

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/13/2024
NAME OF PROVIDER OR SUPPLIER  Legend Oaks Healthcare and Rehabilitation - North		STREET ADDRESS, CITY, STATE, ZIP CODE  11020 Dessau Rd Austin, TX 78754	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodation of their needs and preferences for 3 of 11 residents (Residents #2, 3, and 4) reviewed for resident rights.</p> <p>The facility failed to ensure call buttons were in reach for Residents #2, 3, and 4 on 09/10/24.</p> <p>This failure placed residents at risk of not having their needs met.</p> <p>Findings included:</p> <p>1. Review of the undated face sheet for Resident #2 reflected, a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included hemiplegia and hemiparesis (paralysis on one side of the body), chronic respiratory failure, atrial fibrillation (irregular heartbeat), need for assistance with personal care, muscle weakness, muscle wasting and atrophy, lack of coordination, and cognitive communication deficit.</p> <p>Review of the admission MDS assessment for Resident #2 dated 08/05/24 reflected a BIMS score of 06, indicating severe cognitive impairment. It reflected she required staff assistance for ADLs.</p> <p>Review of the care plan for Resident #2 dated 07/30/24 reflected the following: [Resident #2] has ADL Self Care Performance Deficit r/t HEMIPLEGIA AND HEMIPARETIC FOLLOWING CEREBRAL INFARCTION AFFECTING RIGHT DOMINANT SIDE. Will safely perform Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene) with extensive assistance through the review date. It also reflected the following: [Resident #2] is at risk for falls r/t Weakness. Will not sustain serious injury through the review date. Be sure the call light is within reach and encourage to use it to call for assistance as needed.</p> <p>2. Review of the undated face sheet for Resident #3 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included schizoaffective disorder, pain in right wrist, muscle wasting and atrophy, muscle weakness, need for assistance with personal care, cognitive communication deficit, and low back pain.</p> <p>Review of the quarterly MDS assessment for Resident #3 dated 06/16/24 reflected a BIMS score of 15, indicating intact cognition. It reflected she required staff assistance for ADLs.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the care plan for Resident #3 dated 10/03/22 reflected the following: [Resident #3] has ADL Self Care Performance Deficit r/t Impaired Mobility. Will safely perform ADL's with staff assistance through the review date. Encourage to participate to the fullest extent possible with each interaction. It also reflected the following: .At risk for falls r/t gait, Balance. Will not sustain serious injury through the review date. Be sure the call light is within reach and encourage to use it to call for assistance as needed.</p> <p>3. Review of the undated face sheet for Resident #4 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included flaccid hemiplegia affecting right dominant side, vascular dementia, muscle wasting and atrophy, muscle weakness, lack of coordination, need for assistance for personal care, cognitive communication deficit, and depression.</p> <p>Review of the quarterly MDS assessment for Resident #4 dated 07/19/24 reflected a BIMS score of 09, indicating moderate cognitive impairment. It reflected he required staff assistance for ADLs.</p> <p>Review of the care plan for Resident #4 dated 05/10/23 reflected the following: [Resident #4] has ADL Self Care Performance Deficit r/t Generalized Muscle Weakness, Hemiplegia. Will safely perform ADL's with staff assistance through the review date. Encourage to participate to the fullest extent possible with each interaction. It reflected the following: at risk for falls r/t R Sided Paralysis. Will be free of falls through the review date. Be sure the call light is within reach and encourage to use it to call for assistance as needed.</p> <p>Observation and interview on 09/10/24 at 12:00 PM revealed Resident #2 seated in her wheelchair in her room with her call button on the floor next to her wheelchair. She stated she was not feeling well and would have used the call button to reach out to staff, but did not know where the call button was. She stated she could not have bent down to reach the call button on the floor next to her.</p> <p>During an interview on 09/10/24 at 12:02 PM, the TXN stated the call button should have been in place for Resident #2 and she noticed it was not. She stated she was doing rounds to make sure the residents had what they needed, but she did not usually do rounds on that hall.</p> <p>Observation and interview on 09/10/24 at 12:10 pm revealed Resident #3 seated in her wheelchair in her room. The cord for her call button came out of the wall and was wrapped around her mattress with the fitted bed sheet made up over the rest of the cord and the call button itself, which was under the mattress. She stated she used her call button, but not very frequently. She stated she did not know where the button was. She stated she would come out of her room and go to the nurse's station if she needed something and could not find her call button. When asked what she would do if she were in pain or could not self-ambulate in her wheelchair, she stated she did not know.</p> <p>During an interview on 09/10/24 at 12:14 PM, the TXN stated she found the call button for Resident #3 under the fitted sheet and under the mattress and could not imagine how it had gotten there. She stated CNAs were who made the beds.</p> <p>(continued on next page)</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 09/10/24 at 12:18 PM revealed Resident #4 seated in his wheelchair on one side of his bed, which was parallel to the privacy curtain between his side of the room and his roommate's. His call button cord was on the other side of his bed from him next to the privacy curtain and was on the floor out of view. He stated his call button was usually next to his bed and looked for it on the side of the bed closest to him. He pointed across his bed and stated it was over there and he could not have reached it if he needed it.</p> <p>During an interview on 09/10/24 at 01:30 PM, CNA C stated she made beds on the hall for Residents #2, 3, and 4. She stated she did not know how the call buttons got out of reach and she always made sure the call buttons were in place when she left the residents.</p> <p>During an interview on 09/10/24 at 03:49 PM, the DON stated the call buttons should have always been in reach. She stated the entire nursing department was responsible for ensuring call buttons were accessible to the residents. She stated they conducted in-servicing on call buttons in reach and answering call lights. She stated a potential impact of a call button not being in reach was the resident might not have their needs met.</p> <p>Review of the facility's policy dated 02/24/22 and titled Federal Resident Rights reflected the following: Respect and dignity. You have the right to be treated with respect and dignity, including the right to: reside and receive services in the facility with reasonable accommodation of your needs and preferences, except when to do so in danger or other resident's health or safety.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38073</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident environment was as free from accident hazards as possible for 1 of 11 residents (Resident #1) reviewed for accidents.</p> <p>The facility failed to ensure Resident #1 was transferred safely when CNA A transferred her by mechanical lift by herself on 09/07/24 and 09/08/24.</p> <p>This failure placed residents at risk of injury.</p> <p>Findings included:</p> <p>Review of the undated face sheet for Resident #1 reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included dementia, cognitive communication deficit, and need for assistance with personal care.</p> <p>Review of the quarterly MDS assessment for Resident #1 dated 07/26/24 reflected a BIMS score of 03, indicating severe cognitive impairment. It reflected she was totally dependent on staff for every kind of transfer.</p> <p>Review of the care plan for Resident #1 dated 04/10/24 reflected the following: [Resident #1] has ADL Self Care Performance Deficit r/t. Will maintain current level of functioning in Bed Mobility, Transfers, Eating, Toileting. TRANSFER(CHAIR/BED TO CHAIR TRANSFER, TOILET TRANSFER)): Requires dependence x2 with hooyer lift.</p> <p>Observation of a closed-circuit video dated 09/07/24 at 07:21 AM revealed CNA B began a transfer with Resident #1 using ull body patient lift to move Resident #1 from her bed to her wheelchair. The entire transfer was performed alone by CNA B with no presence of any other staff person in the room. No impacts or falls were observed during the transfer, and Resident #1 did not give any verbal or nonverbal indications of distress.</p> <p>Observation of a closed-circuit video dated 09/08/24 at 07:00 AM revealed CNA B began a transfer with Resident #1 using a bariatric full body patient lift to move Resident #1 from her bed to her wheelchair. The entire transfer was performed alone by CNA B with no presence of any other staff person in the room. No impacts or falls were observed during the transfer, and Resident #1 did not give any verbal or nonverbal indications of distress.</p> <p>Observation on 09/10/24 at 01:40 PM revealed CNA B and CNA C transferred Resident #1 from her wheelchair to her bed using the bariatric full body mechanical lift with no impacts falls or indications that Resident #1 was in distress.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/10/24 at 01:45 PM, CNA B stated she always conducted mechanical lift transfers with two staff members and had never conducted a mechanical lift transfer by herself. She denied conducting a mechanical lift transfer by herself on 09/07/24 or 09/08/24 and stated it was important to always have two people conduct a mechanical lift transfer so that residents did not get hurt.</p> <p>During an interview on 09/10/24 at 02:40 PM, the SC stated she held an in-service a few months ago for the CNAs to ensure they all knew how to perform mechanical lift transfers. She stated the FM of Resident #1 felt they needed training on their transfers, so she was asked to conduct the training. The SC stated CNA B was present for the training. The SC stated the particular method that she trained staff to employ was one staff person behind the resident operating the mechanical lift and one in front guiding her legs and feet. The SC stated all mechanical lifts in the building required two staff members to implement, and the specialized transfer for Resident #1 also required two staff members.</p> <p>During an interview on 09/10/24 at 02:58 PM, the ADON stated mechanical lift transfers always required two people to operate the machine for the safety of residents. He stated if the machine was not operated by two staff members, the resident could fall out. He stated it was also important to have two sets of eyes on the situation to ensure there are no hazards. The ADON stated everyone was responsible for the safety of residents, and no one person was solely responsible for ensuring transfers were done properly. He stated he ensured transfers were conducted properly by doing rounds and keeping an eye on residents.</p> <p>During an interview on 09/10/24 at 03:49 PM, the DON stated all mechanical lift transfers required the participation of two staff members in the facility for the safety of residents. She stated they had trained every staff person who had any involvement in mechanical lift transfers and had recently run a return demonstration skills test for all CNAs to ensure they knew how to implement a safe transfer. She stated she and the ADON and the entire team were responsible for ensuring transfers were done safely. She stated a potential negative outcome to residents of not transferring properly with a mechanical lift was falls and injury.</p> <p>Review of a performance review dated 07/10/24 and signed by CNA B and the SC reflected CNA B received her approval for all aspects of her performance of a mechanical lift transfer, including the following: Gather assistance of at least one staff member prior to beginning, transfer and communicating expectations of transfer, prearranged signals, and plan to complete transferred together.</p> <p>Review of the facility's policy dated June 2018 titled Fall Management System reflected the following: The facility is committed to providing resident autonomy by providing an environment that remains as free of accident hazards as possible. Each resident is assisted in attaining or maintaining their highest practical level of function through providing the resident adequate supervision, assistive devices and functional programs as appropriate to prevent accidents.</p>