STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676272	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation-Kyle	1640 Fairway Kyle, TX 78640

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to ensure the resident's right to a dignified existence for 2 of 8 residents (Residents #34 and #67) reviewed for dignity. The facility failed to ensure Resident #34 was wearing clean clothing throughout the day on 09/04/24 and that Resident #67 was wearing clean clothing throughout the day on 09/03/24 and 09/04/24. This failure placed residents at risk of embarrassment and a loss of dignity. Findings included: 1. Review of the undated face sheet for Resident #34 reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included dementia, lack of coordination, abnormal posture, traumatic subdural hemorrhage with loss of consciousness, muscle weakness, malaise, cognitive communication deficit, need for assistance with personal care. Review of the quarterly MDS for Resident #34 dated 05/29/24 reflected a BIMS score of 99, indicating she was unable to complete the interview. Review of the section on functional abilities and goals reflected she was completely dependent on staff for upper and lower body dressing and moderate/partial assistance in activities of personal hygiene. Review of the care plan for Resident #34 dated 08/19/24 reflected the following: [Resident #34] is at risk for ADL Self Care Performance Deficit. Will maintain current level of function in: Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene; ADL Score through the review date. PERSONAL HYGIENE ROUTINE: requires extensive staff participation for personal hygiene. DRESSING: Requires extensive assistance to dress. Review of the CNA documentation system reflected Resident #34 received assistance with dressing and personal hygiene at 11:18 AM on 09/04/24 by CNA E. Observation on 09/04/24 at 08:39 AM revealed Resident #34 in a tilted-back wheelchair wearing a t-shirt with a popular cartoon character on it. The front of the shirt was wet with thick yellow stains running down. Resident #34 did not respond to efforts to interview her. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER: Legend Oaks Healthcare and Rehabilitation-Kyle		STREET ADDRESS, CITY, STATE, ZIP CODE: 1640 Fairway Kyle, TX 78640	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/04/24 at 12:59 PM, revealed Resident #34 was sitting in her wheelchair at a table in the dining room. She was wearing the same dirty t-shirt, though it was no longer visibly wet. She did not respond to efforts to interview her. Observation on 09/04/24 at 03:04 PM, revealed Resident #34 lying in bed asleep and wearing the same dirty t-shirt. 2. Review of the undated face sheet for Resident #67 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Parkinson's disease with dyskinesia (abnormality or impairment of voluntary movement), dementia, malaise (a general feeling of discomfort, illness, or uneasiness whose exact cause is difficult to identify), lack of coordination, muscle, weakness, abnormal posture, cognitive communication deficit, aphasia, and need for assistance with personal care. Review of the quarterly MDS for Resident #67 dated 07/01/24 reflected a BIMS score of 10, indicative moderately impaired cognition. The section on functional abilities and goals reflected he required substantial/maximal assistance with upper body dressing and was totally dependent on staff for lower body dressing. Review of the care plan for Resident #67 dated 08/27/24 reflected the following: I have ADL Self Care Performance Deficit r/t impaired mobility, weakness. Will maintain current level of function in (SPECIFY) Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene; ADL Score) through the review date. DRESSING: Requires extensive staff participation to dress. Review of the CNA documentation system reflected Resident #67 received assistance with dressing and personal hygiene at 11:24 AM on 09/04/24 by CNA F. Observation on 09/03/24 at 10:02 AM, revealed Resident #67 sitting in his wheelchair in his room with a plastic clothing protector around his neck that had lots of food on it. There was also food and moisture on his shirt behind the clothing protector. He did not respond verbally but made eye contact. Observation on 09/03/24 at 11:30 AM, revealed Resident #67 in his room, still wearing the dirty clothing protector and dirty shirt. Observation on 09/03/24 at 02:48 PM, revealed Resident #67 in his bed, still wearing the dirty shirt but no longer wearing the clothing protector. During an interview on 09/03/24 at 03:09 PM, a FM for Resident #67 stated the only problem she had with the facility was they did not clean his bib or change his pants and clothing when they were dirty from his meals. She stated he wanted to eat independently, and that was great, but he generally made a mess, and the staff often left him that way. The FM stated the issue had been reported to the charge nurse and management, but it continued to occur. Observation on 09/04/24 at 12:51 PM, revealed Resident #67 was wearing a long-sleeved cotton t-shirt and shorts, and there was food and moisture that had spilled down the entire right front half of shirt and shorts. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation-Kyle		STREET ADDRESS, CITY, STATE, ZIP CODE 1640 Fairway Kyle, TX 78640	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/04/24 at 03:04 PM revealed Resident #67 still wearing the shirt and shorts with food and liquid on his shorts and shirt. Still in his clothing protector. During an interview on 09/05/24 at 11:35 AM, CNA E stated Resident #34 could be combative, but not frequently. CNA E stated they changed her clothes if they became dirty. She stated she had not noticed Resident #34's clothes were dirty on 09/04/24. CNA E stated she was supposed to change resident's clothing if they became dirty. CNA E stated Resident #67's family always wanted the clothing protector on him. She stated he got dirty from eating and they should have changed his clothes if he was dirty or wet as well as cleaned the clothing protector if it got dirty. She stated she had not helped him eat the last couple of days and his primary aide was CNA F. During an interview on 09/05/24 at 12:55 PM, CNA F stated she had not noticed anyone with dirty clothing on. She stated she saw Residents #34 and #67 get dirty sometimes. She stated she had not seen that either of them was dirty on 09/04/24, and she did not work on 09/03/24. She stated she was supposed to change residents if their clothing became dirty. During an interview on 09/05/24 at 01:07 PM, LVN G stated if residents spilled food during meals, the staff should have changed them as soon as the meal was over. She stated Resident #67 often had food or saliva on his clothes, and his family wanted his clothing protector on all the time when he was in his chair. She stated Resident #34 also sometimes got food on herself, because grabbed at everything she could. She stated she had not noticed long stretches of Residents #34 and #67 on 09/04/24, and she had not worked on 09/03/24. She stated they should have been changed into clean clothing right after their meals unless they refused, and if they refused, it should have been documented and reported to her. She stated the potential impact of sitting in a food-stained shirt was that the resident's dignity could have been compromised. During an interview on 09/05/24 at 01:53 PM, the ADON stated her expectation of when residents were helped to change clothing when they became dirty, was that they be changed when they went back to their rooms after their meals before they did anything else. She stated the charge nurse was responsible for monitoring to ensure dirty clothes were changed. The ADON stated a potential negative impact of the clothing not being changed was the resident would not feel clean. During an interview on 09/05/24 at 02:14 PM, the DON stated she monitored to ensure residents were changed after their clothing became dirty with food by doing rounds and checking residents. She stated the charge nurse, the ADON, and she were all responsible for ensuring residents were in clean clothing. She stated the potential negative impact of residents sitting in dirty clothes was they could be embarrassed. During an interview on 09/05/24 at 02:42 PM, the ADM stated residents who became dirty during meals needed to be changed right after the meal. He stated the CNAs had hands on responsibility and the nurses needed to be checking to make sure it was done. He stated the rest of the management team also had some responsibility to look out for people and make sure their clothes were clean. He stated a potential negative impact of the failure was that the residents could feel they were being looked at as dirty people. He stated he would not want to be looked at that way. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation-Kyle		STREET ADDRESS, CITY, STATE, ZIP CODE 1640 Fairway Kyle, TX 78640	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy dated 2023 and titled Resident Rights reflected the following: As a resident of this nursing facility, you have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside of the facility. You have the right to exercise your rights without interference, coercion, discrimination, or reprisal from the facility as a resident of the facility and as a citizen or resident of the United States. 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 would endanger your or other residents' health or safety. 49097

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on interview and record review, the facility failed to ensure the residents rights to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive for 1 of 5 residents (Resident #49) reviewed for advanced directives: The facility failed to ensure Resident #49's out of hospital do-not-resuscitate (OOH-DNR) form included all required signatures including a second signature from the resident, witnesses, and physician. This failure could place residents at-risk of having their wishes dishonored or delay necessary medical treatment or intervention. Findings included: Review of Resident #49's face sheet dated 09/05/2024 revealed Resident #49 was admitted on [DATE] with diagnoses of unspecified fracture of right femur (injury between to the bone between the hip and knee), unspecified sequelae of cerebral infarction (conditions as result of stroke), unspecified atrial fibrillation (irregular heartbeat), and dysphagia (difficulty swallowing). Review of Resident #49's care plan dated 07/21/2024 revealed the focus I have elected to be DNR code status. Interventions included to review code status quarterly and as needed with resident. Review of physician's orders for Resident #49 revealed DNR/Do Not Attempt Resuscitation order dated of 09/04/2024. Review of Resident #49's clinical record revealed she had an OOH-DNR form dated 06/06/2019. Further review revealed that under the section all persons who have signed above must sign below, acknowledging that this document has been properly completed there were no signatures from the resident/proxy, witnesses/notary or physician. Review of Resident #49's IDT care plan review dated 08/07/2024 revealed that it was reviewed Resident #49 had a DNR in place and wished to remain DNR at time of the review. During an interview on 09/04/2024 at 3:09 PM with LVN G, she stated that residents are asked when they arrive if they have a DNR in place or if they would like to put one in place if they are cognitive enough to sign. She stated that if they have a DNR form and it is filled out, the nurse reviews it to ensure it has witness signatures and is signed by the doctor. LVN G stated that she looked at the form to see if all the necessary spaces are filled out. LVN G was observed viewing Resident #49's DNR form and stated that it was not valid due to missing second signature. LVN G stated that the nurse is supposed to ensure the form is filled out prior to putting the order in. She stated that the DON, ADON and SW usually view the form before it is put in the resident's record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/04/2023 at 3:18 PM, LVN I stated that the nurse and DON verify that a DNR is complete. She stated that when a resident comes in with a form that is completed copies are provided to the physician and medical records for review. LVN I was observed viewing Resident #49's DNR and stated that it was not valid, and it was missing signatures. LVN I stated that there is a potential of the resident's wishes not being met due to the form being incomplete. During an interview on 09/05/2024 at 11:14 AM, she stated that social services and nursing are responsible for ensuring advanced directives are valid. She stated that a nurse should have reviewed them, and social services is trained to review any advanced directives prior to the document going into the resident's chart. She stated that any advanced directive should have been completed filled out before it was put in the resident's chart. She stated that nurses were trained to recognize that a DNR should be filled out completely before it is excused. She stated that Resident #49's DNR was missing signatures and not considered valid. During an interview on 09/05/2024 11:31 AM with SW, she stated that she has witnessed advanced directives and does also assist with sending them to the doctor to be signed. She stated that she has reviewed DNRs to ensure it complete and will review the document if medical records sent it to her as well. She stated that advanced directives, including DNRs, are audited about every 6 to 8 weeks. She stated that for a DNR it required the name of the resident and signature, two witness signatures and printed names and the doctor signature. She stated that witnesses, resident, and doctor are required to sign twice. She stated that a DNR would not be considered valid if it was missing second signatures. During an interview on 09/05/2024 at 2:19 PM, the ADM stated that he expected that advanced directives are accurately completed prior to the document being entered in the resident charge. He stated that a complete chart review was completed after a resident was admitted ensuring that advanced directives that were provided were accurate. He stated that if a DNR is not filled out correctly then a patient should have been treated as a full code until it is corrected and stated that there were a lot of things that could potentially have happened or nothing at all. Review of facility policy titled Advanced Directives and Associated Documentation with revision date of 12/2023 reflected it is the policy of this facility to implement the resident decisions and directives that are in compliant with State and/or Federal Law and the policies of this facility. Further review revealed that it is the facility's policy to review the Advanced Directive to validate the document reflects the resident choices and that the document is signed and dated by the resident or responsible agent. Review of Health and Safety Code 166.083(7)(13) revealed that a OOH-DNR must contain a statement at the bottom of the document, with places for the signature of each person executing the document, that the document has been properly completed.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 Based on observations, interviews, and record review the facility failed to ensure resident rights for personal privacy for 4 of 10 residents (Resident #5, Resident #14, Resident #92 and Resident #459) reviewed for personal privacy. The facility failed to knock on Residents #5, #14, #92 and #459's room when going into the residents' rooms. The deficient practice could affect all residents right to privacy in the facility and cause the resident to feel like their privacy was being invaded or the facility was not their home. Findings included: Review of Resident #5's Face Sheet dated 09/05/2024 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5's diagnoses included closed fracture with routine healing, fall, type 2 diabetes mellitus with hyperglycemia (high blood sugar), heart failure, hypertension (high blood pressure), counseling, muscle weakness, dysphagia (difficulty swallowing), cognitive communication deficit (problems with communication), Asthma, unsteadiness on feet, abnormalities of gait and mobility, need for assistance with personal care, and personal history of respiratory disease. Record review of Resident #5's Quarterly MDS dated [DATE] revealed Resident #5 had a BIMS score of 15 indicating resident understood and could make self-understood some all the time. Review of Resident #14's Face Sheet dated 09/05/2024 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #14's diagnoses included dementia (memory, thinking, difficulty), bipolar (extreme mood swings), major depressive disorder, osteoporosis (disease that weakens the bones and make them more likely to break), stiffness of ankles, abnormal posture, need for assistance with personal care, reduced mobility, lack of coordination, cognitive communication deficit (problems with communication), muscle weakness, dysphagia (difficulty swallowing), stiffness of hip and knee and dementia (memory, thinking, difficulty). Record review of Resident #14's Quarterly MDS dated [DATE] revealed that Resident #14 had a BIMS score of 09 indicating the resident could understand and make self-understood most of the time. Review of Resident #92's Face Sheet dated 09/05/2024 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #92's diagnoses included intraspinal abscess and granuloma (rare but serious infection in the spine), pulmonary embolism without acute cor pulmonale (blood clot in the lungs without difficulty breathing), type 2 diabetes mellitus with other specified complications (high blood sugar), morbid obesity, paroxysmal atrial fibrillation (irregular heart beat that comes and goes), hyperlipidemia (high cholesterol), thrombophilia (blood disorder that causes clotting), hypertension (high blood pressure), constipation, muscle weakness, dysphagia (difficulty swallowing), cognitive communication deficit (problems with communication), reduced mobility, need for assistance with personal care, and cardiac defibrillator (detects and stops irregular heartbeats). (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #92's Quarterly MDS dated [DATE] revealed that Resident #92 had a BIMS score of 15 indicating the resident could understand and make self-understood all the time. Review of Resident #459's Face Sheet dated 09/05/2024 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #459's diagnoses included fracture of the right hip, anemia (not enough healthy red blood cells), and kidney failure. Record review of Resident #459's Quarterly MDS dated [DATE] revealed that Resident #459 had a BIMS score of 15 indicating the resident could understand and make self-understood all the time. Observation of meal tray pass on 09/03/2024 at 1:08 p.m., revealed that LVN A opened Resident #14's door and just walked in without knocking. Observation of meal tray pass on 09/04/2024 at 12:55 p.m., revealed that cna B did not knock on Resident #5, Resident #92, and Resident #459's door before entering the room. An interview with CNA B on 09/05/2024 at 9:15 a.m., revealed that she had been trained on resident rights. She stated that the policy for knocking was staff were to knock and always ask permission to enter. She said that staff were expected to knock on the residents door all the time. She also said if staff did not knock on the resident's door the resident may feel annoyed or upset. She said she did not knock on the residents doors because she is used to them, and they are used to her, and it was just a habit. She also said that even if the resident is used to her, she should have knocked. An interview with LVN A on 09/05/2024 at 9:22 a.m., revealed she had been trained on resident rights. She stated the policy was that all staff were to knock and wait to get an answer then announce yourself before entering. She said all staff were supposed to knock before going into the resident's room. She said that if staff do not knock the resident may get upset or it may surprise the resident. She also stated that she did not know why she did not knock on the resident's door. She stated that she may have been rushing to get their blood sugar before the resident had their lunch. An interview with the DON on 09/05/2024 at 10:46 a.m., revealed she had been trained on resident rights. She stated that the policy was that all staff were required to knock on the residents door before going into the resident's room. She said that if staff do not knock on the resident's door they may get upset. She said that staff may have gotten distracted or got task oriented and forgot. An interview with the ADM on 09/05/2024 at 2:41 p.m., revealed he had been trained on resident rights. He stated he did not have a policy for knocking on the residents' doors, but his expectation was that all staff knock before entering. He said that if staff did not knock on the resident's door staff could surprise the resident. He also said that depending on the resident they may get upset about staff not knocking. He said he did not know why the staff were not knocking on the residents doors. An interview with Resident #5 on 09/05/2024 at 12:31 p.m., revealed that staff do knock sometimes before entering her room. She said that it did not bother her if staff did not knock. An interview with Resident #14's roommate on 09/05/2024 at 12:20 p.m., revealed Resident #14 went to the dining room for lunch. She stated that staff usually knock on her door before entering. She said there are times that staff do not knock and that she would like for them to knock. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Resident #92 on 09/05/2024 at 12:42 p.m., revealed that staff knock on the resident's door most of the time before entering. She said that she would like for staff to knock all the time. An interview with Resident #459 on 09/05/2024 at 12:36 p.m., revealed that staff knock on the door most of the time. She stated there are times when staff do not knock. She stated she would like staff to knock all the time. Record review of Resident Rights dated October 4, 2016, revealed residents have the right to be treated with dignity and respect. The resident also has the right to personal privacy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 1 of 8 residents (Resident #34) reviewed for ADL care. The facility failed to ensure Resident #34's fingernails were clean and smooth from 09/03/24 to 09/05/24. This failure placed residents at risk of skin tears and infection. Findings included: Review of the undated face sheet for Resident #34 reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnosis included dementia, lack of coordination, abnormal posture, traumatic subdural hemorrhage with loss of consciousness, muscle weakness, malaise (a general feeling of discomfort, illness, or uneasiness whose exact cause is difficult to identify), cognitive communication deficit, need for assistance with personal care. Review of the quarterly MDS for Resident #34 dated 05/29/24 reflected a BIMS score of 99, indicating she was unable to complete the interview. Review of the section on functional abilities and goals reflected she required moderate/partial assistance in activities of personal hygiene. Review of the care plan for Resident #34 dated 08/19/24 reflected the following: [Resident #34] is at risk for ADL Self Care Performance Deficit. Will maintain current level of function in: Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene; ADL Score through the review date. PERSONAL HYGIENE ROUTINE: requires extensive staff participation for personal hygiene. Review of the CNA documentation system reflected Resident #34 received assistance with personal hygiene at 11:18 AM on 09/04/24 by CNA E. Review of the CNA documentation system reflected no nail care was documented for Resident #34 from 08/07/24-09/05/24. During an interview on 09/05/24 at 11:35 AM, CNA E stated Resident #34 was very clingy and liked to grab and snatch everything, so her fingernails often got dirty. CNA E stated Resident #34 could be combative, but not frequently. She stated they tried to get to the fingernails, but there was sometimes not enough time. She stated she did not think nail care was assigned to a particular nursing person. She stated she had not noticed that resident #34's fingernails were long, jagged, or dirty. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/05/24 at 01:07 PM, LVN G stated there were no showers scheduled Sundays, and that was when nail care should have been done. She stated nails should have also been cleaned as needed and in resident showers. LVN G stated some residents were combative, and the CNAs sometimes got scared and came to her for help. She stated she addressed combativeness or refusals by offering residents something different, someone different to care for them, or distracting them with snacks, treats, or music. She stated she monitored to ensure nail care was done by doing rounds, but she mostly relied on the aides to tell her if something needed her attention. LVN G stated no combativeness or refusals by Resident #34 had been reported to her. She stated the potential negative outcome of having long, dirty, jagged fingernails, was Resident #34 could scratch herself or someone else. During an interview on 09/05/24 at 01:53 PM, the ADON stated nail care was delegated to the CNAs as long as the resident did not have diabetes. She stated the expectation was if staff saw long, jagged, or dirty nails, they should be addressed right away. She stated the person responsible for monitoring to ensure nail care was done was the charge nurse. She stated the potential negative outcome to residents for not providing their nail care was bacterial infection and skin alteration. During an interview on 09/05/24 at 02:14 PM, the DON stated she monitored nail care by going around and checking nails, tells CNAs to check nails, and telling nurses to check nails. She stated if residents refused, they tried to send someone back to try again. The DON stated the charge nurses and CNAs were responsible for ensuring nails were done. The DON stated a potential negative impact of not keeping up with nail care was residents could have a skin alteration or infection. During an interview on 09/05/24 at 02:42 PM, the ADM stated they did rounds to ensure nail care had been performed. He stated nursing was responsible for ensuring nail care was done. He stated a potential negative outcome of nail care not being done was the residents could hurt themselves. Review of facility policy dated 05/2007 and titled ADLs reflected the following: Nursing service staff cares for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life and promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity, and respect in recognition of his or her individuality. Each resident receives assistance as needed to manage their physical needs, which includes personal hygiene, grooming, dressing, toileting, transferring, and ambulating.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation-Kyle	1640 Fairway Kyle, TX 78640

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observation, interview and record review, the facility failed to assist residents in obtaining dental services for 2 of 5 (Resident #46, Resident #74) residents reviewed for routine dental services in that: The facility failed to assist Resident #46 in obtaining dental services after learning that her dentures were uncomfortable. The facility failed to assist Resident #74 in obtaining dental services after learning her dentures were uncomfortable. These failures could place residents with dental care concerns at risk for pain, declined oral health, weight loss and decreased quality of life. Findings included: 1. Review of Resident #46 face sheet dated 09/05/2024 revealed Resident #46 was admitted on [DATE] with diagnoses of other sequelae of cerebral infarction (conditions as result of stroke), dysphagia (difficulty swallowing, hemiplegia and hemiparesis following unspecified cerebrovascular disease (paralysis and weakness in part of body following stroke). Review of Resident #46's annual MDS dated [DATE] revealed a BIMS score of 13 which indicated she was cognitively intact. Review of Resident #46's last IDT care plan review dated 07/10/2024 revealed under Dietary Plan of Care (Dental, Oral, and Hydration and Nutritional Status) we will try to incorporate more soft foods as her (Resident #46) dentures have been bothering her Observation on 09/04/2024 at 8:50 AM, revealed Resident #46 had white and grey build up on her bottom teeth near her gums. 2. Review of Resident #74's face sheet dated 09/05/2024 reflected Resident #74 was admitted on [DATE] with diagnoses of End Stage Renal Disease (terminal illness when kidneys can no longer function properly), Type 2 Diabetes Mellitus (a chronic condition that causes high blood sugar levels due to a lack of insulin or insulin resistance), and Peripheral Vascular Disease (a chronic in which blood flow is reduced to organs and limbs outside of the heart and brain). Review of Resident #74's quarterly MDS dated [DATE] reflected a BIMS score of 15 which indicated that she was cognitively intact. Observation on 09/03/2024 at 2:14 PM, revealed resident had no teeth (natural or dentures) in her mouth. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/03/2024 at 2:15 PM, Resident #76 stated that she needed to get her bottom dentures fixed. Resident #76 stated that a CNA dropped her dentures in the skin and broke them. She stated that it had been a few months ago. During an interview on 09/04/2024 at 8:50 AM, Resident #46 she stated that she has upper dentures and stated that she needed to see a dentist, really bad. She stated that she only has upper dentures and that her bottom teeth were her own. She stated that sometimes her teeth hurt and stated that her dentures have been bothering her. She stated that she has asked to see a dentist two or three times. During an interview on 09/04/2024 at 1:57 PM, the ADM stated that he does not have record of Resident #46 seeing a dentist in the last year. During an interview on 09/04/2024 at 2:56 PM, SW stated that she does not believe Resident #46 has seen a dentist tin the last year. She stated that the dentist come at least once a month. She stated that the dentist usually lets her know a week in advance of who would be seen. She stated that she knew Resident #46 wanted to get new dentures and she believed the dentist told her that it may not be possible. She stated that that may have been two or three months ago. SW stated she was not present during the last care plan meeting and was unsure why Resident #46 was not referred to the dentist if she had concerns about her dentures then. She stated that the social worker is responsible for sending referrals to the dentist. She stated she also sent referrals to the dentist and would send it within a day. During an interview on 09/04/2024 at 3:01 PM, SW stated that she did not see any documentation that Resident #74 had been seen by the dentist in the last year. During an interview on 09/04/2024 at 3:05 PM, CNA J stated that the oral care that is provided to residents depends on their needs. She stated that if a resident can brush their teeth on their own, they may just help them set up. She stated that if she noticed a resident's teeth or denture was broken, she would report it to the nurse. She stated that she did not believe Resident #74 had dentures, but she stated that usually Resident #74 does her own oral care. During an interview on 09/04/2024 at 3:07 PM, CNA J stated that Resident #46 has top dentures and that her dentures get taken out at night and sanitized. She stated that she Resident #46 were to complain about her dentures she would let a nurse know. CNA J stated that she had not noticed any build up on Resident #46's teeth. During an interview on 09/05/2024 at 9:58 AM, CNA E she stated that some residents can do their own oral care in the mornings. She stated that some require set up such as getting the toothbrush ready with toothpaste. She stated that if residents cannot do their own oral care, they are offered more assistance. She stated that Resident #74 can do so and believes she has her own teeth. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/05/2024 at 9:59 AM, CNA E stated that Resident #46 has dentures but had a hard time with the dentures fitting. She stated that half of the time she has difficult time with the dentures because they do not fit. She stated that she feels her gums are shaped differently that the dentures. She stated that Resident #46 had top dentures. She stated that Resident #46 has told her she wanted to see a dentist and she has overheard her talking with her family about wanting to see a dentist. CNA E stated that she did not let anyone know that Resident #46 wanted to see the dentist because she was unsure if the facility provides dental services or if the resident's family would provide it. She stated that if she noticed dentures were broken or if the resident was having pain, she would let the nurse know. During an interview on 09/05/2024 at 10:09 AM, CNA F she stated that almost all residents need assistance with oral care. She stated that Resident #46 has dentures and can brush her own teeth. She is not aware if Resident #46 has complained about her teeth but if she noticed broken dentures she would report to the nurse. During an interview on 09/05/2024 at 10:16 AM, LVN G stated that Resident #74 performs her own oral care and can put her dentures on and take them off but sometimes prefers to have her dentures off. She stated that when she asked Resident#74 if she wanted to wear her dentures Resident#74 would reply are you crazy. She stated that Resident #74 sometimes asked for soft feeds. She stated that she has not asked Resident #74 if she needed to see a dentist. During an interview on 09/05/2024 at 10:17 AM, LVN G stated that Resident #46 is able to do her own oral hygiene and has top dentures and her own teeth on the bottom. She stated that if a resident were to complain about broken teeth or dentures, they could offer softer food. LVN G stated that normally the social worker is in charge or dental appointments, but ADON can help too. During an interview on 09/05/2024 at 11:17 AM, the DON stated that if there is an emergency the resident can be sent out for emergency dental. She stated that there are some residents that had insurance that dental services were not covered, or families elect to have the insurance that do not cover dental services. She stated that if a CNA overheard a resident say that they needed to see a dentist they should tell a nurse and the nurse should have notified the DON or NP. She stated that a dental would be made depending on if the complaint was a one-time complaint or if it was consistent. She stated that she would have expected a CNA to tell a nurse if they dropped dentures and were broken. She stated that Resident #74 is very vocal, and she had not heard of issues with her dentures. She stated that she believes Resident #46 family was going to take her to the dentist. During an interview on 09/05/2024 at 2:15 PM, the ADM stated that referring a resident to the dentist would depend on their insurance coverage. He stated that the facility would need to investigate what caused the dentures to break and if the facility caused the issue, then the facility would pay to get them fixed. He stated that the social worker is the person who sets up dental services. He is unsure why Resident #46 had not seen a dentist and stated that she may have potentially had no coverage and he believed the family was going to take Resident #46 to the dentist. Review of facility dental record for last year revealed Resident #46 and Resident #74 had not been seen by the dentist. Review of Resident #46 progress notes revealed no indication that family had planned to take her to see a dentist or that the facility offered to refer her to the dentist. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #74 progress notes revealed no indication that she was offered to see a dentist by the facility despite her asking for softer foods and preferring not to wear her dentures. Review of facility policy titled Dental Services with revision date of 01/2022 revealed it is the policy of this facility to ensure that its residents who require dental services on a routine or emergency basis have access to such services without barrier. It is likewise the policy of the Facility to repair or replace the dentures of a resident except in those situations where the loss or damage directly results from the action of an alert or oriented resident who is responsible for his/her own medical decisions. Further review revealed that the facility will investigate in the event a resident experiences damage to his/her dentures to determine financial responsibility for replacement or repair. For Medicare and Medicare residents, the facility will ensure that needed/emergency dental services are available and may bill or inform resident a deduction for incurred expense may occur. Further review revealed if a resident is unable to pay for dental services the facility will attempt to find alternative funding so that the resident may receive the services to meet their dental needs and maintain their highest practicable level of well-being. Facility policy reflected the facility will promptly (within three business days) refer the resident for dental services and if services does not occur within three business days the facility will documentation actions taken to ensure resident can eat, drink and communication and document the nature of the extenuating circumstances which led to the delay.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49097 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 in one of one kitchen observed for food storage, preparation, and distribution. Cook C did not perform hand hygiene appropriately when preparing pureed foods. This failure could place residents who ate food served by the kitchen at risk of food-borne illness from cross-contamination. Findings included: An observation of CK C on 09/03/24 at 11:30 a.m., CK C staff washed her hands, did not put on gloves, pushed the blade down into the machine with her hand and started putting the meat into the puree machine. She put the pureed meat in a pan on the steam table. She then got a pan of green peas off the stove and put by puree machine went. She then went and washed hands. She then moved the pan regular meat back to the stove. She looked at the recipe, put her hands in her pockets and came back to pan of peas. She then got a ladle and stirred the peas. She did not wash her hands between the tasks. CK C then pushed the blade down with her hand and proceeded to put green peas in the puree machine. She checked the peas pushed the middle blade down again with her hand started the machine again. When finished she put the pureed peas on the steam table. She went and washed her hands. She went and opened the warmer and the oven. She touched her pants and put her hands on her hips while waiting for the puree machine. She then proceeded to push the blade down with her hand in the puree machine. She did not wash her hands in between tasks. An interview with the DM on 09/05/2024 at 9:40 a.m., revealed that kitchen staff have been trained on hand hygiene. She stated that staff are only required to wear gloves when handling ready to make foods. She said that if staff were pureeing food and then touched a drawer, they need to wash their hands. She said all staff are required to practice hand hygiene. She said that hand hygiene prevents cross contamination. She said that if staff fail to wash their hands between tasks it would put the residents at risk for food borne illness. She said that CK C might have gotten nervous with the surveyors watching. She said she would have to ask CK C since she had been out. An interview with CK D on 09/05/2024 at 9:42 a.m., revealed she had been trained on hand hygiene. She stated that staff were supposed to wash their hands in between tasks. She said everyone was to practice hand hygiene in the kitchen. She also said that it was important to wash your hands to prevent the spread of germs and diseases. She said that if staff did not wash their hands, it would put the residents at risk of getting sick. She stated she did not know why the cook did not wash her hands between tasks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the ADM on 09/05/2024 at 2:41 p.m., revealed that all staff hand been trained on hand hygiene. He also said that all staff are to wash their hands in between tasks to prevent the spread of infections. He also said that if staff do not wash their hands in between tasks, it could put the residents at risk of getting sick. He stated he did not know why the cook was not washing her hands between tasks. Record review of Hand Hygiene Policy dated 10/2022 revealed all personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors. Staff are to wash their hands before and after eating or handling food.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observations, interviews, and record review, the facility failed to be equipped to allow residents to call for staff through a communication system which relayed the call directly to a centralized staff work area for 1 of 15 residents (Resident #459) reviewed for call lights. The facility failed to ensure Resident #459's emergency call button in the bedroom was operating properly. This failure could place residents at risk of injury, pain, and hospitalization . The findings included: Record review of a face sheet dated 8/25/2024 for Resident #459 indicated she was a [AGE] year old female admitted [DATE] with diagnoses of fracture of the right femur (broken leg), anemia (low red blood cells in the blood), and acute kidney failure. Record review of a MDS dated [DATE] for Resident #459 indicated she had a BIMS score of 15 indicating she had no cognitive impairment. Record review of a care plan dated 8/26/2024 for Resident #459 indicated she was at risk for falls and was dependent on staff for assistance. During an interview and observation on 9/03/2024 at 10:35 a.m. at Resident #459's room, Observation reflected the bedroom call button in Resident #459's room was not functioning after being pressed twice by resident. The light outside of the room was not illuminated to alert staff that the resident may need assistance . During an interview with Resident #459 stated I feel staff is too young and doesn't follow through timely. When call light pressed takes a long time. During an interview on 9/3/24 at 12:34 p.m., CNA H stated she observed and verified the call light was not working. She stated the call light had worked earlier that morning but was not working at the time of observation. She verified that the potential for harm towards the resident could be an injury, pain or hospitalization . During an interview on 9/3/24 at 12:59 p.m., the maintenance director stated the call light wires were not functioning properly and were replaced upon discovery. He stated the issue was fixed and that the call light was functioning properly. During an interview on 9/4/24 at 9:26 a.m., the DON stated her expectation is to have call lights answered timely and functioning. She stated that malfunctioning call light system could place the resident at risk of not having their needs met. During an interview on 9/5/24 at 2:39 p.m., the Administrator stated It is my expectation that resident call lights be functioning at all times. There could be an urgent resident need that needs to be addressed. He also stated the entire staff is responsible for ensuring call lights are functioning properly. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of maintenance logs dated 7/3/24 and 8/22/24 show functioning bedroom call light tests in Resident #459's room. Record review for undated policy titled, Call Light/Bell, indicated, Answer the light/bell within a reasonable time. If the call light/bell is defective, immediately report this information to the unit supervisor.