STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676137	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Center -	8902 West Rd Houston, TX 77064

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49099 Based on interviews and record review the facility failed to develop and implement a comprehensive person-centered care plan consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 11 residents (Resident #1) reviewed for care plans. The facility failed to ensure that Resident #1's required use of hearing aids as an assistive device for her hearing impairment were documented in her care plan/Kardex. The facility's failure placed residents requiring care at risk of not having their individual needs met, not receiving necessary care and services, and not having continuity of care. Findings included: Review of Resident #1's face sheet dated 02/25/25 reflected a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis that included unspecified macular degeneration (vision impairment resulting in deterioration of the central part of the retina, a thin layer at the back of the eye on the inner side), cognitive communication deficit (communication difficulty caused by cognitive impairment), muscle weakness, and bradycardia (slower than typical heartbeat). Review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 08 indicating moderate cognitive impairment. Hearing, Speech, and Vision reflected, hearing aid or other hearing appliance used was marked yes. Ability to understand others understanding verbal content however able (with hearing aid or device if used) was marked, usually understands- misses some part/intent of message but comprehends most conversation. Review of Resident #1's care plan last revised 02/12/25 reflected a focus for Resident #1 is at risk for communication deficit related to confusion with interventions that included anticipate and meet needs, monitor/document/report to MD any changes in ability to communicate, potential contributing factors to communication problems, potential for improvement, and monitor/record confounding problems: decline in cognitive status .hearing impairment (ear discharge and cerumen (wax) accumulation. The care plan did not contain a focus on Resident #1's hearing deficit and use of hearing aids with interventions. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Kardex dated 02/28/25 reflected no assistive devices indicated, no audio/vision focus. Review of Resident #1's nursing progress notes reflected a nursing note dated 07/06/24 Resident family called from home and reported that Resident #1 lost her left side hearing aid and if we cannot find it, she will come on Monday and report to the ADM and make our facility pay for it, left messages with DON related to this. Review of Resident #1's nursing progress noted reflected social services note dated 09/19/24 SW handed off replacement hearing aids to Resident #1's family, who will take them to have them adjusted for Resident #1. SW opened box and showed Resident #1's family the hearing aids, charger, and cord. Resident #1's family confirmed that all was accounted for and took all equipment. Review of facility grievances reflected a grievance dated 08/01/24 for Resident #1 resident's family reported a concern regarding missing hearing aid with documented resolution facility to cover cost of hearing aid replacement. In an interview on 02/25/25 at 02:14 PM with Resident #1's family, she stated that she believed the facility was not assisting Resident #1 with her hearing aids. She stated that there were times the resident would not have them on, and at one point they were lost. She stated at the time the facility took responsibility for it and assisted with getting them replaced, however the resident went without a full set for months. In an interview on 02/27/25 at 11:01 AM with CNA A, she stated that CNAs would assist residents with hearing aids. She stated she would rely on the care plan or Kardex to determine if the resident required a hearing aid, especially if it was a resident she did not normally work with. CNA A stated that care staff were responsible for putting on a resident's hearing aids in the morning and taking them off at night to charge them so they were ready for the next day. CNA A stated that if hearing aids, were not care planned staff who didn't work with the resident regularly would not know to look for them. She stated it could also result in the resident not being able to hear, would be confused, and would just look at you and not know what you are saying. In an interview on 02/27/25 at 11:22 AM with CNA B, she stated she would look on the Kardex to determine if a resident required an assistive device such as a hearing aid. She stated the CNAs kept up with hearing aids regularly if they knew the resident required them. She stated if a resident was not provided her hearing aids you cannot communicate with them, they will be confused and can take things the wrong way. CNA B stated that if you didn't pay attention to assistive devices required it could cause emotional harm or be neglectful. In an interview on 02/28/25 at 09:38 AM with the SW, she stated that a staff member lost Resident #1's hearing aid which was why the facility reimbursed Resident #1 by getting her a new set. The SW stated that she did not recall the name of the staff member because it was too long ago. The SW stated that if resident's needs with assistive devices were not being met it would have a negative impact on them as they would not be able to hear. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/28/25 at 10:11 AM with CMA C, she stated if there was anything she needed to know, about a resident's assistive devices or if they required, any she would check the Kardex/care plan. CMA C stated she recalled a while back that Resident #1 lost her hearing aids and said that any issues with hearing aids were to be reported to the nurse. She stated if there were no assistive devices documented in the resident's care plan or Kardex, it could result in the resident not getting assistance with her devices or the devices being lost by not being monitored. In an interview and observation on 02/28/25 at 10:53 AM with the DON, she stated that it was her expectation that assistive devices such as hearing aids were documented in the resident's care plan which would then trigger onto the Kardex. She stated the care plan should give care staff the direction of care a resident required. The DON stated that if staff do not observe assistive devices documented or any other issues, it should be reported to a charge nurse. She stated she did not believe there would be any negative outcomes because any issues should be reported, and she believed the charge nurse could take care of any problems through communication. The DON was observed at this time reviewing Resident #1's care plan and verbally confirmed the hearing aids were not documented and should be. In an interview on 02/28/25 at 11:37 AM with the ADM, he stated he thinks that assistive devices are supposed to be care planned as part of the resident assessment. The ADM stated it was his expectation that care plans were accurate and timely and help the resident. The ADM stated if the care plan did not indicate a residents required assistive devices it increased the likelihood that care could be missed and that it was just one more chance to miss getting a resident their hearing aids. Review of the facility Care of Hearing Aid policy last revised 10/2010 reflected: The purpose of caring for a hearing aid is to maintain the residents hearing at the highest attainable level. Review the resident's care plan to assess for any special needs of the resident. Review of the facility Comprehensive Person-Centered Care Planning policy last revised 12/2023 reflected: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care. - The facility IDT will develop and implement a comprehensive person-centered, culturally competent, and trauma-informed care plan for each resident within seven (7) days of completion of the Resident Minimum Data Set (MDS) and will include resident's needs identified in the comprehensive assessment, any specialized services as a result of PASARR recommendation, and resident's goals and desired outcomes, preferences for future discharge and discharge plan. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49099 Based on interviews, and records review, the facility failed to ensure that medical records were accurately documented for two (Resident #2 and Resident #3) of ten residents reviewed for accurate clinical records. The facility failed to ensure the hospital Nurse Report was not destroyed and included in Resident #2's permanent medical record. The facility failed to keep an accurate record of the time Resident #3 was weighed. This deficient practice could place residents at risk for errors in care and treatment. The findings included: Review of Resident #2's face sheet dated [DATE] reflected a [AGE] year-old female who was originally admitted to the facility on [DATE] with diagnoses that included repeated falls, cirrhosis of liver (a chronic liver disease characterized by the formation of scar tissue that replaces health liver cells), and type 2 diabetes mellitus (a chronic condition characterized by high blood sugar levels due to the body's inability to use insulin effectively or produce enough insulin). Review of Resident #2's hospital record reflected she was admitted to the hospital from the facility on [DATE] and died at the hospital on [DATE]. Review of Resident #2's care plan record reflected on [DATE] she was care planned for impaired cognition, ADL self-care performance deficit, risk of falls, nutritional problems or potential for nutritional problems, pressure ulcers or potential for pressure ulcers, and analgesic (medication to relieve pain). Review of Resident #2's initial MDS dated [DATE] and signed completed [DATE] reflected no BIMS score. Review of Resident #3's face sheet dated [DATE] reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted [DATE] with diagnoses that included pneumonia, dementia, type 2 diabetes mellitus (a chronic condition characterized by high blood sugar levels due to the body's inability to use insulin effectively or produce enough insulin), and severe protein-calorie malnutrition. (continued on next page)

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	676137	A. Building B. Wing	02/28/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's care plan reflected a focus for nutritional deficit related to a diagnosis of dementia dated [DATE] with a goal to maintain adequate nutritional status as evidenced by maintaining weight with no signs or symptoms of malnutrition dated [DATE] and interventions dated [DATE] of administering medications as ordered, monitoring/documenting/reported to the medical doctor as needed for signs and symptoms of dysphagia (difficulty swallowing), monitoring/documenting/reported to the medical doctor as needed for signs and symptoms of malnutrition, emaciation, muscle wasting, significant weight loss, obtain and monitor lab/diagnostic work as ordered and report results to the medical doctor and follow up as indicated, and occupational therapy to screen and provide adaptive equipment for feeding as needed. Review of Resident #3's initial MDS dated [DATE] and signed completed [DATE] reflected no BIMS score. Review of facility Nurse Report reflected the following fields of information: Date Time ETA Patient name Age Room # Nurse Taking Report Nurse Calling Report Phone # Transferring Hospital MD Code Status Diagnosis Hospital admitted HX Allergies Oxygen Status (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dialysis (Y/N) Last BM BP HR Temp RR SP02 Neuro Status Mobility/Assistance Diet Isolation G Tube Feeding Wounds (Y/N) Treatment Orders Special Equipment (Y/N) Family Notified of Transfer (Y/N) Review of Resident #3's paper documentation of resident's weight dated [DATE] reflected a handwritten number next to Resident #3's name of 120 pounds, no record of the time the weight was taken. Review of Resident #3's paper documentation dated [DATE] reflected a handwritten number next to Resident #3's name of 121 pounds, no record of the time the weight was taken. Review of Resident #3's paper documentation of resident's weight dated [DATE] reflected a handwritten number next to Resident #3's name of 120 pounds, no record of the time the weight was taken. Review of Resident #3's paper documentation of resident's weight dated [DATE] reflected a handwritten number next to Resident #3's name of 120.6 pounds, no record of the time the weight was taken. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] with the DON at 1:32 pm revealed when a resident was admitted from a hospital to the facility, the facility nurse took a verbal report from the hospital nurse over the phone and the facility Nurse Report document was completed from the information received verbally from the hospital nurse. The DON said the Nurse Report had substantial information, but the Nurse Reports were shredded and never uploaded into the system because they were internally created documents. She said the Nurse Report did have substantial information about the new resident's condition but after the resident arrived at the facility, the facility nurse did an assessment, and that assessment was uploaded in the resident's EMR. She stated the Nurse Report was not relevant and was the resident's baseline and they used it as a guide until they got to know the patient. The DON revealed she looked for Resident #2's Nurse Report and learned from the MRP that it was shredded. Interview on [DATE] with the MRP at 2:32 pm revealed she was familiar with the Nurses Report and had always shredded the Nurses Report because she was not told to upload it in the resident EMR. She said she did not know if it was considered a medical record. She said it was considered a report because it was created by the facility, and she had not been asked to upload it. She said she saw the Nurse Report all the time, had always shredded them, and no one ever discussed that she shredded the Nurse Reports. She said the requirement to retain medical records was [AGE] years . Interview on [DATE] with LVN D at 4:21 pm revealed she was the facility nurse who spoke to hospital nurse over the phone and completed the Nurse Report for Resident #2. She revealed that the Nurses Report form was important because it was a way of knowing what was going on with the resident . She said that if the hospital nurse told her that the resident had a diagnosis of falls, she would have written falls on the Nurses Report under diagnoses. She said when she was finished with the Nurse Report for Resident #2, she put it in a basket for the medical records facility staff to scan and upload for Resident #2's EMR . Interview on [DATE] with LVN E at 8:58 am revealed when a resident was admitted to the facility from the hospital, the facility admitting nurse would get a verbal report over the phone from the hospital nurse working through the list of questions on the Nurses Report. Then record on the Nurses Report the information received from the hospital nurse. LVN E said the Nurse Report was important and it gave them a history of the resident, but the facility did do their own assessment when the residents arrived at the facility. She said she would not consider the Nurses Report a patient record, but something they use to get a background concerning the resident's condition. She said they did refer to it when completing the information for the resident facility initial assessment and base some of the information used on the facility initial assessment from the Nurses Report. She said the Nurses Report was a reference point for the resident and it would be good to be able to refer back to it if needed, maybe to get more clarity on the resident's condition. She said she thought the Nurses Report should be retained in the residents' records and not be shredded. She said a negative effect of not having the Nurses Report would be that the nurse who was doing future assessment did not have it to refer back to as a point of reference for the resident's previous condition. Interview on [DATE] with RN F at 9:26 am revealed the Nurses Report contained vital information and felt it was important because it was the information they use to rely on at the moment. He said the facility was supposed to keep it because it was part of the information they received about the resident condition and felt it was an important piece of paper to keep. He said it could have been used to have clarified Resident #2's change of condition and assist the facility to know if there was a change of condition from the hospital to the facility. He revealed it should be considered part of the residents' medical information and not be shredded. (continued on next page)

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	676137	A. Building B. Wing	02/28/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] with the ADM at 1:12 pm reflected, after the state surveyor read to him the facility policy of Definition of a Record that the Nurses Report met the definition of a record that needed to be included in the resident record and they are going to start uploading the Nurses Report into PCC. He said the information included on the Nurse Report is really good information and he did not know that the Nurse Report, information about residents who admitted from the hospital, were being shredded and felt that the Nurses Report was a part of the resident medical record. Interview on [DATE] at 11:01 am with the RNA revealed she was responsible for weighing the facility residents and reported the weight of the residents and if they were weights by standing, wheelchair, or mechanical lift to the DON. She said her routine was to, in the morning, weigh residents on station 1, then station 2, and then, after lunch, she weighed residents on station 3 and then station 4. She did not write down on paper or record in PCC the time that the residents, were weighed. She said, she just weighs them . Interview on [DATE] with the DON at 12:39 pm revealed the specific time the residents were weighed was not recorded in PCC or on the paper documentation they used to record and document resident weights. No times were written on the paper documentation, only Resident #3's weighed amount was recorded, and the time the weight was performed was not recorded. The DON stated the facility policy did not reflect resident weights needed to be recorded in PCC, but the facility policy did reflect that the time the resident was weighed was to be documented. Interview on [DATE] with the ADM at 1:12 pm reflected that if the facility policy reflected that the time a resident was weighed should be recorded in the resident's medical record, then the facility should follow this policy and record the time the weight was taken. He revealed that if weights were not monitored accurately, it could possibly affect the clinical outcome of a resident because of a lack of accurate information. Name/Date/Time of Family Notified Review of the facility policy Nutrition Status Management dated ,d+[DATE] Revision/Review Date(s): , d+[DATE] and ,d+[DATE] reflected it is the policy of this facility to assess each resident's nutritional status and needs, including medications and medical condition 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. Review of the facility policy Weighing and Measuring the Resident date [DATE] reflected the following information should be recorded in the resident's medical record: The date and time the procedure was performed. Review of facility policy Section: Documentation and Subject: Charting and Documentation dated [DATE] reflected: Definition of a Record (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's clinical record is a concise account of treatment, care, response to care, signs, symptoms, and progress of the resident's condition. If is also necessary to include date needed for identification and communication with family and friend. Complete history of resident and present illness is required under current law and regulations at the time of admission. Disciplines Contributing to the Record include: medicine and nursing. Importance and use of the record: 1. To the resident [sic] it saves time if needed at a future date. 2. To the institution if reflects the quality of care given to the resident. 3. To the physician, it guides him in his treatment, use and effects of drugs and plan for care. 4. In legal defense, it serves as valid information. 5. To the nurse, it provides a multidisciplinary record of the physical and mental status of the resident. Rules for Charting: Notes are to be written on long term residents as determined by the individual nursing service. Daily notes are required as the necessary arises. New admissions should have nurse's notes on for the first 72 hours. The Admitting Nurse must write a complete physical and mental nursing assessment.