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	06/17/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observation, interview, and record review, the facility failed to maintain a treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement for his or her quality of life, recognizing each resident's individuality for 2 of 12 Residents (Resident #2 and Resident #3) who were reviewed for quality of life. 3. The facility failed to ensure Resident #2's soiled personal clothing was taken to the laundry. 4. The facility failed to ensure Resident #3's soiled personal clothing was taken to the laundry. This failure could place residents at risk of odorous living conditions, embarrassment, and diminished feelings of self-worth. Findings included: 1. Record review of Resident #2's AR, dated 6/17/2024, reflected a [AGE] year-old -male, who was admitted to the facility on [DATE]. He was diagnosed with Alzheimer's Disease with late onset (which was a progressive disease having had caused mild memory loss, ability to continue conversations, or the ability to respond to the environment,) and Chronic Respiratory Failure (which was a condition that impeded the body's ability to effectively exchange oxygen and carbon dioxide.) Record review of Resident #2's Quarterly MDS, dated [DATE] indicated the following: Section C, Cognitive Function: Resident #2 had a BIMS Score of 14. A BIMS Score of 14 indicated Resident #2 had no cognitive impairment. Section GG, Functional Abilities and Goals: Resident #2 required supervision or touching assistance for toileting hygiene, upper body dressing, and lower body dressing. Supervision or touching assistance meant the helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. Section H., Urinary and Bowel Continence: Resident #2 was occasionally incontinent of bladder; and always continent of bowel. (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
	676421	A. Building B. Wing	06/17/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's CP reflected a focus area, initiated on 4/12/2022 for ADL care, evidenced by the need for personal assistance. The goal, initiated on 4/12/2022, indicated Resident #2 would maintain ADLs. The intervention for nursing staff, initiated 2/5/2024, was for staff to assist with ADLs as needed. Interview and observation on 6/17/2024 at 11:55 AM with Resident #2 revealed he had not had his laundry taken from the room for 8 days. He stated he had asked nursing staff members to take his clothes to the laundry, but it did not get done. Nursing staff would say they would do it later; and one staff said it was not their role but would tell the right person. He stated the dirty clothes, which would not get cleaned, made him angry and he felt neglected. Observation reflected his room had a strong odor of urine and body odors. His sheets had two brown stains at the foot of the bed. There was a medium sized white laundry basket overflowing with dirty clothing. Olfactory senses determined the clothing basket was the origin of the urine and body odors. The resident was fully dressed and appropriately groomed. 2. Record review of Resident #3's AR, dated 6/17/2024, reflected a [AGE] year-old-male, who admitted to the facility on [DATE]. He was diagnosed with Heart failure (which occurred when the heart muscle did not pump blood as well as it should,) and the Need for Personal Care (which was a medical code which signified he needed assistance with personal care.) Record review of Resident #3's Discharge/Return Anticipated MDS , dated 6/8/2024, Section C., Cognitive Function: Indicated a staff assessment for Cognitive Patterns. Staff assessed Resident #3 with Memory: OK and Independent Decisions were: Consistent and Reasonable. Section GG, Functional Abilities and Goals: Indicated Resident #3 was independent for toileting hygiene, upper body dressing, and lower body dressing. Independent meant the resident completed the activity. Section H., Urinary and Bowel Continence: Indicated Resident #3 was occasionally incontinent of bladder; and always continent of bowel. Record review of Resident #3's CP reflected a focus area, initiated on 3/5/2024 for ADL care, evidenced by self-care deficit. The goal, initiated on 3/5/2024, indicated Resident #3 would maintain ADLs. The intervention for nursing staff, initiated 3/5/2024, was for staff to assist with ADLs as needed, due to fluctuation of self-ability. Observation on 6/17/2024 at 9:50 AM in Resident #3's room reflected odors of urine and body odors. Resident #3 was not in his room at the time of the observation. Interview and observation on 6/17/2024 at 12:20 PM with Resident #3 revealed he had not had his laundry taken to the laundry for a while now. He stated that he has asked nursing staff to get it to the laundry but was told it was not their job. He said he would not let his grandkids come to see him at the facility because of the way the room stunk. He did not want to subject his grandkids to the smell. He stated he felt sad, lonely, neglected, and not important. Observation reflected a medium sized basket of dirty clothes, filled to the top, by the door. The room had strong odors of urine and body odors. Olfactory senses determined the clothing basket was the origin of the urine and body odors. The resident was fully dressed and appropriately groomed. Interview on 6/17/2024 at 2:45 PM with the LS revealed it was the job of the CNA to collect dirty linen, along with personal clothing, and bring the soiled/dirty items to the laundry room. The laundry service staff returned all clean items to the floor, which included resident's clean clothing. (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	06/17/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/17/2024 at 2:50 PM with the HKS revealed it was the job of the CNA to collect dirty clothing from the resident's rooms and bring them to the laundry. Interview on 6/17/2024 at 3:00 PM with LVN E revealed it was the CNAs responsibility to take dirty linens and dirty laundry from the resident's room to the laundry. A nurse could have taken it if the need had arrived, but it was the CNA's responsibility. The laundry was supposed to be removed every shift, if it started to pile up, or smell foul. LVN E stated baskets of dirty clothing, which smelled like urine or feces, risked causing nose irritation and nausea. As well, residents could become angry and family members might not think their loved ones were being taken care of. Interview on 6/17/2024 at 4:50 PM with CNA F revealed residents have dirty laundry baskets in their rooms. She did not know if it was the CNAs responsibility to collect dirty lines and clothes from residents' rooms and take it to the laundry. She thought laundry personnel collected the dirty linens and clothing. She stated she learned the practice through word of mouth. Interview on 6/17/2024 at 4:55 PM with CMA G revealed she had been a CNA at the facility at one time. She stated it was the responsibility of the CNA assigned to the resident to collect, and transport, dirty clothing from the resident's room to the laundry. Interview and record review on 6/17/2024 at 5:15 PM with the SC revealed CNA staff were assigned linen, which included resident's dirty clothing, each shift. Record review reflected a copy of the staffing schedule for 6/17/2024. The staffing schedule was an excel spreadsheet with a column for the staff member and a column for notes (explained the duty.) Each hallway had an assigned CNA staff member responsible for linens. Interview on 6/17/2024 at 6:51 PM with the DON revealed CNAs were responsible to take a resident's dirty clothing from their room to the laundry. Dirty clothes removal was supposed to be done daily but the clothes were supposed to be taken to the laundry if a resident asked, if the dirty clothes piled up in the basket, or if the clothes started to smell. Residents exposed to foul smelling laundry left in their rooms risked feelings of dissatisfaction or embarrassment. The strong pungent odor of urine, which smelled mostly like ammonia, could cause irritation of the nose, and even cause a resident to sneeze. Interview on 6/17/2024 at 7:20 PM with the ADM revealed she expected her staff to follow the schedule and take resident's dirty clothes to the laundry at the end of each shift. The ADM wanted CNA staff to make sure the resident had a homelike environment. Safeguards in place to deter dirty laundry build up were daily administration and management rounds to make observations of the rooms and make corrections as needed. Dirty clothing baskets were not something she had observed, and she felt the incident was isolated. There was no failure. Record review of staffing schedule for 6/17/2024 reflected the practice that a CNA was assigned linen, which included resident's dirty clothing, daily. Record review of the facility's ADL, Services To Carry Out Policy, dated 7/2020, reflected a resident were given the appropriate treatment and services to attain, or maintain, the highest practicable physical, mental, psychosocial well-being of each resident in accordance with a written plan of care. (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	06/17/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Laundry Management Policy, dated 6/2014, indicated the facility must make provisions for resident's personal clothing. Record review of the facility's Infection Control Policy, dated 10/2022, reflected facility personnel would handle, store, process, and transport linens so as to prevent the spread of infection.

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	06/17/2024

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

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observation, interview, and record review, the facility failed to maintain a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safety, for 2 of 12 Residents (Resident #2 and Resident #3) reviewed for safe and clean environment. 1. The facility failed to ensure Resident #2's soiled personal clothing was taken to the laundry. 2. The facility failed to ensure Resident #3's soiled personal clothing was taken to the laundry. This failure could place residents at risk of odorous living conditions, embarrassment, and diminished feelings of self-worth. Findings included: 1. Record review of Resident #2's AR, dated 6/17/2024, reflected a [AGE] year-old -male, who was admitted to the facility on [DATE]. He was diagnosed with Alzheimer's Disease with late onset (which was a progressive disease having had caused mild memory loss, ability to continue conversations, or the ability to respond to the environment,) and Chronic Respiratory Failure (which was a condition that impeded the body's ability to effectively exchange oxygen and carbon dioxide.) Record review of Resident #2's Quarterly MDS, dated [DATE] indicated the following: Section C, Cognitive Function: Resident #2 had a BIMS Score of 14. A BIMS Score of 14 indicated Resident #2 had no cognitive impairment. Section GG, Functional Abilities and Goals: Resident #2 required supervision or touching assistance for toileting hygiene, upper body dressing, and lower body dressing. Supervision or touching assistance meant the helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. Section H., Urinary and Bowel Continence: Resident #2 was occasionally incontinent of bladder; and always continent of bowel. Record review of Resident #2's CP reflected a focus area, initiated on 4/12/2022 for ADL care, evidenced by the need for personal assistance. The goal, initiated on 4/12/2022, indicated Resident #2 would maintain ADLs. The intervention for nursing staff, initiated 2/5/2024, was for staff to assist with ADLs as needed. (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	06/17/2024

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

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 6/17/2024 at 11:55 AM with Resident #2 revealed he had not had his laundry taken from the room for 8 days. He stated he had asked nursing staff members to take his clothes to the laundry, but it did not get done. Nursing staff would say they would do it later; and one staff said it was not their role but would tell the right person. He stated the dirty clothes, which would not get cleaned, made him angry and he felt neglected. Observation reflected his room had a strong odor of urine and body odors. His sheets had two brown stains at the foot of the bed. There was a medium sized white laundry basket overflowing with dirty clothing. Olfactory senses determined the clothing basket was the origin of the urine and body odors. The resident was fully dressed and appropriately groomed. 2. Record review of Resident #3's AR, dated 6/17/2024, reflected a [AGE] year-old-male, who admitted to the facility on [DATE]. He was diagnosed with Heart failure (which occurred when the heart muscle did not pump blood as well as it should,) and the Need for Personal Care (which was a medical code which signified he needed assistance with personal care.) Record review of Resident #3's Discharge / Return Anticipated MDS , dated 6/8/2024, Section C., Cognitive Function: Indicated a staff assessment for Cognitive Patterns. Staff assessed Resident #3 with Memory: OK and Independent Decisions were: Consistent and Reasonable. Section GG, Functional Abilities and Goals: Indicated Resident #3 was independent for toileting hygiene, upper body dressing, and lower body dressing. Independent meant the resident completed the activity. Section H., Urinary and Bowel Continence: Indicated Resident #3 was occasionally incontinent of bladder; and always continent of bowel. Record review of Resident #3's CP reflected a focus area, initiated on 3/5/2024 for ADL care, evidenced by self-care deficit. The goal, initiated on 3/5/2024, indicated Resident #3 would maintain ADLs. The intervention for nursing staff, initiated 3/5/2024, was for staff to assist with ADLs as needed, due to fluctuation of self-ability. Observation on 6/17/2024 at 9:50 AM in Resident #3's room reflected odors of urine and body odors. Resident #3 was not in his room at the time of the observation. Interview and observation on 6/17/2024 at 12:20 PM with Resident #3 revealed he had not had his laundry taken to the laundry for a while now. He stated that he has asked nursing staff to get it to the laundry but was told it was not their job. He said he would not let his grandkids come to see him at the facility because of the way the room stunk. He did not want to subject his grandkids to the smell. He stated he felt sad, lonely, neglected, and not important. Observation reflected a medium sized basket of dirty clothes, filled to the top, by the door. The room had strong odors of urine and body odors. Olfactory senses determined the clothing basket was the origin of the urine and body odors. The resident was fully dressed and appropriately groomed. Interview on 6/17/2024 at 2:45 PM with the LS revealed it was the job of the CNA to collect dirty linen, along with personal clothing, and bring the soiled/dirty items to the laundry room. The laundry service staff returned all clean items to the floor, which included resident's clean clothing. Interview on 6/17/2024 at 2:50 PM with the HKS revealed it was the job of the CNA to collect dirty clothing from the resident's rooms and bring them to the laundry. (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	06/17/2024

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

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/17/2024 at 3:00 PM with LVN E revealed it was the CNAs responsibility to take dirty linens and dirty laundry from the resident's room to the laundry. A nurse could have taken it if the need had arrived, but it was the CNA's responsibility. The laundry was supposed to be removed every shift, if it started to pile up, or smell foul. LVN E stated baskets of dirty clothing, which smelled like urine or feces, risked causing nose irritation and nausea. As well, residents could become angry and family members might not think their loved ones were being taken care of. Interview on 6/17/2024 at 4:50 PM with CNA F revealed residents have dirty laundry baskets in their rooms. She did not know if it was the CNAs responsibility to collect dirty lines and clothes from residents' rooms and take it to the laundry. She thought laundry personnel collected the dirty linens and clothing. She stated she learned the practice through word of mouth. Interview on 6/17/2024 at 4:55 PM with CMA G revealed she had been a CNA at the facility at one time. She stated it was the responsibility of the CNA assigned to the resident to collect, and transport, dirty clothing from the resident's room to the laundry. Interview and record review on 6/17/2024 at 5:15 PM with the SC revealed CNA staff were assigned linen, which included resident's dirty clothing, each shift. Record review reflected a copy of the staffing schedule for 6/17/2024. The staffing schedule was an excel spreadsheet with a column for the staff member and a column for notes (explained the duty.) Each hallway had an assigned CNA staff member responsible for linens. Interview on 6/17/2024 at 6:51 PM with the DON revealed CNAs were responsible to take a resident's dirty clothing from their room to the laundry. Dirty clothes removal was supposed to be done daily but the clothes were supposed to be taken to the laundry if a resident asked, if the dirty clothes piled up in the basket, or if the clothes started to smell. Residents exposed to foul smelling laundry left in their rooms risked feelings of dissatisfaction or embarrassment. The strong pungent odor of urine, which smelled mostly like ammonia, could cause irritation of the nose, and even cause a resident to sneeze. Interview on 6/17/2024 at 7:20 PM with the ADM revealed she expected her staff to follow the schedule and take resident's dirty clothes to the laundry at the end of each shift. The ADM wanted CNA staff to make sure the resident had a homelike environment. Safeguards in place to deter dirty laundry build up were daily administration and management rounds to make observations of the rooms and make corrections as needed. Dirty clothing baskets were not something she had observed, and she felt the incident was isolated. There was no failure. Record review of staffing schedule for 6/17/2024 reflected the practice that a CNA was assigned linen, which included resident's dirty clothing, daily. Record review of the facility's ADL, Services To Carry Out Policy, dated 7/2020, reflected a resident were given the appropriate treatment and services to attain, or maintain, the highest practicable physical, mental, psychosocial well-being of each resident in accordance with a written plan of care. Record review of the facility's Laundry Management Policy, dated 6/2014, indicated the facility must make provisions for resident's personal clothing. (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	06/17/2024

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

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Infection Control Policy, dated 10/2022, reflected facility personnel would handle, store, process, and transport linens so as to prevent the spread of infection.

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	06/17/2024

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observation, interview and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological's, to meet the needs of the resident for 1 of 1 Residents (Resident #1) reviewed for pharmaceutical services. The facility failed to administer the correct dosage of medication to Resident #1. This failure could place residents at risk for mental anguish and medically adverse reactions. Findings included: Record review of Resident #1's AR, dated 6/17/2024, reflected a [AGE] year-old-woman who admitted to the facility on [DATE]. She was diagnosed with restless leg syndrome (which was a condition that caused a very strong urge to move one's legs,) and Other Specified Anxiety Disorders (which was a medical condition marked by feeling of fear, dread, and uneasiness significant enough to distress and disruptiveness,) and Chronic Obstructive Pulmonary Disease (COPD) (which was a respiratory condition characterized by persistent breathlessness and cough.) Record review of Resident #1's Discharge MDS, dated [DATE], reflected the following: *Section C., Cognitive Patterns: Resident #1 had a BIMS Score of 15. A BIMS Score of 15 indicated the resident had no cognitive impairment. *Section I, Active Diagnosis: Resident #1 had an active diagnosis of an anxiety disorder. Record review of Resident #1's CP reflected a focus for shortness of breath, initiated 4/30/2024, with a goal, initiated on 4/30/2024, to maintain normal breathing patterns. The intervention from nursing staff, initiated on 4/30/2024, was to monitor/document changes in orientation, increased restlessness, anxiety, and air hunger. Record review of Resident #1's Order Summary Report reflected Resident #1 was ordered Requip, ropinirole HCl, 3 MG at bedtime for restless leg syndrome. Order date was 4/21/2024 and discontinued on 5/22/2024. Record review of Resident #1's MAR, dated 4/24/2024, reflected Resident #1 received Requip, ropinirole HCl, 3 MG at bedtime for restless leg syndrome Record review of Resident #1's Medication Error Report, dated 4/24/2024, reflected Resident #1 received three (3) tablets of Requip, ropinirole HCl 3 MG, on 4/24/2024, opposed to the prescribed dosage of one (1) 3 MG tablet. The Medication Error Report reflected Resident #1 resulted in no harm. The Medication Error Report was signed on 4/25/2024 by the ADM, the DON, and the MD. Record review of a signed statement dated 4/24/2024 from the CMA A, who administered the wrong dosage, indicated [I read the order wrong. I gave her 3 pills. It should have been 1 tab for 3 MG.] (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	06/17/2024

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's medical record reflected a report, dated 4/24/2024 at 10:41 PM, which indicated Resident #1 was given incorrect dose of medication. The report indicated Resident #1's description was [I got three pills of Requip. I always get one but got three.] Mental Status indicated Resident #1 was orientated to person, place, time, and situation. No distress noted at this time. No predisposing physiological factors. No predisposing situations factors. Record review of Resident #1's progress noted dated 4/24/202 at 10:28 PM by LVN B, indicated Resident #1 had a COC, Change in Condition, due to Resident #1 having received the wrong dosage of medicine. Record review of Resident #1's progress notes dated 4/24/2024 at 11:01 PM by LVN B, indicated the resident said she got more medication than she gets. Vital signs taken. NP and DON notified. Family called and message left, incoming nurse informed to follow up. Record review of Resident #1's blood pressure revealed the following: *4/24/2024 at 10:32 PM was 147/78. *4/24/2024 at 11:33 PM was 132/67. Record review of Resident #1's progress notes, dated 4/24/2024 at 11:21 PM by RN C, reflected an order for a STAT ECG/EKG. Called provider. Record review of Resident #1's oxygen levels on 4/24/2024 at 11:33 PM was 99 Percent (oxygen provided through nasal cannula.) Record review of Resident #1's progress notes reflected a nursing entry, dated 4/25/2024 at 1:30 AM by RN C, indicated STAT ECG/EKG completed at this time; tech states results would be sent to PCP. Resident tolerated procedure well. No issues or concerns voiced. Record review of Resident #1's ECG/EKG report, dated 4/25/2024 at 1:37 AM, no evaluation provided. Record review of Resident #1's Cardiology Consult, dated 4/25/2024 at 3:58 AM, indicated to notify a clinician of any change in condition. Record review of Resident #1's progress notes reflected a nursing entry, dated 4/25/2024 at 4:15 AM by RN C, indicated ECG/EKG results sent to reviewing agency. Record review of Resident #1's progress notes reflected a telehealth evaluation, dated 4/25/2024 at 4:57 AM by RN C, indicated EKG/ECG result revealed normal sinus rhythm, nonspecific T wave abnormality (the repolarization of the ventricles,) prolonged QT abnormal (the total time from ventricular depolarization to complete repolarization) ECG/EKG. Per nurse, EKG was done due to med given in error. Patient was schedule for 3 MG Requip but got 9 MG. Patient blood pressure stable, has high QTC (corrected total time from ventricular depolarization to complete repolarization) of 472 and no previous EKG to compare. (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	06/17/2024

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress notes reflected a NP Progress Note, dated 4/26/2024 at 11:20 PM by the NP, indicated Resident #1 required close monitoring because of an accidental administration 3 times the amount of Requip, ropinirole HCl, 3 MG. Resident had episodes of hypertension (low blood pressure,) but returned to baseline without further intervention. Resident #1 reported feeling scared about the situation but had no further concerns. Record review of Resident #1's Nurse Practitioner Progress note, dated 4/29/2024 at 10:02 PM by the NP, indicate Resident #1 reported she was feeling drowsier over the last couple of days. Record review of Ropinirole (Oral Route) Side Effects - Mayo Clinic; www.mayoclinic.org, viewed on 6/24/2024, indicated symptoms of overdose of ropinirole were agitation, confusion, dizziness, lightheadedness, racing heartbeat, grogginess, lack of strength, unusual drowsiness, and vomiting. Interview on 6/17/2024 at 10:40 AM with Resident #1 revealed she was in her room, speaking to a friend on the telephone, on the night of 4/24/2024 around 9:00 PM. The CMA A came to her room, around 9:00 PM, to give her night medications. She took her medications and continued speaking on the phone with her friend. During the conversation on 4/24/2024 after medications were taken, the friend informed Resident #1 she was speaking more slowly and had different mannerisms than earlier in the conversation. When she heard her friend's comments, she felt scared that she was beginning to have a stroke. She could not annunciate her words; she felt dizzy; and her legs were weak. Resident #1 stated she went to the nurse's station, in her wheelchair, and spoke to the CMA A, where she discussed her night medications and learned she received triple the prescribed dosage of her Requip, ropinirole HCl, 3 MG at bedtime for restless leg syndrome. When she learned of the medication error, she stated she became worried and angry. She stated the nursing staff responded to her medication error and took her oxygen levels, which were allegedly 86 percent, and her blood pressure, which was allegedly 80/40. She stated she received oxygen through a nasal cannula. She stated she spoke to the NP the next day, but the NP was not able to confirm the oxygen levels, which were allegedly 86, and her blood pressure, which was allegedly 80/40, because those statistics were not in the computer. She stated it took her several days, about 2-3, before she stated feeling normal again. Interview on 6/17/2024 at 4:30 PM with the MD revealed he was notified the CMA A gave Resident #1 three (3) tablets of Requip, ropinirole HCl 3 MG, on 4/24/2024, opposed to the prescribed dosage of one (1) 3 MG tablet. The error was a singular event, and the CMA A was educated. From a medical standpoint, Resident #1 was monitored, and he did not see any adverse reactions due to the medication error. He did not see anything remarkable in Resident #1's vitals and neurological standpoint. Blood pressure was ok, oxygen percentages were ok, respirations were ok. He received multiple updates, and she was stable. Interview and observation on 6/17/2024 at 4:55 PM with CMA G revealed that the CMAs were taught to check the resident's information on the computer screen and the information on the medication card two times before and administering. She demonstrated how the information was checked two individual times. She learned this process in the medication aide class. (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	06/17/2024

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/17/2024 at 7:00 PM the DON revealed Resident #1 did have a medication error on 4/24/2024 perpetrated by CMA A. CMA A gave Resident #1 three (3) tablets of Requip, ropinirole HCl 3 MG, on 4/24/2024, opposed to the prescribed dosage of one (1) 3 MG tablet. She stated the facility followed policy; The medication error did not rise to the level or a significant medication error. Resident #1 was placed on oxygen the night of the medication error, but not due to low oxygen levels. She stated Resident #1 was placed on oxygen due to her increased anxiety. CMA A had not been back at the facility; she did not even come back to the facility to sign the medication error counseling/disciplinary notice. Interview on 6/17/2024 at 7:30 PM the ADM revealed the expectation for her nursing staff to administer medications as prescribed. Any medication error was to be reported and responded to per policy. Safeguards in place to prevent medication errors were pharmacy reviews and random medication observations. The medication error on 4/24/2024 with Resident #1 was a failure of the CMA A having misread the order. The CMA A was no longer at the facility. The ADM did not report the medication error, as the facility did not gauge it as a significant medication error. Record review of the facility's Counseling/Disciplinary Notice, dated 4/25/2024, reflected CMA A was provided a written warning for the medication error on 4/24/2024. The document did not contain employee comments of an employee signature. Record review of the facility's in-service, dated 4/24/2024, reflected training for reporting change and medication rights. The In-Service training pertained to the rights of medication administration. Right patient, right drug, right dose, right route, right time, and right documentation. The medications were supposed to be checked: 1. When the medication was being removed, the prescription labels should be checked against the medication administration record. 2. As the medication is being removed from the bubble pack, the prescription label should be checked against the medication administration record. 3. The final check should occur at the residence bedside, just before medications were given. Having compared the information three times is a safety mechanism and when followed it decreases the number of medication errors. Record review of the facility's Medication Error and Adverse Reactions Policy, dated 12/2023, reflected a medication error was the observed or identified preparation or administration of medications or biological's which was not in accordance with the prescriber's order, then you were factures specifications regarding the preparation and administration of the medication or biological or accept their professional standards and principles which applied to professionals having provided services. A significant medication error met one which caused the residents discomfort or jeopardized their health and safety. Significant may be subjective or relative having depended on the individual situation and duration. 1. Adverse drug reactions and medication errors where diverse clinical consequences must have been reported to the resident's attending physician immediately. (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	06/17/2024

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Nursing service must have immediately implemented and followed the position's orders. Resident's condition must have been closely monitored for 72 hours, or as may be directed. 3. A detailed account of the incident must have been recorded on an incident report, which included date and time, kind of medication error, naming the physician, date/time the physician was contacted, the physician's orders, residents' condition, and other information having been necessary or appropriate. 4. Documentation of the residence condition in response to treatment must have been recorded during the monitoring period. 5. The medical director, director of nursing, and consultant must have been informed of all medication errors and adverse reactions. 6. Medication errors and adverse drug reactions, with and without adverse clinical consequences, were reported or referred to the QAPI/QAA Committee.