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	02/06/2025

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

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observation, interview, and record review the facility failed to ensure the resident's right to be free from misappropriation of resident property for 2 of 3 residents (Residents #2 and #3), reviewed for drug diversion in that: 1. After Resident #2 was discharged from facility on 8/1/2024, the facility failed to remove Resident #2's medication blister pack of Hydrocodone/acetaminophen 10-325mg (a combination opioid pain medication used for treating moderate to severe pain, also referred to as Norco) and its corresponding count card from the medication cart, resulting in 8 tablets of this narcotic pain medication being available to be diverted by RN- B for her own personal use. 2. The facility failed to prevent the misappropriation of 5 tablets of Resident #3's Hydrocodone/Acetaminophen 7.5-325mg from being diverted by RN-B for her own personal use. This failure could place residents at risk of misappropriation, and not receiving their prescribed pain medication as ordered. The findings were: 1.Record review of Resident #2's face sheet dated 02/06/2025 revealed the resident was an [AGE] year-old woman admitted to the facility on [DATE]. Her diagnoses included: Pyogenic Arthritis (also known as infectious arthritis which occurs when an infection spreads to a joint causing inflammation); Infection and Inflammation Reaction due to Internal Left knee Prosthesis; and Pain due to internal Orthopedic Prosthetic Devices, Implants and Grafts. Record review of Resident #2's Census sheet showed she was discharged from facility on 08/01/2024. Record review of Resident #2's Admission MDS assessment dated [DATE] revealed she had a BIMS score of 15 indicating intact cognition and was assessed as having received PRN pain medications OR was offered and declined in the last 5 days and described her pain frequency as almost constantly. Record review of Resident #2's Care Plan initiated 07/23/2024 revealed focus areas which included: the resident is currently prescribed an Opioid; potential for adverse outcomes from opioid use; and has acute/chronic pain. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Order Summary dated 7/31/2024 revealed an order for Hydrocodone -Acetaminophen Tablet 10-325mg. Give 1 tablet by mouth every 8 hours as needed for Pain., Start date 7/22/2024. Record review of Resident #2's Narcotic Count Sheet (undated) for her Hydrocodone-Acetaminophen with first entry on 07/24/2024 revealed the medication was given starting on 7/24/2024 through 08/14/2024. Resident #1 was discharged on [DATE]. There was a tablet documented as having been given on 08/01/2024 at 07:30a.m., and this was also documented as given as a PRN medication at that same time on her MAR. All of the other entries on the narcotic count card for Resident #2's Hydrocodone-Acetaminophen being given in August were signed by RN-B, and occurred on: - 08/05/2024 at 21:00 (9:00 pm) - 1 tab - 08/06/2024 at 16:00 (4:00 pm) - 1 tab - 08/06/2024 at 2130 (9:30 pm) - 1 tab - 08/07/2024 at 2000 (8:00 pm)- 1 tab - 08/08/2024 at 1500 (3:00 pm) - 1 tab - 08/08/2024 at 2200 (10:00 pm) - 1 tab - 08/13/2024 at 1430 (2:30 pm) - 1 tab - 08/14/2024 at 1800 (6:00 pm) - 1 tab 2.Record review of Resident #3's face sheet dated 02/03/2025 revealed the resident was a [AGE] year-old woman initially admitted to the facility on [DATE], with a re-admitted [DATE]. Her diagnoses included: Dementia (a general term for loss of memory, language and problem-solving skills); Wedge Compression Fracture of First and Fourth Lumbar Vertebrae (a type of spinal fracture where the front part of a vertebra collapses, creating a wedge-like shape); Pain in right hip; and Low back pain Record review of Resident #3's Quarterly MDS assessment dated [DATE] revealed she had been assessed with a BIMS score of 12, indicating moderate cognitive impairment, and for pain management was noted to have not received PRN pain medications OR was offered and declined in the last 5 days. Record review of Resident #3's Care Plan initiated 10/03/2022 revealed focus areas which included; the Resident is currently prescribed an Opioid; potential for adverse outcomes from Opioid use and has chronic pain r/t osteoarthritis and interventions which included Administer analgesia medication as per orders. Record review of Resident #3's Order Summary as of 07/01/2024 revealed an order for Norco Tablet 7. 5-325mg (HYDROcodone-Acetaminophen). Give 1 table by mouth every 6 hours as needed FOR SEVERE PAIN. Record review of Resident #3's Narcotic Count (undated) for her PRN Hydrocodone-Acetaminophen with first entry on 10/12/2023 revealed tablets were given starting on 10/12/2023 through 08/12/2024. The entries on the narcotic count card were as follows: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5 tablets total given in October 2023, just one a day, on 10/12/2023, 10/14/2023, 10/19/2023, 10/22/2023 and 10/28/2023. - 4 tablets total given in February 2024, 3 of those given on 2/15/2024 throughout day by different nurses - 1 tablet only given during the month of March 2024 on 3/29/2024. - 5 tablets given between 08/07/2024 through 08/12/2024 all signed by RN-B. These administrations were not documented on Resident #3's MAR Observation and Interview with Resident #3 on 02/03/2025 at 10:14 a.m. revealed she was nicely groomed and she appeared calm and was smiling. Resident #3 stated she does not have pain anymore, but when she does, the Nurses are very good about giving her pain medication when she needs it. She stated she has never been without her pain medications when she asked for them. Record review of the facility self-report intake dated 8/15/2024 revealed that in the evening of 8/14/2024, during a review of narcotic count sheets, it was discovered that RN-B had diverted hydrocodone from a discharged patients' medication. The Nurse was suspended pending an investigation. The RN in question admitted to diversion of the medications from the discharged patient and another current resident. Pain assessments were done and no pain concerns were vocalized or observed for affected residents. Audits were completed of medication carts. Police, MD, family, Ombudsman and pharmacy consultant and internal compliance notified. In-servicing provided. Noted facility will replace diverted medication at no cost to residents. Interview on 02/06/2025 at 07:25a.m. with LVN-E revealed he has worked at the facility for 8 years, night shift from 10p - 6am on the short-term rehab side. LVN-E stated that he did do controlled medication counts with RN-B at shift change, she was the off-going Nurse and he was the in-coming Nurse. He stated he did not find any discrepancies in the medication counts when he worked with her. LVN-E stated he was suspicious of RN-B though because she was spacey and looked like she had to be on something. LVN-E stated the process for handling/storing of controlled medications for discharged residents, was he takes the narcotic count sheet for that medication, wraps it over the medication blister pack and puts it in the back of the all the other controlled medications so they know that patient has been discharged . He stated the medication should continue to be counted at every shift and it stays locked in the medication cart until the DON or ADON removed it. LVN-E could not remember if he had wrapped the count sheet around the narcotic for Resident #2 back in August, but did state he does check the 24-hour report for discharged residents before his shift. .During an interview with the DON on 02/04/2025 at 2:30 p.m. the DON reviewed the timeline of events of the drug diversion as follows: - RN-B was hired on 08/05/2025, she completed RELIAS training, then started on the floor paired with other Nurses for her first week, from 08/05/2024 through 08/09/2024. The DON stated RN-B worked only on 400 Hall. -On the following week, starting on 08/12//2024, RN-B started working the floor on 400 Hall on her own. The DON stated she believed this was when RN-B took the narcotics, and just back-dated on the narcotics count sheet. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 08/13/2024, the DON counselled RN-B regarding documentation not being completed, and doing non-work activities during work, and RN-C started monitoring her more closely. - On 08/14/2024, the DON stated RN-C discovered drug diversion with Resident #2's Hydrocodone-Acetaminophen, because she knew Resident #2 had been discharged earlier but noted that the count sheet showed medications were still documented as having been given to her. She stated that RN-C notified her that evening, and she came back to facility to start investigation. The DON stated they started an audit on the medication carts, and she and RN-C started questioning RN-B, who admitted to taking the narcotics for her own use, was termed, and escorted out of building. - On 08/15/2024 - The paperwork for the termination of RN-B was completed. In-servicing of staff started. Interview on 02/04/2025 at 3:47p.m. with RN-C revealed she was the ADON in August 2024 who first discovered that RN-B had diverted medications. RN-C stated that RN-B was a new hire but had previous experience as a Nurse in a nursing facility and had completed about 4-5 days of orientation/training. RN-C stated she had started observing RN-B more closely after about her 4th or 5th day of training due to problems RN-B seemed to be having with time management. She stated she was observing for things like was RN-B documenting as she went, and not waiting till end of shift, and was also auditing her medication cart, checking the documentation on the narcotic count sheet and on the MAR. She stated while auditing RN-B's medication cart on 08/14/2024, she noted RN-B had documented that she gave pain medications to Resident #3 for several days in past week, but RN-C stated she knew Resident #3 well and knew she does not ask for pain medications anymore. It looked off to her, so she called the DON who had left the facility already but came back to facility. RN-C stated she and the DON pulled RN-B aside and started questioning her. RN-C stated RN-B initially denied diverting narcotics, but when questioned further, RN-B confessed to taking the narcotics for her own use and told them she had been in a motor vehicle crash and her back hurt her, she needed the pills for the pain. RN-C stated they checked all the residents, audited all the medication carts and did pain assessments on everyone. RN-C stated that they conducted in-services that night regarding the correct way to medication narcotic counts at shift change, proper documentation in the count back and in electronic record and removal of medications for discharged residents. RN-C also stated they notified families of those affected, notified police, physicians and providers. During Interview with the DON on 02/05/2025 starting at 08:16a.m the DON confirmed that on the August 2024 Narcotics count sheets for both Residents #2 and #3, both the on-coming staff and off-going staff had signed the count sheet which the DON stated meant both had counted the controlled medications at each shift change from 08/05/2024 through 08/14/2024. The DON stated that the staff should have recognized during the controlled medication counts that Resident #2 had been discharged but was still having medications signed off as having been given after her discharge. The DON further stated that they conducted a root cause analysis and found the cause of the diversion to be Nurse's not conducting narcotic counts correctly, not focusing on the task. The DON stated she conducted lots of in-services on doing controlled med counts correctly which included reading resident's name, medication/dosage and visualizing the number of medications. She stated she also conducted in-service training on handling of narcotics for discharged residents. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated the in-service on handling of narcotics for discharged residents, was that staff were to notify her, keep the narcotics in the locked container in the med cart until, she, and only she removes it, as she is the only person to have both keys to the controlled medication storage in the Administrators office. The DON stated the in-service included that she will pick up the controlled medication for the discharged resident the next business day, and if she was on leave or not available, the DON stated that the controlled medication stays in the medication cart and continues to be counted until she can pick up the medication and count card. The DON stated she had taken some leave around the time Resident #2 was discharged on [DATE] and her discharge had been missed, which was why the narcotics stayed in the medication cart until the theft was discovered on 08/14/2024. The DON further stated the staff were not supposed to mark on the narcotics count sheet, or medication card that the resident had been discharged , or remove the card from the count book, just keep the narcotic medication locked in the cart, and the narcotic count card in the count book and count it with the other controled medications. She stated she expected the Nurse's to check the 24-hour report and dashboard at the beginning of their shifts to see which residents had been discharged , and to be aware of who had been discharged while conducting the controlled medication counts at each shift change. The DON stated the staff were to notify her of any controlled medication count discrepancies. The DON also stated that they did not have a policy that specifically addressed the process for disposition of controlled medications for discharged patients. Record review of the In-Servicing Training titled discharged Residents Narcotics dated 08/16/2024 and presented by the DON revealed If the resident is being discharged or discharged from the facility, Notify the DON the DON will be the only one to pick up the Narcotics. The Card and Narcotic counting sheet must stay as is Standard of Practice must count every shift. DON will pick up the Narcotics next business day. Record review of facility Termination Form for RN-B dated 08/15/2024 revealed RN-B was a full-time employee whose last day worked was 08/14/2024 and termination date was 08/15/2024. It was documented as an Involuntary Termination, for Gross Misconduct. Under additional explanation for termination, it was written Disclosed she took the narcotics in question. The Termination Form for RN-B was signed on 8/15/2024 by the DON and HR Director. Record review of the facility policy titled Controlled Medication Storage revised 11/13/2018 revealed At each shift change, a physical inventory of all controlled medications is conducted by licensed nurses and/or certified medication aides and is documented on the controlled substances accountability record. The licensed and/or certified staff member A will look at the medication itself and call out the resident's name, medication, and the amount of medication that is there. Staff member B will look at the controlled medication count record form to verify that the amount and all information is exactly the same as the amount that staff member A has called out. Also, at each shift change the nurse and/or certified medication aides that is going off and the nurse and/or certified medications aides that is coming into work will sign the controlled drugs-count record which acknowledges that each of them have counted the controlled drugs on hand and have found that the quantity of each medication counted is in agreement with the quantity stated on the controlled drugs-count record.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observations, interviews, and record review, the facility failed to review and revise resident care plans after each assessment for 1 of 5 residents (Resident #4) reviewed for care plan revision/timing. The facility failed to ensure Resident #4's care plan addressed changes in her bowel incontinence and subsequent increase in risk for skin breakdown. This deficient practice could affect residents' care and services and may cause a delay in treatment and/or decline in health. Findings included: Record review of Resident #4's face sheet dated 002/03/2025 revealed she was an [AGE] year old woman, initially admitted on [DATE] and readmitted on [DATE] with diagnoses which included: Dementia (general term for loss of memory, language, problem-solving and other thinking abilities); pleural effusion (a buildup of fluid between the tissues that line the lungs and the chest); and osteomyelitis (inflammation of bone caused by infection). Record review of Resident #4's Admission MDS assessment dated [DATE] revealed she had a BIMS score of 7, indicating moderate cognitive impairment, and she was assessed as being dependent meaning helper does all the effort in toileting hygiene. Further review revealed she was assessed as being at risk of developing pressure ulcers/injuries. Record review of Resident #4's Braden Scale for predicting Pressure Sore Risk dated 12/12/2024 revealed her sensory perception was assessed as slightly limited meaning she could not always communicate discomfort or the need to be turned or had sensory impairment which limited her ability to feel pain or discomfort in 1 or 2 extremities. Resident #4's Moisture degree was assessed as rarely moist: skin is usually, dry: linen only requires changing at routine intervals. Record review of Resident #4's Order Summary as of 1/29/2025 revealed orders for - Apply Triad to sacrum and buttocks TID for prevention every shift for monitoring. Start date 01/10/2025. - Imodium A-D Oral Tablet 2MG (Loperamide HCL) Give 1 tablet by mouth every 6 hours as needed for diarrhea Start date 01/27/2025; and Record review of Resident #4 eMAR - Medication Administration note dated 01/26/2025 revealed Change of condition for; (Diarrhea) Provider notified Record review of Resident #4's eMAR-Medication Administration Note dated 01/27/2025 at 1533 (3:33p.m.) revealed .NP aware of diarrhea-Imodium PRN ordered. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's eMAR-Medication Administration Note dated 01//28/2025 at 0437 (4:37 a.m) revealed Note Text: Imodium A-D Oral Tablet 2 MG Give 1 tablet by mouth every 6 hours as needed for diarrhea .PRN Administration was: Ineffective. Record review of Resident #4's eMAR-Medication Administration Note dated 01//28/2025 at 16:58 (4:58pm) revealed Resident has been having diarrhea, Doxycycline on hold for 2 days Record review of Resident #4's N Adv Skilled Evaluation dated 01/30/2025 at 1420 (2:20pm) revealed under Gastrointestinal: Diarrhea noted, and under Skin section Skin note: pressure ulcer to coccyx. The Note also noted that Resident #4 was sent to hospital. Interview on 02/04/2025 at 11:29 a.m. with CNA-F revealed she worked the evening shifts on 1/27/2025 and 1/28/2025 on Resident #4's hall, and stated that she did not get Resident #4 up into her chair for her meals those days, because Resident #4 had massive diarrhea, noting that she cleaned Resident #4 at least 4 times that evening, but even as she cleaned her, she would continue to have diarrhea. CNA-F also stated that Resident #4 had developed a red rash around her peri area and buttocks and having a lot of pain. CNA-F stated that she reported the diarrhea to the Nurse who told her that the diarrhea was caused by a medication she was on. During an interview with CNA-G on 02/04/2025 at 12:01 p.m. with CNA-G revealed that she worked day shift on the Tuesday (1/28/2025) before Resident #4 was sent to hospital, and Resident #4 had non-stop diarrhea and her bottom was very red. She stated the Nurse told her the diarrhea was a result of a medication she was on. Interview on 02/04/2025 at 1:59p.m. with NP - H revealed that Resident #4 had been on the antibiotic Doxycycline for osteomyelitis for 20 days when she developed pneumonia and was prescribed another antibiotic Levaquin by the on-call doctor. NP-H stated the on-call doctor did not know she was already on Doxycycline, so she discontinued the Levaquin when she got the alert he had ordered it. NP-H stated Resident #4 was on both antibiotics for only about one day and had already started having some on/off diarrhea before the Levaquin was ordered. She stated she ordered probiotics and high fiber diet for the diarrhea. NP-H stated she was not aware of any pressure ulcer on her sacral area, but had been informed that she had redness and MASD (moisture-associated skin damage). Stated she ordered Triad paste and Nystatin/ Triamcinolone. She stated she felt the rash was fungal in nature. Interview with LVN-I on 02/06/2025 at 9:14 a.m. revealed she was the Wound Care Nurse and had been working at the facility for about 2 months. LVN-I stated that she was aware that Resident #4 had developed MASD from chronic diarrhea about a week and a half before she went to hospital, and the Nurses were treating with Triad. She stated that she was seeing Resident #4 daily for wound dressing changes on her legs but conducted full-body assessments only once a week. She stated that the last time she assessed Resident #4 was on 1/28/2025 and that Resident #4 had the red rash, but did not have a pressure ulcer on her sacrum at that time. LVN-I stated she was also aware of the diarrhea that Resident #4 had been experiencing and had spoken to the NP to see if something else could be ordered for the rash other than the Triad. She stated the NP told her she would order Triamcinolone and Nystatin, and an air mattress, but Resident #4 was sent to the hospital before that could be ordered. LVN-I stated other interventions she made was to instruct the CNA's to use soap and water instead of wipes to clean Resident #4's peri area and buttocks, She also stated that the Wound Care NP had ordered at the beginning of January the standard supplements to support wound healing, such as Zinc, Pro-State and vitamins. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's Care Plan initiated 12/12/2024 revealed the following focus areas in the care plan had not been updated since their initiation date to reflect development of new actual impairment in skin integrity in peri-area, buttocks and sacrum: - .is on antibiotic Therapy r/t wound infection initiated 12/16/2024. - .has a potential for pressure ulcer development r/t weakness, B&B incont initiated 12/13/2024. - .has actual impairment to skin integrity r/t wound on R posterior LE; and R Lateral foot superior and wound on R heel and R lateral foot inferior aspect initiated 12/31/2024. Interview with the DON on 02/06/2025 at 4:44p.m revealed that they had done a skin condition IDT on Resident #4 on 01/02/2025, and addressed the chronic non-pressure wounds she was admitted with on her right leg and foot, and discussed interventions including nutritional supplements, bilateral prevalon boots (heel protection boots for pressure relief) and antibiotic for osteomyelitis. The DON also stated that Resident #4 experienced a change of condition on 1/24/2025 with the development of acute diarrhea and a red rash on her peri-area, buttocks and sacral area. The DON stated that Resident #4's Care Plan had not been updated to reflect the acute changes of condition Resident #4 had recently experienced but should have been. The DON stated that the MDS Nurse was currently on vacation, and that she was responsible for updating Care Plans for acute changes, but had been unaware of the rapid onset of the diarrhea and development of red rash in Resident #4's peri area and buttocks. Record review of the facility policy titled Comprehensive Person-Centered Care Planning revised 5/2022 revealed It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44020 Based on observation, interview and record review the facility failed to ensure residents who need respiratory care were provided such care, consistent with professional standards of practice for 1 of 2 residents (Resident #1) reviewed for respiratory care. Facility failed to ensure Resident # 1 received respiratory therapy as ordered. This facility could result in residents receiving inadequate treatment. Findings included: Record review of Resident #1's face sheet, dated 02/07/2025, revealed Resident #1 was admitted on [DATE] with diagnoses which included: metabolic encephalopathy, severe sepsis with septic shock, pneumonia, syncope and collapse. Record review of Resident #1's Admission MDS assessment, dated 01/26/2025, revealed Resident #1's BIMS score was 03 for severe cognitive impairment. Record review of Resident #1's physician order summary report, dated, 02/05/2025, revealed a physician order reading, O2 at 2-4L/MIN via nasal cannula as needed for SOB, Respiratory Distress, Cyanosis, Labored Breathing. Record review of Resident #1's progress notes, dated 02/05/2025, revealed a nursing note reading, [Resident's name] this afternoon in room with O2 at 83% on room air, family was at bedside, patient not in distress. Patient's cannula was swapped to concentrator in room, 4L initially until patient's sats went up to 97%, patient was then put down to 2L and stayed at 96-97% range, family at bedside, patient not SOB, continue to monitor. Observation on 02/03/2025 at 10:38 a.m. revealed Resident #1 sitting in the dining room on the skilled unit at a table in her w/c wearing nasal cannula with oxygen tank to the back of w/c. Oxygen tank to the back of the w/c revealed setting of 4 liters with the gauge in the yellow area (the oxygen level is nearing a low point, requiring caution and planning to refill soon) for the oxygen level in the tank. Interview on 02/03/2025 at 1:15 p.m. the family member of Resident #1 stated, when she came in yesterday Resident #1 was sitting in the dining room with no oxygen and when staff was asked the family member was informed Resident #1 was doing well on room air, however when the staff member took her oxygen sats (a measure of the amount of oxygen in the blood) she was at 87%. Resident #1's family member stated the staff member then provided an oxygen tank. (continued on next page)

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	02/06/2025

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 02/05/2025 at 1:55 p.m. revealed Resident #1 sitting in her w/c next to the side of her bed wearing nasal cannula while connected to the oxygen tank on the back of w/c. Oxygen tank out view of the family who was sitting on the bed visiting with Resident #1. Resident #1's family stated Resident #1 was mentally clearer since using the oxygen regularly. Observation of the oxygen tank revealed it to set to 3 liters and empty with the gauge at the bottom of the red area to the gauge. Observation and interview on 02/05/2025 at 2:00 p.m. LVN A stated Resident #1's oxygen was ordered as PRN (as needed). LVN A was observed checking the oxygen tank on the back of Resident #1's w/c in which he stated it was empty and she would need a new one. LVN A was observed then taking blood oxygen sats (a measure of the amount of oxygen in the blood) with pulse oximeter (measures how much oxygen is in the bloodstream as it travels around the body) with the pulse oximeter reading 83%, LVN A then removed the oxygen tubing from the portable tank and attached it to the oxygen concentrator against the wall behind the w/c setting to 4 liters while he again to took her oxygen sats with the pulse oximeter until it elevated to 97% and then turned the setting down to 2. LVN A stated oxygen sats were taken once a shift. LVN A stated Resident #1 had been at lunch and should have been put back on the concentrator when she returned to her room. LVN A stated he believed she had been placed on the tank before lunch. LVN A further stated the tanks should last for about 3 or 4 hours at 2 liters (flow of oxygen gas per minute). LVN A stated he should have paid more attention to the tank of Resident #1 or should have asked his CNA to check when she went in the room. LVN A stated he was not sure who had brought Resident #1 back to her room, but she should have been put on the oxygen concentrator. Interview on 02/06/2025 at 10:57 a.m. the PTA stated therapy would check resident's oxygen sats (a measure of the amount of oxygen in the blood) throughout the sessions especially if the resident was having difficulty breathing. The PTA stated Resident #1 was wearing oxygen on 02/05/2025 during her therapy session and she had a full tank. Further stating Resident #1's rate was usually set to 4 liters (flow of oxygen gas per minute). Interview on 02/06/2025 at 1:49 p.m. the DON stated nursing was responsible for changing and swapping out the oxygen tanks when needed. She further stated anybody could eyeball the oxygen tank or observe it's levels. The DON stated typically a tank was good for 8 hours if it was set at 2 liters (flow of oxygen gas per minute), but if it was cranked up it would lessen the time for use. The DON stated typically the physicians prefer for the oxygen sats to be above 90%. She further stated oxygen was important for the body's oxygenation (the process of delivering oxygen to the body's tissues) and to lessen the risk of altered mental status. Interview on 02/06/2025 at 3:44 p.m. via telephone with the nurse practitioner for Resident #1 stated she would like for a resident's oxygen sats remain greater than 90% and liters are adjusted to keep the oxygen sats at 90% or higher. The nurse practitioner further stated in general an oxygen sat of 83% would be too low. The nurse practitioner reviewed Resident #1's orders and stated Resident #1 had an order for 2 to 4 liters as needed, every shift was to check the oxygen sats every shift, however the sats were to be checked as needed also. The nurse practitioner further stated Resident #1 was using oxygen due to having a known respiratory condition and had pneumonia with sepsis. The nurse practitioner stated when oxygen was low for a prolong period it could cause poor oxygenation (the process of delivering oxygen to the body's tissues) to areas of the body. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's policy titled Oxygen Administration, revised 05/2007, read Policy: It is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency measure until the order can be obtained., Purpose: The purpose of the oxygen therapy is to provide sufficient oxygen to the blood stream and tissues.,

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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** 33866 Based on interviews and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 3 residents (Resident #3) reviewed for accuracy of records, in that: The facility failed to ensure the medication administration records (MAR) for Resident #3 accurately reflected the administration of her PRN medication Hydrocodone-Acetaminophen (also known as Norco) on 5 different administrations in February and March 2024. This failure could put residents at risk of improper medication administration based on inaccurate documentation and prevent accurate tracking of residents' condition and need for pain management. The findings were: Record review of Resident #3's face sheet dated 02/03/2025 revealed she was a [AGE] year-old woman initially admitted to the facility on [DATE], with a re-admitted [DATE]. Her diagnoses included: Dementia (a general term for loss of memory, language and problem-solving skills); Wedge Compression Fracture of First and Fourth Lumbar Vertebrae (a type of spinal fracture where the front part of a vertebra collapses, creating a wedge-like shape); Pain in right hip; and Low back pain Record review of Resident #3's Quarterly MDS assessment dated [DATE] revealed she had been assessed with a BIMS score of 12, indicating moderate cognitive impairment, and for pain management was noted to have not received PRN pain medications OR was offered and declined in the last 5 days. Record review of Resident #3's Care Plan initiated10/03/2022 revealed focus areas which included: the Resident is currently prescribed an Opioid; potential for adverse outcomes from Opioid use; has chronic pain r/t osteoarthritis and interventions which included Administer analgesia medication as per orders. Record review of Resident #3's Order Summary as of 07/01/2024 revealed an order for Norco Tablet 7. 5-325mg (HYDROcodone-Acetaminophen). Give 1 tablet by mouth every 6 hours as needed FOR SEVERE PAIN. Record review of Resident #3's Narcotic Count Sheet for her PRN Hydrocodone-Acetaminophen started on 10/12/2023 revealed tablets were listed as having been given on the Narcotic Count Sheet starting on 10/12/2023 through 08/12/2024. The entries on the narcotic count card were as follows: - 4 tablets total given in February 2024, 3 of those given on 2/15/2024 at 0800 (08:00am), 1610 (4:10 pm) and 2300 (11:00pm) by different nurses and 1 on 2/18/2024. - 1 tablet given during the month of March 2024 on 3/29/2024. Record review of Resident #3's MAR's for February and March 2024 revealed there were no entries made on her MAR indicating that PRN Hydrocodone-Acetaminophen had been administered to Resident #3 on the dates listed in February and March 2024 on the Narcotic Count sheet. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 02/05/2025 at 1:45pm, the DON reviewed the February and March 2024 MAR's for Resident #3, and the February and March 2024 Narcotics Count Card for Resident #3's Hydrocodone-Acetaminophen, and she confirmed that there were no entries documented on the February and March 2024 MAR's for Resident #3 which corresponded with the dates and times the Hydrocodone-Acetaminophen was documented as having been given to Resident #3 on the Narcotics Count Card. The DON stated that the correct process would be for the Nurse to assess and document the resident's pain level, administer the PRN pain medication to the Resident, and document that PRN pain medication both on the MAR and on the Narcotic Count sheet, and then re-assess and document the resident's pain level later and document. The DON stated that she believed the pain medication was administered as noted on the Narcotic Count Sheet, because it was documented by different Nurses. The DON stated that by not documenting the administration of PRN pain medication on the MAR, it may result in a Resident's frequency of pain not being assessed correctly by her medical team and could lead to drug diversion. The DON further stated that she had been made aware in August 2024 or problems with inaccurate documentation on the MARs of PRN medications, so developed a new process of having the ADON's audit the administration of narcotics and checking to see if documented correctly using the dashboard. Record review of the facility policy titled Nursing Services .Subject: Administration of Drugs revised 07/2015, revealed When PRN medications are administered, the nurse must record: A. Justification/reason the medication is given. B. The date and time administered via eMAR C. Any results achieved from administering the drug and the time such results were observed; and D. The signature (via eMAR) of the person administering the drug.