STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676421	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - Waxaha	151 Country Meadows Boulevard Waxahachie, TX 75165

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41513 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 3 residents (Resident #2) reviewed for care plans. Resident #2 did not have completed comprehensive care plans for resident needed supervision or touching assistance while eating. This deficient practice could place residents at risk of not having their individual care needs met in a timely manner or diminished quality of life. Finding included: Record review of Resident #2's undated face sheet reflected a [AGE] year-old male, who initially admitted to the facility on [DATE] with a diagnosis including Hypertensive (high blood pressure) emergency, need for assistance with personal care, muscle weakness, hyperlipidemia (elevated level of lipids), and hypothyroidism (underactive thyroid gland). Review of Resident #2's care plan with a revision date on 03/25/24 reflected resident has a nutritional problem, hypothyroidism, and risk for malnutrition feeds self. Review of Resident #2's MDS dated [DATE] reflected a BIMS of 7, indicating she was moderately cognitively impaired. Section GG (Functional Abilities and Goals) reflected she required supervision or touching assistance while eating. Review of Resident #2's Dietary Communication dated 03/12/24 reflected, feeding assistance: set up and supervision. Review of Resident #2's Nutrition and hydration risk evaluation dated 03/12/24 and signed by ADON reflected a score of 13 and a category of high risk. Section II. Self-Feeding Ability reflected Fed by Staff or Tube Fed. Review of Resident #2's Nutrition Risk assessment dated [DATE], section VI. Dinning ability reflected Set up/Supervision. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's Nursing progress notes dated 03/27/23 at 01:51 PM reflected, Eating: Self-performance supervision. Eating: Support Provided setup help only. Review of the nutrition/hydration risk evaluation list for residents who feeds self with verbal cues and resident fed by staff or tube feed dated 03/28/24 reflected Resident #2 as fed by staff or Tube fed with an assessment date on 03/12/24. During an interview on 03/28/24 at 1:10 PM CNA D stated Resident #2 did not require supervision or assistance during meals. She stated if Resident #2's RP was not at the facility she would assist resident to open any containers. She stated the staff would go to Point Click Care (PCC) to identify if the residents required assistance during their meals. Surveyor requested that CNA D show Resident #2's type of assistance required during meals on PCC . Review of the Resident #2's PCC dated 03/28/24 at 1:12 PM reflected Resident #2's care profile Special instructions: SBA dressing/bathing/toileting: extensive x1- Supervision with hot liquids/fed by staff. During an interview on 03/28/24 at 1:13 PM with CNA D reflected, after review of PCC, CNA D stated Resident #2 required supervision and assistance during meals. She stated that when the resident's RP was not at the facility she assisted and supervised the resident and added that resident's RP was always at the facility. During an interview on 03/28/24 at 1:17 PM CNA E stated Resident #2 did not required assistance or supervision during meals and stated Resident #2 was able to eat by herself. She stated she just open things for her and cut Resident #2's food. Surveyor asked CNA if she cut the food for the resident today and CNA stated she cut Resident #2's food for this meal. During an observation on 03/28/24 at 1:24 PM at Resident #2's room (room [ROOM NUMBER]) revealed Resident #2's food tray with a plate of meat balls, bread, greens, and noodles. Meet balls were not cut. During an observation and interview on 03/28/24 at 1:28 PM at Resident #2's room (room [ROOM NUMBER]) revealed Resident #2's eating by herself trying to cut the meat balls with her spoon. The family member was not at the facility. Resident #2 stated the staff had offered to assist her with her meals only once since she had been admitted to the facility. She stated it would be nice for the staff to cut her food or assisted her since she could not see that well. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/28/24 at 1:37 PM DON stated the residents was on the list of high-risk residents for nutrition/hydration risk evaluation required staff assistance and supervision during their meals. She stated Resident #2 should be fed by the staff and required staff assistance and supervisions during her meals including cutting Resident #2' food. She stated Resident #2 required assistance during her meals because when the resident was admitted to the facility the resident was weak and confused. She stated staff was able to find this information on the resident care profile and on the resident care plan. She stated Resident #2's care plan and care profile should reflect that resident required assistance during her meals. She stated that DON and ADON were responsible to update residents' care plans. She stated staff was trained to look at resident care profile to identify what assistance residents need during their meals. She stated there would not be negative outcome if the care plan was not updated with the assistance required during meals since the information would be on the care profile and staff was educated to use the care profile. She stated the purpose of the care plan was for the staff to identify residents' problems and what interventions were in place and for the staff to know how to take care of the residents. During an interview on 03/28/24 at 3:48 PM CNA F stated staff would find the type of required assistance for a resident during meals on PCC under care plans. During an interview on 03/28/24 at 4:23 PM CMA G stated the staff would check care plans to identify if residents required assistance or supervision during meals. She stated if a resident required assistance and supervision the staff could not leave the room. She stated they had to cut residents food before providing the tray to the residents who required assistance. During an interview on 03/28/24 at 4:35 PM CMA H stated the staff would check residents' care profile to identify if the residents required supervision or assistance during meals. She stated if a resident required assistance or supervision, they had to feed the resident at the dining room or stay in the resident's room. During an interview on 03/28/24 at 4:41 PM ADON stated she was responsible to do Residents' nutrition and hydration risk assessment. She stated it was determined on the assessment if the residents need supervision during their meals and that information should be reflected on the care plan. She stated the information reflected on the nutrition and hydration risk assessment should be the same information reflected on the resident care profile. She stated if a resident was determined to need assistance or supervision on the nutrition and hydration risk assessment, it should be reflected on the care plan. She stated if this information was not reflected in the care plan there was a risk for the residents to suffer aspiration or choking. She stated Resident #2 required supervision with verbal cues, and added, this was due to resident degeneration and the resident was not able to see very well. She stated that Resident #2 was able to feed herself with cues. She stated this was determined today (03/28/24) during the QAPI meeting. ADON stated she conducted resident's assessment for Nutrition and Hydration Risk Evaluation. She stated the QAPI meeting was after lunch today (03/28/24). She stated that before the QAPI meeting today (03/28/24) Resident #2 required staff assistance with her meals. Review of Resident #2's updated Nutrition and Hydration Risk Evaluation, dated 03/28/24 and signed by ADON, reflected a score of 8 and a category of Medium Risk. Section II. Self-Feeding Ability reflected Feed self with verbal cues. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's updated care plan with a revision date on 03/28/24 reflected resident has a nutritional problem, hypothyroidism, and risk for malnutrition feeds self-with verbal ques. Review of the Inservice Training Report, dated 03/05/24, titled Diet, Tray Cards, Adequate Supervision and Assistive Devices reflected: Adequate Supervision Resident are assessed via the LN Nutrition/Hydration Risk Assessment in PCC. This information and ability to self-feed or need for supervision or assistance is entered into the care profile and entered into the plan of care. Staff will use this information to provide the care assistance/supervision needed for each resident. Review of the Policy/ Procedure for Care planning dated 07/2020 reflected: Policy: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident. Procedure: 8. Initial care plan/Interim care plan- initial care plan is started within 24 hours of admission to provide an overview of residents' care needs. Initial plan of care can be started on PCC/POC and/or through the use of resident care guidelines, shift to shift report. 9. The resident's plan of care-focus, goals, and interventions- are communicated and implemented by member of the health care continuum accordingly. 10. The resident's care plan of care is reviewed and revised on an ongoing basis, quarterly at aa minimum and or/as needed with changes in condition.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46565 Based on observation, interview, and record review, the facility failed to ensure the residents environment remained as free of accident hazards as was possible and ensure each resident received adequate supervision for one (Resident #1) of five residents reviewed for accidents and hazards, in that: The facility failed to assist and monitor Resident #1 during meal service on 02/20/24 when she was served dinner despite a hospice order dated 02/11/24 stating that she should be assisted with meals and not left alone with food, and Resident #1 choked and was subsequently sent to the ER where she was diagnosed with aspiration pneumonia and remained hospitalized until 02/25/24. An Immediate Jeopardy (IJ) was identified on 03/05/24. While the IJ was removed on 03/06/24, the facility remained out of compliance at a scope of isolated with potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed residents at risk of choking, aspiration pneumonia, and hospitalization . Findings included: Review of Resident #1's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a brain disorder that gets worse over time), heart failure, dysphasia (difficulty with swallowing), and the need for assistance with personal care. Review of Resident #1's significant change in condition MDS assessment, dated 02/13/24, reflected a BIMS of 9, indicating she was moderately cognitively impaired. Section GG (Functional Abilities and Goals) reflected she required supervision or touching assistance while eating. Section K (Swallowing/Nutritional Status) reflected she required a mechanically altered diet. Review of Resident #1's quarterly care plan, revised 02/05/24, reflected she had an ADL self-care performance deficit with an intervention of staffing assisting with ADLs as needed. Review of Resident #1's ER records, dated 02/09/24, reflected she was admitted due to aspirating while eating cake at the facility. Review of Resident #1's undated hospice binder revealed a narrative note dated 02/11/24 starting at 3:42 pm until 7:10 pm and the note stated Resident #1 was on mechanical soft diet with comfort food and thickened liquids. It further revealed she needed to be fed or at least assisted with feeding. She was not to be left in room alone with food due to the threat of choking. Review of Resident #1's hospice orders dated 02/11/24 reflected an order that stated assist patient with feeding, do not leave alone while eating. Review of Resident #1's hospice notes documented by HN A, dated 02/13/24, reflected the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	. Discussed [HN A]'s observation of [Resident #1] coughing with fluid intake this morning during RNV. Advised to continue with mechanical soft diet and honey thickened liquids as well as aspiration teaching/precautions to be followed with all po intake. [Resident #1] to have 1:1 assistance with all meals . Review of Resident #1's progress notes, dated 02/20/24 at 6:33 PM and documented by NURSE B, reflected the following: This nurse along with another nurse observed [Resident #1] had excess phlegm and coughing; [Resident #1] suctioned by nursing staff for excess phlegm . FM #1 states they do not want [Resident #1] to have any bread at mealtime . Review of Resident #1's progress notes, dated 02/20/24 at 8:01 PM and documented by NURSE B, reflected the following: [Resident #1] vomiting and in respiratory distress. Hospice Nurse A was called and came to evaluate the resident. FM #1 also at bedside. Transfer to (hospital) . During an interview and observation on 03/05/24 at 8:16 am with FM #1 he stated Resident #1 was on a mechanical soft diet and that she choked on a piece of cake on 02/09/24 and went to the emergency room and was hospitalized . At this time, FM #1 decided to have Resident #1 admitted to hospice services on return to the facility. He stated that he told the DON that he did not want Resident #1 to have bread any more due to the choking incident. He reiterated this at a meeting on 02/19/24 with the FM #1, FM #2, FM #3, FM #4, the Hospice Nurse, the DON and ADM because on the camera footage he could see Resident #1 had bread on her tray and was concerned about her choking. He stated on 02/20/24 around 5:00 pm FM #2 checked the camera and saw Resident #1 eating alone with bread on her plate. He also showed a picture dated 02/14/24 at 8:26 am that showed Resident #1 unsupervised while eating a meal. In addition, on 02/26/24, the day after she returned from the hospital, she was brought a tray with a sandwich on it and the FM #1 stated a family member called the facility about the concern. He also showed a picture dated 02/29/24 that had a meal ticket that stated, No Bread and Do Not Give Bread and the meal had 2 slices of wheat bread. During an interview and observation on 03/05/24 at 4:00 pm with FM #2 she stated that on 02/19/24 she was part of a meeting with the Hospice Nurse, the DON, the ADM and FM #1, FM #3, and FM #4 during which she voiced her concerns related to Resident #1 choking and reiterated that the family did not want Resident #1 to have bread. FM #2 the stated that on 02/20/24 at 5:00 pm she saw Resident #1 eating alone in her room and she saw bread on the plate. She showed her phone with a text message dated 02/20/24 at 5:04 pm with the DON in which she said she was worried because Resident #1 was alone in her room with her meal and had bread on her tray and FM #2 stated she was concerned about Resident #1 choking. The DON responded on 02/20/24 at 5:27 pm and apologized and said she informed the aides and let them know again. She stated Resident #1 was sent to the ER that evening. She showed a video dated 02/20/24 at 4:59 pm that showed Resident #1 alone in her room with bread on her meal tray. During an interview on 03/05/24 at 4:00 pm with FM #3 and FM #4 they both stated they attended the meeting on 02/19/24 with the DON, the ADM, the Hospice Nurse, FM #1 and FM #2 and the family voiced their concerns about assistance with meals and ensuring Resident #1 was not provided any bread due to their concern about choking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview 03/05/24 at 12:11 pm with Hospice Director she stated that Resident #1 was admitted to hospice services on 02/11/24 and the original hospice orders dated on admission were to give Resident #1 a mechanical soft diet with thickened liquids and to assist Resident #1 with all meals and not to leave her alone while she was eating. Review of hospital progress notes printed 02/26/24 for Resident #1 revealed the results of a chest x-ray dated 02/20/24 at 9:03 pm that stated new patchy airspace opacities compatible with aspiration or pneumonia. Further review of the hospital notes revealed a progress note by the physician dated 02/24/24 at 2:09 pm and revealed Resident #1 was admitted with an episode of choking on bread leading to aspiration pneumonia (inflammation causing infection in the lungs) Review of the facility policy dated January 2022 titled end of life care; hospice and/or palliative care revealed an interdisciplinary assessment would be utilized to develop an individualized plan that would be implemented to prevent and relieve symptoms and family would be an integral part of the plan .assessment should include Preferences and goals of care of the resident and family . resident's functional status and what help was required . family members will be an active part of the care planning team . hospice services would be integrated into the care plan. Review of the facility policy dated 10/2022 titled Physician Orders revealed that drugs and treatments shall be administered/carried out upon the order of a person duly licensed and authorized to prescribe such drugs and treatments. During an interview on 03/05/24 at 3:45 pm with Nurse C she stated hospice orders should be handed to the nurse on duty and that nurse should contact hospice physician and verify the orders, then contact the facility physician to inform him/her of the hospice orders, then the nurse should input the orders from hospice in the EHR. During an interview with the DON and ADM on 03/05/24 at 2:26 pm the DON stated that tickets should be checked by dietary staff in the kitchen and the nurse in the hall before food was given to a resident. The DON stated she was not aware the family did not want the resident to have bread until dinner on 02/20/24. The also stated she was not aware of the order for assistance with meals from hospice because it was not in the EHR. This was determined to be an Immediate Jeopardy (IJ) on 03/05/2024 3:11 PM. The ADM and DON were notified and provided with the IJ template on 03/05/24 at 5:15 PM. The following POR was accepted 03/06/24 at 9:05 am an the IJ was lifted on 03/06/24 at 12:17 pm: Plan of Removal F689 : 03/05/24 Per the information provided in the IJ Template given on 3/5/2024, the facility failed to ensure each resident receives adequate supervision and assistive devices to prevents accidents. 1. The Medical Director was notified of the Immediate Jeopardy on 3/5/2024 at 7:21pm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. Summary of IJ and corrective action to be reviewed by QAPI Committee weekly x 4 weeks or until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance. Monitoring the POR In an interview on 03/07/24 at 10:10 AM, MD stated that he was informed of the IJ by the facility administration on 03/05/24. In an interview on 03/06/24 at 8:27 AM DON and ADM stated that Resident #1's family had decided to change her to no food by mouth on 03/06/24 as her end of life was imminent. In an interview on 03/07/24 1:42 PM Clinical Resource RN stated that she had completed an in-service with the DON, ADON, Cluster DON on the ensuring diet orders were current and accurate, that residents who required supervision receive the supervision that they required and resident who required assistive devices for meals had those assistive devices. Clinical Resource RN stated that she reviewed all competency checks that were administered to ensure staff passed prior to allowing them to work the floor. In an interview on 03/07/24 at 1:50 PM DON stated that she had received training from Clinical Resource RN ensuring diet orders were current and accurate, that residents who required supervision receive the supervision that they required and resident who required assistive devices for meals had those assistive devices. DON stated that she along with the ADONs and Cluster DONs educated all facility staff via telephone and in-person in-services on the importance of ensuring that residents were being served meals according to their meal ticket, that when a meal cart was received from the kitchen that the nurse on duty completes a quality assurance check to ensure that meal served aligns with meal ticket and then when the aide passes the meal out the aide was also verifying accuracy. DON stated that Cluster DON and ADON's completed all nutritional assessment on all residents in the facility, revised care plans to be more specific for all residents. DON stated that she administered competency checks to all nursing staff and those who were they were unable to reach would be educated prior to working their next shift. Interviews were conducted with staff across multiple shifts on 03/07/24 from 8:03 AM through 1:21 pm Dietary Manager, 3 CNA's, 2 RN's and LVN, ST had all been in-serviced by either the DON or ADON. Staff stated they were educated on the importance of ensuring that residents were being served meals according to their meal ticket, that when a meal cart was received from the kitchen that the nurse on duty completes a quality assurance check to ensure that meal served aligns with meal ticket and then when the aide passes the meal out the aide was also verifying accuracy. In an interview on 03/06/24 at 12:05 PM with Cluster DON revealed that she had assisted DON with nutrition assessments, revised care plan, in-serviced staff on the importance of ensuring that residents were being served meals according to their meal ticket, that when a meal cart was received from the kitchen that the nurse on duty completes a quality assurance check to ensure that meal served aligns with meal ticket and then when the aide passes the meal out the aide was also verifying accuracy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/07/24 at 12:20 PM revealed lunch was being served to residents. Dietary staff was observed taking the meal cart to the nurses station, Charge Nurse was observed verifying meal served with meal tray ticket and CNA was observed passing the meals to the residents. Observation of the assisted dining room revealed 5 residents were seated at their table. Staff were observed sitting eye level, feeding residents. Review of LN-Nutrition/Hydration Risk Evaluation dated 03/06/24 revealed the facility had completed 107 nutritional risk, 6 residents identified as High Risk. Review of Resident #1's nurses note for 03/06/24 at 10:25 AM and 11:54 AM revealed that family had refused the resident's meal tray. Review of Resident #1's nurses note for 03/05/24 at 5:22 PM reflected: Note Text: Notified family at bedside that hospice had given order for pleasure feeds only due to their request of resident not receiving any foods unless she requests it. Explained that pleasure feeds would only be given upon request. Family voiced understanding and stated that the resident was not wet at this time, and they did not want resident disturbed and that they request pudding ad thickened fluids if needed. MD notified of new hospice orders. Review of a train-the-trainer in-service dated 03/05/24 revealed the corporate nurse trained DON, ADONs, Cluster Partners, Staffing Coordinators and Executive Director on Diets, Tray Cards, Adequate Supervision, and Assistive Devices. Further review revealed all staff trained passed the post-training knowledge check. Review of in-service training record revealed an in-service on 03/05/24 related to Diets, Tray Cards, Adequate Supervision and Assistive devices. Further review revealed post-test knowledge checks for all in-serviced staff. Separate in-services were reviewed for CNAs, Therapy, Nurses, and Medication Aides; it was documented if the staff member was in-serviced in person or over the telephone. Review of a signed document revealed that the medical director was notified of the IJ 03/05/24 at 7:21 pm by the DON and was signed by the DON. Review of resident roster revealed every resident in the facility was assessed for dietary needs by DON. Review of report titled assessment history: nutrition/hydration risk evaluation revealed the evaluation was completed for every resident in the facility on 03/05/24. Review of facility report titled care plan item/task listing report printed 03/06/24 revealed that every care plan for every resident care was updated based on nutrition assessment by DON for dietary needs. Review of an in-service on physical assist and supervision dated 03/05/24 revealed that staff were educated that all residents that require physical assist or supervision were required to eat in the dining room and nurses were required to check all meal trays before they were given to a resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676421	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - Waxaha	151 Country Meadows Boulevard Waxahachie, TX 75165

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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 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The ADM was informed the Immediate Jeopardy was removed on 03/06/2024 at 12:17 p.m. The facility remained out of compliance at a scope of isolated with potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.