STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676238	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - North	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)
F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on interviews and record reviews, the facility failed to ensure each resident had the right to access personal and medical records pertaining to himself or herself within 24 hours and allow the resident to obtain a copy of the records or any portions thereof upon request for 1 (Resident #1) of 6 residents reviewed for resident rights. The facility failed to provide a copy of Resident #1's medical records to Resident #1's RP after requesting the records on 02/21/25. This failure could place residents at risk of not having access to records when requested. Findings include: Review of Resident #1's Face Sheet, dated 04/28/25, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] and discharged from the facility on 01/13/25. Resident #1 was her own financial RP and care conference person and had someone designated as a financial RP and care conference person. Review of Resident #1's Admission Record, dated 04/28/25, reflected she had diagnoses including unspecified dementia and cognitive communication deficit. Review of Resident #1's Quarterly MDS Assessment, dated 10/25/24, reflected she had a BIMS score of 1, which indicated she had severe cognitive impairment. Review of Resident #1's Care Plan, revised 10/28/24, reflected she was at risk for impaired cognitive function. Review of HIM's Email Thread, reviewed on 04/28/25, reflected the HIM emailed and asked Resident #1's RP to fill out and return the Authorization for Release of Information document on 02/25/25. Resident #1's RP emailed a completed Authorization for Release of Information document to the HIM, SW, ADM, and DON on 03/03/25. HIM emailed Resident #1's RP's completed Authorization for Release of Information document to the facility's legal team, ADM, and DON on 03/04/25. The facility's legal team emailed and informed the ADM and DON to release of Resident #1's medical records to Resident #1's RP on 03/05/25. (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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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/28/25 at 9:08 p.m., the HIM stated she was responsible for receiving and processing residents' or RP's medical records requests. The HIM stated it took her three days to process a resident's or RP's medical records request. The HIM stated she sent Resident #1's RP's medical records request to the facility's legal team because Resident #1's RP informed her that they had a lawyer. The HIM could not recall when Resident #1's RP sent her a medical records request. The HIM stated she could not recall if Resident #1's RP received a copy of Resident #1's medical records. An attempt to interview Resident #1's RP was made on 04/28/25 at 9:24 a.m. and 10:06 a.m. A voicemail and call back number were left. Resident #1's RP did not return the surveyor's calls before exit. During an interview on 04/28/25 9:58 a.m., the SW stated the HIM was responsible for receiving and processing residents' or RP's medical records requests. The SW stated Resident #1's RP emailed her and requested a copy of Resident #1's medical records in March 2025. The SW stated she forwarded Resident #1's RP's medical records request to the HIM. The SW stated she did not know if Resident #1's RP received a copy of Resident #1's medical records. During an interview on 04/28/25 at 10:08 a.m., the DON stated the HIM was responsible for receiving and processing residents' or RP's medical records requests. The DON stated the HIM received a medical records request from Resident #1's RP in February 2025. The DON stated Resident #1's RP's medical records request was sent to the facility's legal team. The DON stated she did not know if Resident #1's RP's medical records request was fulfilled or denied by the facility's legal team. During an interview on 04/28/25 at 10:12 a.m., the ADM stated the HIM was responsible for receiving and processing residents' or RP's medical records requests. The ADM stated the facility waited for the facility's legal team to advise before releasing a copy of the residents' medical records to the resident or RP. The ADM stated he expected the facility to provide residents or RPs with a copy of the resident's medical records within 30 days. The ADM stated Resident #1's RP requested a copy of Resident #1's medical records on 02/21/25. The ADM stated Resident #1's RP was cleared by the facility's legal team to receive a copy of Resident #1's medical records about one week ago from the time of the interview. The ADM stated he did not know why the HIM had not sent a copy of Resident #1's medical records to Resident #1's RP. During a group interview on 04/28/25 at 10:26 a.m., the DON stated the HIM told her that she did not receive a follow-up email from the facility's legal team regarding Resident #1's RP's medical records request being cleared for release after 03/04/25. The DON stated her and the ADM reviewed the email thread regarding Resident #1's RP's medical records request on 04/28/25 and found out the HIM was not included on the facility's legal team's email response regarding the approved release. The DON and ADM stated they did not follow-up with the HIM regarding Resident #1's RP's medical records request because they thought the HIM was included on the email with the facility's legal team and sent the medical records to Resident #1's RP. Review of the facility's Content of Medication Record policy, revised on 08/2007, reflected there was no medical record request procedures and processing time frames indicated. Review of the facility's Resident Rights policy, revised 12/2023, reflected there was no resident right to receive a copy of medical records listed.