| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676312 | A. Building<br>B. Wing | 04/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Legend Oaks Healthcare and Rehabilitation - West S | 222 Bertetti Dr<br>San Antonio, TX 78227 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957<br><br>Based on interview and record review, the facility failed to ensure that all allegations involving abuse, neglect, and misappropriation were reported immediately, but no later than 2 hours after the allegation was made to the State Survey Agency for 1 of 5 residents (Resident #1) reviewed for reporting of suicidal attempt, in that:<br><br>On 03/21/24, the facility did not report to the State Survey Agency (HHSC) (Health and Human Services Commission) a complaint of Resident #1 attempting suicide in the facility by ingesting mouthwash.<br><br>This failure could place residents at risk for harm to include neglect, a diminished quality of life, and possible death.<br><br>The findings included:<br><br>Record review of facility's Abuse policy dated revised 10/2022 reflected: .Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .<br><br>Record review of facility's Reporting policy dated revised 10/2022 reflected: .1. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will .[report] . Not later than tow (2) hours after the allegation if made if the events that cause the allegation involves abuse or results in serious bodily injury .Not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury .<br><br>Record review of Resident #1's face sheet dated 4/09/24 revealed diagnoses of Parkinson's disease, suicidal ideation, and COPD (chronic obstructive pulmonary disease).<br><br>Record review of Resident #1's MDS dated [DATE] revealed BIMS of 11 (moderately impaired) and independence with ADLs in the areas of eating and drinking.<br><br>Record review of Resident#1's Physician Orders, dated March 2024, revealed an order for Remeron 7.5 mgs bedtime - Monitor for depression Q shift.<br><br>Record review of Resident #1's PHQ9 revealed 12/01/23 score was 8 (moderate depression) and 3/03/24 score was 9 (moderate depression).<br><br>(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: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #1's Hospital H&P dated 4/13/23 revealed resident was admitted for suicidal ideation which included smothering himself with a bag and licking a roll of deodorant. The resident was frustrated over payments to the nursing home. Resident was admitted for SI. [Resident was discharged to the facility on [DATE] with a diagnosis of SI.]<br><br>Record review of Resident#1's Nurse Note, dated 3/21/24 at 10:57 AM and authored by RN B revealed resident was found in his room .shaking uncontrollably stated 'I tried to kill myself'. Assessment and vitals taken and MD, NP A, family member notified. [EMS and law enforcement called.]<br><br>Record review of Resident #1's Nurse Note, dated 3/21/24 at 1:21 PM and authored by RN B revealed resident was found in his room by CNA C approximately at 10:30 AM shaking and the resident stated, I know what's wrong with me, I tried to kill myself, I drank that whole bottle. A large empty mouthwash bottle was noted at bedside. EMS arrived approximately at 10:50 AM.<br><br>Record review of Resident #1's EMS run report dated 3/21/24 at 11:44 AM read: Arrived on scene to find SQ44 assessing 90YOM who had ingested approximately 100-200ml [mouthwash]in attempt to end his life . stable vitals .PT admitted to the suicide attempt .PT has history of SI.<br><br>Record review of Resident #1's ER report dated 3/21/24 reflected the resident wanted to commit suicide by ingesting one-third bottle of [mouthwash] and other cleaning agents. Recommendation: inpatient psychiatric hospital.<br><br>Record review of Resident #1's detention order dated 3/21/24 at 11:55 PM revealed emergency detention for SI.<br><br>Record review of Resident #1's law enforcement report, Report #SAPD24062237 dated 3/21/24 at 12:05 PM, read .When I (Law Enforcement H) made contact with [Resident #1], he stated he didn't want to live anymore and wants to die due to conditions of the nursing home, his life and he confirmed he ingested items. I assessed that [Resident #1] had to be emergency detained or he would do more harm to himself if left alone.<br><br>Record review of facility's Census List revealed that Resident #1 was discharged on [DATE].<br><br>During an interview on 4/09/24 at 11:52 PM, RN B stated she saw an empty mouthwash bottle on 3/21/24 around 10:30 AM; the resident was shaking and not himself and slumped over in the W/C in his room . roommate was sleeping . RN B stated Resident #1 pointed to the empty bottle and said, I know what is wrong with me .I drank the bottle.<br><br>During telephone interview on 4/09/24 at 3:50 PM, Resident #1 stated he attempted suicide on 3/21/24 around 10:30 AM by drinking two swallows of mouthwash. The resident stated he had attempted suicide one time before at the nursing home. The resident stated the suicide attempt on 3/21/24 was spontaneous and he had not planned the attempt.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676312 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/12/2024 |
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| Legend Oaks Healthcare and Rehabilitation - West S | 222 Bertetti Dr<br>San Antonio, TX 78227 |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During telephone interview on 4/10/24 at 10:10 AM, the Medical Director stated Resident #1 attempted suicide by drinking a small amount of mouthwash to get attention. The MD stated the residents with Major Depression diagnosis needed to be screened and preventative measures put in place. The MD stated that preventative measures for a high risk resident with depression should include room closer to nurse station, frequent vital signs and monitoring, and checking items brought in from the outside.<br><br>Attempted telephone interview on 4/10/24 at 10:27 AM, message left for Resident#1's family member to call the Surveyor I.<br><br>During an interview on 4/09/24 at 10:30 AM, the DON stated Resident #1 was still in a psychiatric hospital in another city. The DON stated the police was present on the day of the incident, 3/21/24. The DON stated Resident #1 was sent to theER on [DATE] for a suicide attempt ; and was discharged from the nursing home census sheet.<br><br>During an interview on 4/10/24 at 9:10 AM, the DON stated that she felt the incident did not rise to a level of submitting a report to HHS, because there was no neglect of Resident #1. The DON stated, it was a lesson learned not to report when she had doubts about reporting to HHS.<br><br>During an interview on 4/10/24 at 12:30 PM, the Administrator stated: the incident was not reportable to HHS based on the Provider Letter [PL 2019-17 dated July 10th, 2019]on Abuse and Neglect, because there was no neglect. The Administrator stated that the facility's conclusion was that the resident's attempted suicide was due to family dynamics. The Administrator stated that EMS, Law Enforcement, the Medical Director , and the Emergency Contact person were notified of the incident on 3/21/24; and no need existed to contact HHS within the two hours of the incident.<br><br>Record review of the facility's Suicide Threats policy, undated, read Resident suicide threats shall be taken seriously and addressed appropriately . |

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|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation - West S | | STREET ADDRESS, CITY, STATE, ZIP CODE 222 Bertetti Dr San Antonio, TX 78227 | |

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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 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957<br><br>Based on observation, interviews, and record reviews, the facility failed to ensure each resident received adequate supervision to prevent accidents for 2 of 5 residents (Resident #1 and Resident #2) reviewed for adequate supervision in that:<br><br>The facility did not put in place adequate supervision for Resident #1 who had a history of suicidal ideations and a Major Depression diagnosis. On 03/21/24 at 10:30 AM, he was found slumped over on a W/C in his room after he tried to commit suicide by ingesting mouthwash. He was sent to the ER before law enforcement did an emergency detention for suicide attempt.<br><br>The facility did not put in place adequate supervision for Resident #2 with a diagnosis of Major Depression and was not aware of items brought in from the outside that could pose a danger of self-harm for Resident #2.<br><br>These failures resulted in the identification of an Immediate Jeopardy (IJ) on 04/10/24 at 6:25 PM. While the immediacy was removed on 04/12/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility's need to monitor the implementation of the plan of removal.<br><br>This failure to not take immediate action to ensure that residents with suicidal history and/or major depression did not have access to items from the outside could cause injury, harm, impairment, or death to self.<br><br>The findings included:<br><br>Record review of Resident #1's face sheet dated 4/09/24 revealed diagnoses of Parkinson's disease, suicidal ideation, and COPD (chronic obstructive pulmonary disease). Record review of Resident #1's face sheet dated 4/09/24 revealed no diagnosis for PICA (an eating disorder. (The medical term comes from the Latin for magpie (Pica pica), a bird that by folklore incessantly gathers objects to satiate its curiosity).<br><br>Record review of Resident #1's MDS dated [DATE] revealed BIMS of 11 (moderately impaired) and independence with ADLs in the areas of eating and drinking.<br><br>Record review of Resident #1's comprehensive person-centered care plan, dated 5/01/23, revealed the resident's interventions for depression included Monitor Behavior for Depression Withdrawn/Depressed.<br><br>Record review of Resident#1's Physician Orders, dated March 2024, revealed an order for Remeron 7.5 mgs bedtime - Monitor for depression Q shift.<br><br>Record review of Resident #1's PHQ9 revealed 12/01/23 score was 8 (moderate depression) and 3/03/24 score was 9 (moderate depression).<br><br>(continued on next page) |

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Record review of Resident #1's Hospital H&P dated 4/13/23 revealed resident was admitted for suicidal ideation which included smothering himself with a bag and licking a roll of deodorant. The resident was frustrated over payments to the nursing home. Resident was admitted for SI. [Resident was discharged to the facility on [DATE] with a diagnosis of SI.]

Record review of Resident#1's Nurse Note, dated 3/21/24 at 10:57 AM and authored by RN B revealed resident was found in his room .shaking uncontrollably stated 'I tried to kill myself'. Assessment and vitals taken and MD, NP (Nurse Practitioner)A, family member notified. [EMS and law enforcement called.]

Record review of Resident #1's Nurse Note, dated 3/21/24 at 1:21 PM and authored by RN B revealed resident was found in his room by CNA C approximately at 10:30 AM shaking and the resident stated, I know what's wrong with me, I tried to kill myself, I drank that whole bottle. A large empty mouthwash bottle was noted at bedside. EMS arrived approximately at 10:50 AM.

Record review of Resident #1's EMS run report dated 3/21/24 at 11:44 AM read: Arrived on scene to find SQ44 assessing 90YOM (EMS crew member assessing a [AGE] year old male)who had ingested approximately 100-200ml [mouthwash]in attempt to end his life .stable vitals .PT admitted to the suicide attempt .PT has history of SI.

Record review of Resident #1's ER report dated 3/21/24 reflected the resident wanted to commit suicide by ingesting one-third bottle of [mouthwash] and other cleaning agents. Recommendation: inpatient psychiatric hospital.

Record review of Resident#1's hospital lab, dated 3/21/24 revealed no abnormalities.

Record review of Resident #1's detention order dated 3/21/24 at 11:55 PM revealed emergency detention for SI.

Record review of Resident #1's law enforcement report, Report #SAPD24062237 dated 3/21/24 at 12:05 PM, read .When I (Law Enforcement H) made contact with [Resident #1], he stated he didn't want to live anymore and wants to die due to conditions of the nursing home, his life and he confirmed he ingested items. I assessed that [Resident #1] had to be emergency detained or he would do more harm to himself if left alone.

Record review of Resident #1's psychiatric notes from date range 1/04/24 to 3/14/24 and authored by Psychiatric NP G revealed treatment plan was reviewed and no recommendations made to update the CP. NP G stated that, in the weekly sessions, the resident did not expressed SI or a plan of suicide. NP G stated the dates of weekly sessions were: 1/04, 1/11, 1/18, 1/25, 2/01, 2/08, 2/15, 2/22, 2/29, 3/07 and 3/14/24.

Record review of facility's Census List revealed that Resident #1 was discharged on [DATE].

During an interview on 4/09/24 at 11:12 AM, NP A stated that, given the resident had a suicidal history, she should have been informed of the mouthwash or any other substance that could create harm to the resident. The NP stated that she was aware of the resident's suicide history.

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 4/09/24 at 11:52 PM, RN B stated she saw an empty mouthwash bottle on 3/21/24 around 10:30 AM; the resident was shaking and not himself and slumped over in the W/C in his room . roommate was sleeping . RN B stated Resident #1 pointed to the empty bottle and said, I know what is wrong with me .I drank the bottle. RN B stated that she was not aware whether an assessment was done when the [family member] brought the mouthwash to the resident. RN B stated that she was aware the resident had a suicidal history. RN B stated, as a nurse I would want to know what was brought to the resident from the outside to prevent any harm to the resident. RN B was not aware of any audit or inventory done on Resident#1's room given he had a suicidal history.<br><br>During an interview on 4/09/24 at 12:32 PM, CNA C (6A-2P) stated she provided ADL care to Resident #1 for over one year and was not aware of his suicidal history. The CNA stated that if she was aware of the resident's suicidal history, she would check more often for items that they could use to harm themselves.<br><br>During interview on 4/09/24 at 2:16 PM with CNA D (2P-10P shift) and at 2:39 PM with CNA E (10P-6A shift), they revealed they were not aware that Resident #1 had a suicidal ideation history. Both CNA D and CNA E stated that, if they had knowledge of the resident's history, they would have closely monitored the resident and observed for objects in the room that could lead to the resident harming himself.<br><br>During telephone interview on 4/09/24 at 3:50 PM, Resident #1 stated he attempted suicide on 3/21/24 around 10:30 AM by drinking two swallows of mouthwash. The resident stated he had attempted suicide one time before at the nursing home. The resident stated the suicide attempt on 3/21/24 was spontaneous and he had not planned the attempt. Resident #1 stated that items from the outside were not checked and nursing staff had not inventoried his room.<br><br>During an interview on 4/09/24 at 4:27 PM, LVN F stated she attended training on suicidal prevention and the highlights were to monitor and report and make sure the resident was safe.<br><br>During interview on 4/09/24 at 4:50 PM, Psychiatric NP G stated she was aware Resident #1 had a suicidal history and referral was made to her about one year ago. The NP stated that definitely yes a resident with suicidal ideations needed for the facility to check items coming in his room. Also, the NP stated that an inventory should have been done of the resident's room for items that belonged and items that did not belong in the room.<br><br>Record review of Resident #2's face sheet, dated 4/10/24, and EMR (electronic medical record) revealed the resident was readmitted on [DATE] with diagnoses of end-stage renal disease, diabetes 2, and Major Depression. Resident was a female, age 89. RP was listed as the resident. BIMS score of 11 dated 1/08/24. PHQ9 score of 8 (moderate depression) dated 1/04/24.<br><br>Observation of Resident #2's room and interview on 4/10/24 at 9:45 AM revealed 1 shampoo bottle, 2 lotion bottles, and a mouthwash bottle one-third empty. The resident stated she felt sad sometimes .yes, sometimes I feel like killing myself .don't remember when .and don't know why .no plans to hurt myself today . don't know how to hurt myself .the mouthwash and shampoos were brought by my [family] .no problems today.<br><br>(continued on next page) |

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|---|---|
| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 4/10/24 at 9:10 AM, the DON stated the only item found in Resident #1's room was an empty bottle of mouthwash in the trash can. The DON stated that on 3/20/24 and 03/21/24, the CNA assignment sheet did not specifically direct the CNAs to check for signs and symptoms of suicide ideation involving Resident #1. The DON stated that the mouthwash came in from the outside. The DON stated that [family member] did not tell the facility of items brought in from the outside that could have been in the resident's drawer. The DON stated there was no specific policy to inventory items that came in from the outside for residents that had suicidal ideations, homicidal ideations, or substance use disorders. The DON stated, based on recent PHQ9 for 25 residents with Major Depression, none had a severe score requiring higher levels of supervision or interventions. The DON stated that all 22 rooms housing where the 25 residents resided were inventoried on 3/21/24 and no items that could create harm to the residents were found. The DON stated that the facility only did an informal investigation of the incident on 3/21/24 and the investigation included checking the rooms of all LTC residents, in-service on suicidal ideation, call law enforcement, EMS, RP, and MD.<br><br>During telephone interview on 4/10/24 at 10:10 AM, the Medical Director stated Resident #1 attempted suicide by drinking a small amount of mouthwash to get attention. The MD stated the residents with Major Depression diagnosis needed to be screened and preventative measures put in place. The MD stated that preventative measures for a high risk resident with depression should include room closer to nurse station, frequent vital signs and monitoring, and checking items brought in from the outside. The MD stated that he was not aware of any high risk residents for depression with suicidal ideations or history in the facility as of 3/21/24 after Resident #1's transfer to the ER.<br><br>Attempted telephone interview on 4/10/24 at 10:27 AM, message left for Resident#1's family member to call Surveyor I.<br><br>During an interview on 4/09/24 at 10:30 AM, the DON stated Resident #1 was still in a psychiatric hospital in another city. The DON stated the police was present on the day of the incident, 3/21/24. The DON stated Resident #1 was not anticipated to return to the facility because the VA contractor informed her that placement should be at a nursing home with a psychiatric unit. The DON stated Resident #1 was sent to theER on [DATE] and was discharged from the nursing home.<br><br>During an interview on 4/10/24 at 12:30 PM, the Administrator stated that Resident #1's room was checked as part of daily nursing routine [rounds every two hours] and nursing staff did rounds every two hours.<br><br>During an interview on 4/11/24 at 2:01 PM, LVN F stated monitoring meant looking for changes and S/S of depression and SI. LVN F stated, it is a standard practice to make sure the resident had no harmful items . we did not have a practice to check items coming from the outside. Regarding Resident #2, LVN F stated she worked with Resident #2 since admissions and the resident had never voiced SI or revealed any signs or symptoms of SI.<br><br>During an interview on 4/11/24 at 2:29 PM, the DON stated that Resident #2 never voiced SI and no nursing staff member ever informed her that the resident was depressed or suicidal.<br><br>Record review of facility's SI in-services, date range 3/21/24 to 3/27/24, revealed 100% signatures for a total staff number of 127.<br><br>(continued on next page) |

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Record review of facility's list dated 4/09/24 revealed 25 residents with a diagnosis of Major Depression residing in 22 rooms.

Record review of facility's Abuse policy, revised 10/2022, reflected .Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .

Record review of the facility's Suicide Threats policy, undated, read Resident suicide threats shall be taken seriously and addressed appropriately .If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician has determined that a risk of suicide does not appear to be present .

The facility did not have a policy on checking for items or inventory of resident rooms for residents that were at risk suicidal ideation, homicidal ideation, or substance use disorder or other highs risk diagnoses.

The Administrator was given the IJ template and was notified of the IJ on 4/10/24 at 6:25 PM and a POR was requested.

On 04/11/24 at 3:18 PM, the POR was accepted. It was documented as follows:

[Facility]

Plan of Removal

4/10/2024

Per IJ Template- F689

Immediate Action

oMedical Director notified of Immediate Jeopardy on 4/10/2024 at 7:30 pm.

oResident RP [family member] was notified of incident on 3/21/2024.

oResident #1 is no longer in the facility.

oAll rooms for residents with History of Suicidal ideations and a Major depression Diagnosis were searched on 4/11/24 and completed for any items that can be ingested any items found will be removed.

oResidents #2 RP [ family member] was notified of comment made by Resident #2 The resident stated she felt sad sometimes . yes, sometimes I feel like killing myself .don't remember when . and don't know why . no plans to hurt myself today . don't know how to hurt myself . the mouthwash and shampoos were brought by my family.

oResident # 2 was interviewed on 4/10/24 by the DON, did not voice any suicidal ideations. Room searched for any items that can be ingested and removed on 4/10/24.

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|

F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

oCall was placed to Psych (Psychological )Services for Resident #2 on 4/10/24 at 8:15 Pm for evaluation and will be evaluated no later than 4/11/24, 5PM.

oFamily members for the residents with History of Suicidal ideations and a Major depression Diagnosis were notified on 4/11/24 of room search and of any items that can be ingested and removed.

oFamilies of identified residents were asked to please inform facility of items being brought into the facility. Notification started on 4/10/24 and will be completed no later than 4/11/24 by noon.

oThe following in-services were conducted Abuse and neglect, Removal of potential harmful items, Suicide ideations Policy on Suicide threats, Change of Condition, and Assignment sheets will indicate residents with Suicidal ideations and a Major depression. In-services will be completed by noon on 4/11/2024. Any employee not receiving in-services will not be allowed to work their shift until in-services have been received. In-services will be in person or via (by) phone.

oAll trainings will be verified for completion by the DON/Designee on going starting 4/11/24.

oOff Cycle QAPI completed on 4/11/2024 10am.

Identification of Others Affected:

All residents with History of Suicidal ideations and a Major depression Diagnosis have the potential to be affected by this alleged deficient practice.

Systemic Change to Prevent Re-occurrence.

1.DON / ADON in-services were conducted Abuse and neglect, Removal of potential harmful items , Suicide [ideation] Policy on Suicide threats, Change of Condition, and Assignment sheets will indicate residents with Suicidal ideations and a Major depression .in-services will be completed no later than 4/11/24 by noon. Any employee not receiving in services will not be allowed to work until In-service was received .

2.Starting 4/11/24 any new admissions with History of Suicidal ideations and a Major depression Diagnosis will be reviewed to ensure any needed intervention was initiated. Families will be asked upon admission to please inform facility of items being brought into the facility this will be in the admission packet. Nurse Manager on weekend duty will contact DON /designee of new admissions

3.All new hired employees beginning 4/11/2024 will receive the following in-services : Abuse and neglect, Removal of potential harmful items, Suicide [ideation] Policy on Suicide threats , Change of Condition and Assignment sheets will indicate residents with Suicidal ideations and a Major depression before starting on the floor.

Monitoring:

1.DON /Designee will review all admissions and readmissions starting 4/11/2024 with History of Suicidal ideations and a Major depression to ensure proper interventions are initiated. Nurse Manager on weekend duty will contact DON of new admission and readmission on the weekend.

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676312 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation - West S | | STREET ADDRESS, CITY, STATE, ZIP CODE 222 Bertetti Dr San Antonio, TX 78227 | |

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 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 2.Summary of IJ and corrective action to be reviewed by QAPI monthly until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance.<br><br>Verification of Plan of Removal:<br><br>Observation on 4/11/24 at 4:10 PM revealed items of shampoo, lotion and perfume were removed from Resident #2's room and bagged.<br><br>Observation on 4/12/24 at 10:00 AM of the front desk check-in kiosk revealed the added question I acknowledge that I will check in with the designated nurse, at the nurse's station if I am bringing in personal need items in order to verify all items are approved.<br><br>Observation on 4/12/24 from 2:00 PM to 2:30 PM of residents [25] with Major Depression diagnoses rooms revealed that 22 rooms had no items that could pose a danger to the residents.<br><br>During an interview on 4/11/24 at 10:00 AM, RP for Resident #5 stated he was informed of the room inventory, items removed, and the need to check with nursing when bringing items from the outside.<br><br>During an interview on 4/11/24 at 4:30 PM, the DON stated Designee will review all admissions and readmissions starting 4/11/2024 with history of suicidal ideations and a Major Depression diagnosis to ensure proper interventions are initiated. Nurse Manager on weekend duty will contact DON of new admissions and readmissions on the weekend.<br><br>During an interview on 4/11/24 at 4:35 PM, the HR Manager stated, All new hired employees beginning 4/11/2024 will receive the following in services: Abuse and neglect, Removal of potential harmful items, Suicide ideation policy on suicide threats, Change of condition and assignment sheets will indicate residents with suicidal ideations and a Major Depression diagnosis before starting on the floor.<br><br>During an interview on 4/11/24 at 4:45 PM, RP for Resident #2 stated that he was informed of the room inventory, items removed, and the need to check with nursing when bringing items from the outside.<br><br>In interviews on 4/11/24 to 4/12/24 from 10:00 PM to 11:45 AM with 5 day shift (6 AM to 2 PM) nursing staff (1 LVNs, 2 CNAs, 2 Other (1 cook and 1 maintenance)), 5 night shift (2 PM to 10 PM) nursing staff (2 RNs, 1 CNA, 1 NA, and 1 Other (laundry)), and 5 night shift (10 PM to 6 AM) nursing staff (1 RN, 2 LVNs, and 2 CNAs), they confirmed they had been in-serviced on reporting abuse and neglect, harmful items to remove from a resident's room with SI history or Major Depression, familiarization with the Suicide Threat policy, signs and symptoms of change of condition, and the nurse aide assignment sheet containing the check box for SI/Major Depression monitoring.<br><br>Record review of text message sent to MD on 4/10/2024 at 7:30 PM revealed the MD was contacted.<br><br>Record review of Resident #1's progress note dated 3/21/24 at 13:21 revealed Resident #1's emergency contact was notified of the incident.<br><br>Record review of facility census dated 4/11/24 revealed Resident #1 was discharged from the facility on 3/21/24.<br><br>(continued on next page) |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676312 | A. Building<br>B. Wing | 04/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Legend Oaks Healthcare and Rehabilitation - West S | 222 Bertetti Dr<br>San Antonio, TX 78227 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of Resident #2's progress note, authored by the DON, revealed the RP was notified to check whether the resident made statements of SI in the past. There were no current plans to harm herself or SI.<br><br>Record review of Resident #2's progress note dated 4/10/24 revealed referral to psychiatric services for 4/11/24.<br><br>Record review of Resident#2's NP G psychiatry noted dated 4/11/24 revealed Resident #2 was assessed and found not to be suicidal or have a suicide plan. NP G's recommendation was to continue with psychiatric services.<br><br>Record review facility's checklist of notification dated 4/10/24 revealed all affected resident RPs were notified and the notifications were captured in each resident's progress note.<br><br>Record review of off cycle QAPI meeting was done on 4/11/24 at 10:00 AM and included administrator, MD, and DON. The pharmacy representative was briefed on the meeting on 4/12/24.<br><br>Record review of facility's new admission log revealed no admissions on 4/11/24 for residents with Major depression or SI.<br><br>Record review of facility's new hire log revealed no new hires on 4/11/24 and included the in-services the new employee had to complete. Record review of facility's new admission packet revealed a section on list of items to be checked if brought into the facility.<br><br>An IJ was identified on 4/10/24. While the IJ was removed on 04/12/24, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility's need to monitor the implementation of the plan of removal. |