

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation - Ennis		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 Medical Center Drive Ennis, TX 75119	

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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070</p> <p>Based on observation, interview and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for one of four residents (Resident #20) reviewed for resident rights.</p> <p>The facility failed to ensure CNA A did not stand over Resident #20 while assisting the resident with her meal in her room on 02/26/2025.</p> <p>This failure could place residents at risk of feeling rushed to eat or not interested in eating, which could result in weight loss and decreased psycho-social well-being of anguish or frustration.</p> <p>The findings included:</p> <p>Record review of Resident #20's MDS Assessment, dated 01/31/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #20 had a staff assessment BIMS score of 06, which indicated the resident was severely impaired. She had partial to moderate assist with eating and active diagnoses which included: Dementia (confusion), malnutrition (not nourished), anxiety disorder (nervous), and muscles weakness. She had a mechanically altered and therapeutic diet and no issues with swallowing food and drinks.</p> <p>Record review of Resident #20's Care Plan, dated 01/08/2025 and revised, revealed, The resident has potential nutritional problem r/t GERD (gastrointestinal reflux disease) , dementia, hypokalemia (high potassium): Goals - The resident will maintain adequate nutritional status as evidenced by maintaining weight with no S/Sx of malnutrition through review date: 01/08/2025 and intervention: Eating - The resident requires set up assist of (1) staff for eating.</p> <p>Observation on 02/26/2025 at 8:40 a.m. in Resident #20's room revealed CNA A was standing at the bedside next to Resident #20 who was lying in the bed . There was 90% of Resident #20's breakfast on her plate and CNA A had a spoon in her hand with food on it. CNA A lifted the food and was telling Resident #20 she needed to eat her food and to try and take just a few more bites. Resident #20 said she would try but was not really hungry.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 02/26/2025 at 12:30 p.m. in Resident #20's room revealed CNA A was standing at the bedside next to Resident #20 who was lying in the bed . There was 75% of Resident #20's lunch on her plate and CNA A stated to the State Surveyor she was going to try and get her to at least take a couple of more bites of her lunch.</p> <p>Interview on 02/26/2025 at 1:00 p.m., CNA A stated they were supposed to sit down to feed the residents. CNA A stated she knew she was supposed to have gotten a chair and she had just forgotten. CNA A said she was trained this was not correct and was against the resident rights to stand over her and assist her to eat. CNA A stated she was sorry. The CNA stated she had in-service training on resident rights and she knew this was a part of not dignifying their rights .</p> <p>In an interview on 02/26/2025 with CNA C revealed if a staff member was assisting a resident to eat, they were to sit next to them, whether they were sitting up or lying down . CNA C stated all staff were trained on resident rights in the past 6 months and that was a part of the residents right.</p> <p>Interview on 02/27/2025 at 8:30 a.m., the DON stated the staff should be feeding the residents sitting down at eye level with the residents. She stated sitting down while feeding the residents was good for the staff to see how the resident swallowed. She stated feeding the residents standing up was a dignity issue.</p> <p>Record review of the facility's policy and procedure titled Resident Rights, dated 11/28/2017, reflected Policy Statement Residents shall receive assistance with meals in a manner that meets the individual needs of each resident . 2. Facility staff will serve resident trays and will help residents who require assistance with eating. 3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. not standing over residents while assisting, them with meals</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070</p> <p>Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistive devices to prevent accidents for four of four residents (Residents #12, #19, #58, and #171) reviewed for accidents and hazards.</p> <p>The facility failed to properly maintain wheelchairs and anti-pressure cushions for Residents #12, #19, #58, and #171 .</p> <p>These failures could place residents at risk for equipment that is in unsafe operating condition, which could cause injury.</p> <p>Findings included:</p> <p>1. Record review of Resident #12's quarterly MDS assessment, dated 02/10/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #12 had diagnoses which included CVA (Stroke), hemiplegia (partial weakness on right side of the body) and difficulty walking.</p> <p>Record review of Resident #12's plan of care, dated 01/10/2025, reflected goals and approaches to include wheelchair mobility for locomotion.</p> <p>Observation and interview on 02/25/2025 at 10:00 a.m. revealed Resident #12 was lying in the bed, waiting to get up, and had no skin problems. The wheelchair's left armrest was an open metal piece with sharp edges, a piece of foam that was loose and was folded backwards with duct tape around the foam piece. The right-side arm rest was missing. Resident #12 stated the arm rest did not work. Resident #8 said that was his wheelchair he used it the way it was. Resident #8 did not seem to be bothered by the condition of the wheelchair . In the seat of the wheelchair was blue anti-pressure cushion which was cracked and the foam was exposed on the front and top of the cushion. Resident #12 stated it made the wheelchair easier to sit in .</p> <p>2. Record review of Resident #19's quarterly MDS assessment, dated 01/25/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #19 had diagnoses which included Cerebral Vascular Accident (stroke), difficulty walking, and generalized weakness.</p> <p>Record review of Resident #19's plan of care, dated 01/05/2025, reflected goals and approaches to include wheelchair mobility.</p> <p>Observation on 02/25/2025 at 12:23 p.m. revealed Resident #19 was in her wheelchair in the dining area, and the wheelchair's right armrest was cracked with exposed foam. Resident #19 stated, the armrest was rough. There were noted ecchymosis (bruise) to both of the resident's arms, no skin tears.</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 - Some</p>	<p>3, Record review of Resident #58's MDS assessment, dated 01/31/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #58 had diagnoses which included Hip fracture (broken hip), dementia (confusion), muscle weakness, and age-related osteoporosis (bone weakness).</p> <p>Record review of the Resident #58's, plan of care, dated 01/08/2025, reflected goals and approaches to include wheelchair mobility.</p> <p>Observation on 02/25/2025 at 10:00 a.m. revealed Resident #58 was in her wheelchair in the activities area, and the wheelchair's left armrest was cracked with the foam exposed. There were no skin tears on arms .</p> <p>4. Record review of Resident #171's MDS assessment, dated 02/19/2025. Reflected the MDS was in progress and dated 02/21/2025, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #171 had diagnoses which included fracture of left femur closed (closed left hip fracture) and left artificial hip joint.</p> <p>Record review of Resident #171's plan of care, dated 02/19/2025, reflected goals and approaches to include wheelchair mobility .</p> <p>Observation and interview on 02/25/2025 at 12:30 p.m. revealed Resident #171 was in his wheelchair, in the dining room and with no skin problems. The wheelchair's right armrest was cracked with the foam exposed. Resident #171 was asked about the wheelchair, and he shook his head and smiled .</p> <p>In an interview on 02/26/2025 at 12:30 p.m., CNA A stated when a resident's wheelchair needed repair the staff were to enter it into the electronic maintenance system in the computer. CNA A stated she never wrote anything in the computer though she usually told the maintenance supervisor .</p> <p>In an interview on 02/27/2025 at 10:30 a.m., LVN B stated when a resident's wheelchair needed repair the staff were to write it in the electronic maintenance system, tell the maintenance man, who would tell them to place the information in electronic maintenance system .</p> <p>In an interview on 02/27/2025 at 8:30 a.m., the DON revealed if the staff saw wheelchairs needed repair, the staff was to place a ticket in the electronic system. The Maintenance Supervisor would then know to repair the wheelchair.</p> <p>In an interview on 02/27/2025 at 11:02 a.m., the Maintenance Supervisor stated he repaired the wheelchairs when there was needed repairs. He stated staff were to place the needed repairs in the electronic maintenance system. The Maintenance Supervisor was informed about the residents' wheelchairs condition, and he stated if the wheelchairs' issues had not been placed in the electronic maintenance system for repair he would not know. The Maintenance Supervisor stated all staff could place information about needed repairs in the system. The Maintenance Supervisor reviewed in his phone for tickets, in the electronic maintenance system, concerning repairs, there were none found for wheelchair repairs.</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 - Some</p>	<p>A record review of the facility's policy and procedure Maintenance, dated July 2018, reflected It is the policy of this community to maintain all equipment provided by the facility, in good working order to ensure the safety and wellbeing of all residents and staff . Equipment provided by the community will be: 1. Maintained in working order.</p>		