STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676392	A. Building B. Wing	08/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - New Br	2468 Fm 1101 New Braunfels, TX 78130

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26481 Based on observations, interviews, and record reviews the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 7 Residents (Resident #2) reviewed for treatments and services. The facility failed to ensure Resident #2 received dressing changes to the abrasion on her arm every Monday, Wednesday and Friday as ordered by physician. This failure could affect residents with wound dressings and place them at risk for infection. Findings included: Record review of Resident #2's Admission Record (face sheet), dated 08/01/2024, revealed she was admitted to the facility on [DATE] with diagnoses which included atherosclerotic heart disease (hardening of the arteries), high blood pressure, cognitive communication deficit (difficulty speaking because of impaired brain function) and repeated falls. On Resident #2's Admission Record, Friend C was listed as her second emergency contact. Record review of Resident #2's MDS, an Admission assessment dated [DATE], revealed her BIMS score was 12 out of 15 indication her cognitive skills for daily decision making were intact. Record review of Resident #2's care plan for the focus area of a potential for pressure ulcer development, initiated on 07/28/2024, revealed under interventions was to Administer treatments as ordered and monitor for effectiveness. Record review of Resident #2's Skin Evaluation, dated 07/29/2024, revealed the resident had an abrasion on her right elbow and the resident stated it occurred during a fall she had prior to her admission to the facility. Record review of Resident #2's physician orders revealed an order with a start date of 07/29/2024 to cleanse abrasion to the right elbow with wound cleanser, pat dry, apply xeroform (a specialized sterile, medicated gauze) and cover with a dry dressing three times weekly and PRN. Under Directions was every day shift, every Mon [Monday], Wed [Wednesday], Fri [Friday] for wound treatment and every 24 hours as needed for wound treatment. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's June 2024 TARs revealed wound care to Resident #2's right elbow was documented as completed by Wound Care Nurse LVN A on 07/31/2024 (Wednesday). Observation and interview on 08/01/2024 at 10:45 a.m., revealed Resident #2 was in her room with Friend C, and Resident #2 had a bandage on her right elbow dated 07/29/2024. Friend C was asked about the bandage on Resident #2's elbow, he stated What date is that, July 29th, I think someone needs to look at that. Further observation and interview on 08/01/2024 at 12:38 p.m. of Resident #2 revealed she still had a bandaged on her right elbow dated 07/29/2024 and Resident #2 stated she did not think the bandage had been changed since she was admitted . In an interview on 08/01/2024 at 12:39 p.m. with CNA B, who was in Resident #2's room, stated the date on bandage on Resident #2's right elbow was dated 07/31/24 after she looked at the bandage. In an interview on 08/02/2024 at 12:09 p.m., Wound Care Nurse LVN A stated on 07/31/24, she had checked off in Resident #2's electronic clinical record that the wound care was done before she went into the room to do the wound care. When LVN A went into the room, the resident was not there, she went back two more times on 07/31/24 and Resident #2 was still not in the room and the nurse stated she forgot the wound care had not been done. In a further interview on 08/02/2024 at 4:25 p.m., Wound Care Nurse LVN A stated the harm from not providing wound care was that it could disrupt the wound healing process, cause adverse reactions, and lead to an infection. In an interview on 08/03/2024 at 12:08 p.m., the DON stated the Wound Care Nurse LVN A had documented in Resident #2's electronic clinical record the wound care was completed on 07/31/24 before it was actually done, and when the nurse went to do the wound care, she could not find the resident in her room or in the therapy room and forgot to do the wound care. When asked what harm could happen if wound care was not provided as ordered, the DON stated Resident #2's wound care involved Xeroform, which had an antimicrobial product that decreased the risk of infection. In an interview on 08/03/2024 at 12:55 p.m., the Administrator stated the harm of not providing wound care to a resident as ordered by the physician would depend on the severity of the wound or how the orders were not followed. The Administrator stated Wound Care Nurse LVN A had documented in the electronic clinical record the wound care was done before she did it and when she tried to find the resident, she got side-tracked. Record review of the facility's Skin and Wound Management Policy, revised 01/2022, revealed on page 4, under Procedure was j. Treatments per physician order, should be documented in the resident's clinical record at the time they are administered.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26481 Based on observation,s, interviews and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #2) of 7 residents reviewed for accuracy and completeness of clinical records. The facility failed to accurately document Resident #2' s wound care status in her treatment administration record. Resident #2's wound care to her right elbow was documented as completed when it had not been provided to the resident. This failure placed facility residents at risk for lack of wound care or incorrect wound care due to misinformation by incomplete and inaccurate medical record. Findings included: Record review of Resident #2's Admission Record (face sheet), dated 08/01/2024, revealed she was admitted to the facility on [DATE] with diagnoses which included atherosclerotic heart disease (hardening of the arteries), high blood pressure, cognitive communication deficit (difficulty speaking because of impaired brain function) and repeated falls. On Resident #2's Admission Record, Friend C was listed as her second emergency contact. Record review of Resident #2's MDS, an Admission assessment dated [DATE], revealed her BIMS score was 12 out of 15 indication her cognitive skills for daily decision making were intact. Record review of Resident #2's care plan for the focus area of a potential for pressure ulcer development, initiated on 07/28/2024, revealed under interventions was to Administer treatments as ordered and monitor for effectiveness. Record review of Resident #2's Skin Evaluation, dated 07/29/2024, revealed the resident had an abrasion on her right elbow and the resident stated it occurred during a fall she had prior to her admission to the facility. Record review of Resident #2's electronic record physician orders revealed an order with a start date of 07/29/2024 to cleanse abrasion to the right elbow with wound cleanser, pat dry, apply xeroform (a specialized sterile, medicated gauze) and cover with a dry dressing three times weekly and PRN. Under Directions was every day shift, every Mon [Monday], Wed [Wednesday], Fri [Friday] for wound treatment and every 24 hours as needed for wound treatment. Record review of Resident #2's June 2024 TARs revealed wound care to Resident #2's right elbow was documented as completed by Wound Care Nurse LVN A on 07/31/2024 (Wednesday). (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 08/01/2024 at 10:45 a.m., revealed Resident #2 was in her room with Friend C, and Resident #2 had a bandage on her right elbow dated 07/29/2024. Friend C was asked about the bandage on Resident #2's elbow, he stated What date is that, July 29th, I think someone needs to look at that. Further observation and interview on 08/01/2024 at 12:38 p.m. of Resident #2 revealed she had a bandage on her right elbow dated 07/29/2024 and Resident #2 stated she did not think the bandage had been changed since she was admitted . In an interview on 08/01/2024 at 12:39 p.m. with CNA B, who was in Resident #2's room, stated the date on bandage on Resident #2's right elbow was dated 07/31/24 after she looked at the bandage. In an interview on 08/02/2024 at 12:09 p.m., Wound Care Nurse LVN A stated on 07/31/24, she had checked off in Resident #2's electronic clinical record that the wound care was done before she went into the room to do the wound care. When LVN A went into the room, the resident was not there, she went back two more times on 07/31/24 and Resident #2 was still not in the room and the nurse stated she forgot the wound care had not been done. In a further interview on 08/02/2024 at 4:25 p.m., Wound Care Nurse LVN A stated the harm from not accurately documenting wound care was provided in the clinical record the wound care could be overlooked. In an interview on 08/03/2024 at 12:08 p.m., the DON stated the Wound Care Nurse LVN A had documented in Resident #2's electronic clinical record the wound care was completed on 07/31/24 before it was done, and when the nurse went to do the wound care, she could not find the resident in her room or in the therapy room and forgot to do the wound care. When asked what harm could happen if wound care was documented in the clinical record as completed when it was not, the DON stated she could not think of any harm and stated the facility's standard of practice was not followed. In an interview on 08/03/2024 at 12:55 p.m., the Administrator stated the harm of documenting wound care of being completed when it was not done could result in the care could go undone as the risk. The Administrator stated the DON was looking for a policy on Accuracy of Clinical Records and he did not think the facility had one and the best practice was to make sure the clinical record was accurate. In an interview on 08/03/2024 at 1:25 p.m., the DON stated the facility did not have a policy on accuracy of clinical records and the best thing the company had was from their General Health & Information Record Manual, page 76, titled Timeliness of Entries and Electronic Signatures. The DON stated the manual was a corporate manual available for all management staff to use as guidance. Record review of the undated document titled Timeliness of Entries and Electronic Signatures document, revealed there was no page number on it and under Timeliness of Entries was Entries should be made as soon as possible after an event or observation is made. An entry should never be made in advance. Record review of the facility's Skin and Wound Management Policy, revised 01/2022, revealed on page 4, under Procedure was j. Treatments per physician order, should be documented in the resident's clinical record at the time they are administered.