 at 12:09 p.m. the DON stated the catheter should not be touching the floor including the tubing because it was a risk for infection control. The DON stated the resident was sent to the hospital the day prior and returned with a diagnosis of a UTI. The DON stated the resident was having a PICC line inserted to receive IV antibiotics. The DON stated they did not have any paperwork available for the hospital visit. The DON stated staff was expected to wear a gown and gloves for residents on enhanced barrier precautions. The DON stated she did not think moving a resident in bed required the gown. The DON stated for example therapy staff did not wear the gowns if they were walking residents in the hallways. The DON stated staff did wear them for residents on EBP when they did transfers. The DON stated if staff's clothing made contact with the residents bedding and the resident during care then they should wear a gown.</p> <p>Record review of the facility's policy titled IPCP Standard and Transmission-Based Precautions, dated 3/2024, stated .3. Enhanced Barrier Protection (EBP): used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs) .c. c. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include:</p> <ul style="list-style-type: none"> i. Dressing ii. Bathing/showering iii. Transferring iv. Providing hygiene v. Changing linens vi. Changing briefs or assisting with toileting vii. Device care or use: central vascular line (including hemodialysis catheters), indwelling urinary catheter, feeding tube, tracheostomy/ventilator . <p>45857</p>		