

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation - Waxaha		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772</p> <p>Based on observations, interviews, and record review, the facility failed to report allegations of abuse, neglect, exploitation, or mistreatment to the state agency within 2 hours for 1 of 9 Residents (Resident #162) reviewed for required reporting.</p> <p>The facility failed to report an incident of neglect after a failed resident transfer, which resulted in an injury and a 2 day hospitalization .</p> <p>This failure placed residents at risk of continued incidents of neglect.</p> <p>Findings included:</p> <p>Record review of an intake, dated 11/7/2024 at 8:21 AM, reflected a complaint made by a responsible party on behalf of Resident #162. The intake alleged on 11/2/2024 a staff attempted to transfer Resident #162 from her wheelchair to her bed. The complainant alleged Resident #162 required 2 people to transfer her, but only 1 staff member was present. The complainant alleged Resident #162 received a wound, a huge gash to her leg. Resident #162 was rushed to the hospital where she received a blood transfusion. Upon her release, Resident #162 was supposed to have returned to see the wound care doctor on 11/6/2024, but the facility allegedly did not read the discharge papers and did not get her to the appointment. The Responsible parties for Resident #162 were extremely worried about the lack of care.</p> <p>Record review of Resident #162's AR, dated 11/13/2024, reflected a [AGE] year-old-woman who was admitted to the facility on [DATE]. She was diagnosed with muscle weakness, need for assistance with personal care (which was a diagnosed medical classification influenced by health status and needed support with health services), unsteadiness on feet, other reduced mobility, unspecified lack of coordination, other abnormalities of gait (manner of walking) and mobility, unspecified abnormalities of gait and mobility, Parkinson's disease (which was progressive disorder that affected the nervous system and the parts of the body controlled by the nerves), other lack of coordination, body mass index 36.0-36.9- adult , generalized anxiety disorder (which was a mental heal condition marked by heightened responses (worry) to certain situations and stimuli), and other recurrent depressive disorders (which was a mental condition characterized by depressed mood, loss of pleasure, or interest in life).</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #162's Quarterly MDS Assessment, dated 8/13/2024, reflected the resident had a BIMS Score of 15. A BIMS Score of 15 indicated the resident had no cognitive impairment. The resident had no impairment in either upper extremity (shoulder, elbow, wrist, and hand;) Resident had no impairment in either lower extremity (hip, knee, ankle, and foot.) The resident utilized a wheelchair and a walker for mobility. The resident required partial/moderate assistance for eating, oral hygiene, and personal hygiene (which meant the helper provided less than half the effort while the resident completed the greater portion of the activity). The resident was dependent upon staff for toileting hygiene, showering/bathing self, and putting on/taking off shoes (which meant the helper provided all the effort of the activity). The resident received substantial/maximal assistance with upper body dressing (which meant the helper provided more than half the effort while the resident completed the lesser portion of the activity). Lower body dressing: not applicable, not attempted, and the resident did not perform this activity prior. The resident required substantial/maximum assistance with roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer (which meant the helper provided more than half the effort while the resident completed the lesser portion of the activity).</p> <p>Record review of Resident #162's CCP reflected a Focus area for ADL Self Care performance deficit, revised on 3/29/2024, R/T limited mobility for Parkinson's Disease. The Goal, revised on 7/11/2024, indicated resident would maintain current level in bed mobility, transfers, eating, dressing, grooming, toilet use, and personal hygiene. The Intervention, created on 8/1/2022, delegated nursing facility staff to provide 1 staff limited assist for toilet use and 1 person contact guard for transfers; a Focus area for skin tear to left knee, initiated 11/2/2024, R/T transferring. The Goal, initiated on 11/5/2024, indicated the skin tear on the left knee would heal and the resident would be free from skin tears. The Intervention, initiated on 11/2/2024, delegated nursing facility staff to identify potential causative factors, notify Med. Dir., and family, of skin tears occur, prevent skin tears, monitor location, size, and treatment of skin tear, and use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces; a Focus area for potential/actual skin impairment to skin integrity, initiated 11/02/2024, R/T laceration to the left lower leg with sutures in place. Follow up with Physician at hospital on 11/12/2024. Enhanced Barrier Precautions ordered. An addition goal, initiated on 11/8/2024, indicated the resident would not have any complications R/T skin in jury type. The Interventions, initiated on 11/2/2024, delegated nursing facility staff to monitor location, size, and treatment of skin tear, and use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces.</p> <p>Record review of Resident #162's Order Summary Report reflected orders for:</p> <ol style="list-style-type: none"> 1. Change of condition for: (add what the Change of Condition) Provider notified: Med. Dir.; resident sent to emergency room for laceration to lower left extremity; family visiting at time of incident. Every shift for 3 Days, started 11/3/2024. 2. Clean left knee with wound cleanser pat dry then use xeroform gauze on stitches line to keep moist, <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>cover with 4-inch x4 inch gauze and (dressing) pad and wrap with kerlix (gauze) and ace once a day and as needed. Left knee should not be bend for at least a week and patient should not be in a wheelchair for more than 4 hours a day. Each day shift for secondary to trauma, started 11/5/2024.</p> <p>Record review of a facility communication for Resident #162, dated 11/2/2024, indicated Resident #162 experienced a change in condition on 11/2/2022 due to a skin laceration, puncture, or wound. The condition was a new condition and the resident experienced pain at the degree of 8 out of 10. At the time of the assessment, the skin wound, or ulcer, progress was unable to be determined. The resident was on anticoagulant therapy (blood thinner).</p> <p>Record review of a nursing home to hospital; transfer form, dated 11/2/2024, indicated Resident #162 transferred from the nursing home to a local hospital on 11/2/2024 for a skin wound, or ulcer. Blood pressure was 202/104. ADLs, such as bathing, dressing, transfers, toileting, and eating required assistance. Additional relevant information was resident saying laceration was received to the lower left leg during a transfer from the bed to wheelchair. Pressure bandage applied, 911 called, nurse practitioner, notified family, family visiting when accident occurred. (Form Incorrect-Transfer was from the wheelchair to the bed.)</p> <p>Record review of Resident #162's hospital discharge paperwork reflected Resident #162 presented to the emergency department from a local nursing home on 11/2/2024 at 8:50 PM with an acute left lower extremity bleeding from a wound that occurred today just prior to arrival. Height was 5 feet 6 inches; Weight was 183 pounds. Large lower extremity wound oozing blood. [NAME] blood cell counts on 11/2/2024 were first recorded at 5:38 PM results with 7.7 and again at 7:22 PM results 11.7. Principle Problem: Acute blood loss, anemia</p> <p>Secondary to left lower extremity injury.</p> <p>*Presented with acute onset bleeding from left lower extremity wound after injury at nursing home, currently on dual antiplatelet therapy.</p> <p>*Hypotensive with blood pressure in 80s/60s, status post (experienced a medical event) fluid bolus with improvement.</p> <p>*Hemoglobin 11.4 to 10.3</p> <p>* Status post pressure dressing with Tranexamic Acid (medication to prevent bleeding) and lidocaine with epinephrine impregnated quick clot, achieving adequate hemostasis; status post 1 unit packed red blood cells emergently.</p> <p>*No overt signs of continued blood loss at this time.</p> <p>*Monitor Hereditary Hemochromatosis (a genetic disorder that causes iron to build up in organs) every 12 hours, transfuse if Red Blood Cells are less than 7, or active bleeding</p> <p>*Patient also requested wound care referral to wound care physician on discharge.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #162's PN, dated 11/12/2024 at 4:27 PM, reflected Resident #162 reported a pain level at a severity of a 3 out of 10. Pain medication administered as needed/ effective. Entered by LVN C.</p> <p>Observation and interview on 11/12/24 at 4:34 PM with Resident #162 revealed the resident in her room sitting in her wheelchair watching television. The resident was well groomed and in good spirits. She made appropriate eye contact and was easy to engage. The room was free from odors but was slightly cluttered. The interview revealed she was expecting a visit from someone from the complaint department. The resident explained that on 11/2/2024, she was helped in a transfer from her wheelchair to her bed by CNA P. During the transfer, the CNA was not able to hold her up and she hit her leg against a part of the bed that caused a tear in her skin. The mobility support bar, which was on the side of the bed where the transfer occurred, was unlocked from the vertical position to the horizontal position. She explained she was rushed to the hospital, where she stayed for about 2 days. While there, she received pain medication, an infusion of blood, and several stitches. She made mention she had just come back from the wound care doctor earlier that same day.</p> <p>Interview and observation on 11/13/24 at 3:03 PM with the MNTD revealed Resident #162's bed mobility support bars were attached to the bed, on each side, with three bolts. The mobility bar was a slender, upside-down U-shaped bar, about 36 to 42 inches long. The top end of the slender upside-down U-shaped bar extended in the direction of the ceiling. The bottom of the slender upside-down U-shaped bar extended in the direction of the floor. The bottom 6-8 inches of the slender upside-down U-shaped bar had a welded junction box. The welded junction box was the location of the mobility bar where the three attachment bolts were housed. The 6-8-inch welded junction box section was the point where the slender upside-down U-shaped bar was attached to the bed. The slender upside-down U-shaped bar was hollow and each of the hollow ends, at the bottom of the welded junction box, were covered with smooth ended round black safety caps. Slightly higher than the center point of the welded junction box, was a black knob. To change the slender upside-down U-shaped bar from the vertical to horizontal position, the black knob was pulled outwards to release a stabilizing pin. When the stabilizing pin was disengaged, the slender upside-down U-shaped bar rotated from the vertical to horizontal position. When rotated, the top of the slender upside-down U-shaped bar pivoted 90 degrees towards the head of the bed; the bottom of the slender upside-down U-shaped bar, which was welded junction box and the two plastic capped ends, rotated 90 degrees towards the foot of the bed. The MNTD touted years of experience with the facility's mobility bars and did not know how the resident could have torn her skin on any part, or configuration, of the bed's mobility bar. The MNTD stated there were no sharp edges on the mobility bar; no sharp edges on the sides on the rounded bar; no sharp edges on the welded junction box; and no sharp edges on the smooth ended round black safety caps. Observations of the MNTD in Resident #162's room, revealed the MNTD running his fingers along the curved bar that extended vertically from the side of the bed, the welded junction box, and the 2 smooth ended round black safety caps. His inspection revealed no edges that could have contributed to Resident #162's skin tear. He said there was no way the resident hurt herself on the mobility bar.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Group interview, observation, and record review on 11/13/2024 at 4:40 PM with Resident #162 and RP #1000, in Resident #162's room, revealed RP #1000 was concerned about the skin tear Resident #162 suffered, on 11/2/2024. RP #1000 was not present at the time of the accident. RP #1000 pointed out a bouquet of flowers CNA P sent the resident. RP #1000 did not think the CNA P meant to hurt the resident; furthermore, RP #1000 felt the accident was just that, an accident. RP #1000 did question the size, height, and weight of CNA P, who performed the transfer, and described how her Resident #162 towered over CNA P. Observations of the room revealed Resident #162's bed. The foot of the bed was at the 6 o'clock position, the head of the bed was at the 12 o'clock position, the side of the bed closest to the window was at the 3 o'clock position, and the side of the bed closest to the bathroom was at the 9 o'clock position. Resident #162 described the wheelchair to bed transfer at the time of the accident. Resident #162 stated CNA P came to the room to help her from the wheelchair to the bed. Resident #162 was at the 4 o'clock position in her wheelchair facing the bed at a 45-degree angle (the portion of the left armrest, where the left hand of the resident would have been, was closest to the bed.) CNA P locked the wheels on the wheelchair and started to perform the transfer. At the beginning of the transfer, Resident #162 asked CNA P to stop because her legs were not in the correct position. CNA P continued with the transfer. During the transfer, the resident was lifted and shifted to their left slightly more than 90 degrees to place her buttocks on the side of the bed at the 3 o'clock position. During the transfer, and before Resident #162 realized what was happening, the accident had occurred. She stated her left leg struck something hard and the accident occurred. Measurements were taken from the top height of the mattress (6 inches in thickness) at the 3 o'clock position to the floor. The distance was 25 inches. Three hard surfaces existed between the mattress and the floor. One hard surface between the top of the mattress and the floor was a metal mattress support structure (Surface A.) Surface A was at 2 inches in vertical length and located just beneath the mattress. A second hard surface was a middle metal support rail with an information plate on it (Surface B.) Surface B was at 2 inches beneath Surface A and Surface B was at 3 inches in vertical length. A third hard surface was the lowest metal support rail closest to the floor (Surface C.) Surface C was at 2 inches in vertical length and directly beneath Surface B; Surface C was recessed inwards under the bed. When rubbing a finger against the bottom edge of Surface B, there was a straight and prominent 90-degree edge. There was a dark circular stain on the floor. The stain was 8-12 inches in distance from the outline of the bed, just to the left, while facing the window at the 3 o'clock position (2:45 position.) The stain was described by Resident #162 as a blood stain left by the accident. The size of the stain was slightly larger than the diameter of a softball. Measurements were taken of the distance between Resident #162's left knee to left ankle. The distance was 15 inches. The resident's left leg and left ankle were thickly wrapped with ace bandages at the time of the interview, so the distance from the ankle to the bottom of the foot was estimated to be an additional 2 inches. At the time of the transfer on 11/2/2024, the resident was not wearing any shoes. The bed's mobility bar, the slender upside-down U-shaped bar, was attached to the bed at the 1:45 position of the bed. It was attached by 3 bolts on the welded junction box, 6-8 inches in vertical length, at the height of Surface B. After disengaging the stabilizing pin by pulling the black knob, the slender upside-down U-shaped bar rotated 90 degrees; the curved end at the top rotated towards the head of the bed; and the welded junction box rotated in the direction of the foot of the bed. The welded junction box, which was at the bottom of the slender upside-down U-shaped bar, had no parts extending its length, but the 2 smooth ended round black safety caps. The welded junction box was the point of a 90-degree rotation. Since there were no parts extending its length downward, except the smooth ended round black safety caps, the rotation did not extend any of its parts towards the foot of the bed, but the smooth ended round safety caps. The mobility bar, in the horizontal position, was parallel in direction, and the same heights of Surface B. RP #1000 observed the inspection of Resident #162's bed and mobility bar and stated, there was no way Resident #162 could have hurt her leg on the mobility bar in the horizontal position. Record review of photos, provided by RP #1000, reflected the injury to Resident #162's lower left extremity. Looking at the photo, the picture of the left leg was viewed from the vantage point of the resident looking down at their leg. The left kneecap was at the 6 o'clock position, the left outer side of her left kneecap was at the 9 o'clock position, the left shin was at the 12 o'clock position, and the right inner side of her left kneecap was at the 3 o'clock position. The photos reflected a straight tear in the skin beginning just beneath, or at the same level, of Resident #162's left kneecap area (Spot A.) The tear began at the 3 o'clock position</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and observation 11/13/24 at 5:16 PM with RP #3000 revealed she was at the facility on 11/2/2024 at the time Resident #162 had the injury to her left lower leg. Just before the injury occurred, CNA P came to the room to transfer Resident #162 from her wheelchair to her bed. RP #3000 was asked to leave the room, by the resident, while she was being transferred. While outside of the room, the door was open; curtain was not drawn. RP #3000 was standing across the hall from the resident's door; the door was at RP #3000's 11:00 position; and the resident's bed was 20 feet away, to her front. In RP #3000's line of sight to her the resident, was staff with a medication cart. The medication cart staff had her back to the inside of the resident's room with objects in their hands. The medication staff was not making any noises. After a span of 1-2 minutes, RP #3000 heard Resident #162 protesting the method CNA P was attempting to transfer her (exact words not remembered.) About a minute after the protest, Resident #162 was heard emitting a cry out in pain. After the cry of pain, she clearly heard CNA P cry out, oh no. After the CNA cried out oh no, the staff member at the medication cart turned around and went in to assess the situation. RP #3000 stated the facility responded, called 911, and got her to the hospital. RP #3000 did not observe, nor had she looked for, the resident with a gait belt (a cloth strap used to help life a resident) around her waist. She did not think the size, height, and weight of CNA P was appropriate to transfer someone with the size, height, and weight of Resident #162, since she was transferring Resident #162 alone.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/13/24 at 6:04 PM with CNA P revealed she was the CNA who transferred Resident #162 from her wheelchair to her bed on 11/2/2024. She explained how she transferred the resident by placing the wheelchair next to the bed. The foot of the bed was at the 6 o'clock position, the head of the bed was at the 12 o'clock position, the side of the bed closest to the window was at the 3 o'clock position, and the side of the bed closest to the bathroom was at the 9 o'clock position. The resident's wheelchair was at about a 45-degree angle to the bed close to the 4 o'clock position. The opening of the wheelchair was facing towards the bed. The resident was seated in the wheelchair with her legs stretched outwards to the front. The wheels were locked; the bed was in the lowest position. CNA P was standing in front of the resident, facing her, with her legs inside of the positioning of the resident's legs. The resident wrapped her arms around the CNA's waist. The CNA put her arms under the resident's armpits (inside the resident's grip around the CNA's waist) and laced her left hand over right wrist; her right hand was in a fist. Before they started the transfer, the CNA stated Resident #162's legs were pointed straight out. She stated she moved the resident's legs in a manner to move them away from the bed, so she did not hit them during the transfer. When trying to move the resident's legs prior to performing the transfer, the resident stopped her and stated, No No No , don't do that, watch my legs. The CNA stated she stopped at that moment thinking she needed more support. She stated she grabbed a gait belt and wrapped it around the resident's upper abdomen area, just under her breasts. CNA P was standing in front of the resident, facing her, with her legs inside of the positioning of the resident's legs. The resident wrapped her arms around the CNA's waist. The CNA put her arms under the resident's armpits (inside the resident's grip around the CNA's waist) and grabbed onto the gait belt. The resident's legs were still straight out. She stated the resident would not let the CNA bend them. When the CNA lifted and turned the resident, the CNA pivoted to her right; while the resident pivoted to her left to be placed on the bed. At the time of the lifting, CNA P stated the resident's legs were at an approximate 45-degree angle from the resident's hips to the ground; both legs were on the outside of the CNA's legs. Resident #162's legs were angled downwards and away from the bed pointing towards the 3 o'clock position. When Resident #162's buttocks came to rest on the mattress, her legs were straight at a downward 45-degree towards the floor still directed towards the 3 o'clock position. It was at that moment when the resident stated ouch, ouch, my leg. CNA and the resident looked down at the same time and noticed the tear of the skin on her lower left leg, two or three inches under the knee. CNA stated she stated, OMG, I am so sorry, and yelled out for help. The resident handed the CNA a brief, and she applied direct pressure. The nursing staff arrived and called 911. Resident #162 went to the hospital. When asked how CNA P thought the injury occurred, she mentioned it could have been the bottom of the mobility bar and the two black buttons on the bottom. When asked, she stated she was not sure if the resident's legs were as straight as they were described earlier; furthermore, it was possible the resident's side of her left shin was up against the bed frame during the transfer.</p> <p>Interview and observation on 11/13/2024 at 6:55 PM with ADM B revealed the possible source of Resident #162's left lower leg injury could have been Surface B's prominent edge on her bed. ADM B was observed looking at a bed, which was not being used. She stated she would look at the bed in further detail with the maintenance director.</p> <p>Interview and observation on 11/14/2024 at 2:30 PM with CNA P revealed the use of a gait belt had not been discussed in any interview prior to her interview on 11/13/2024 at 6:04 PM. When asked for clarity, CNA P stated she did stop the transfer and apply a gait belt to continue the transfer. CNA P's size, height, and weight were observed as petite.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/15/24 at 4:47 PM with the DON revealed Resident #162's skin tear was not reported to the state because the resident, who had a high BIMS Score, was able to explain what happened during the transfer. The facility did not feel the skin tear was the result of neglect or mistreatment; therefore, it did not meet the criteria for reporting.</p> <p>Interview on 11/20/2024 at 11:13 AM with Resident #162 revealed the initial objection, where she cautioned the way CNA P was transferring her, was at the start of the transfer. Resident #162 told CNA P that her leg was caught on the bed. CNA P did not pause. CNA P did not stop and apply a gait belt. CNA P continued with the transfer. The resident stated the portion of her left leg, which was caught on the bed, was the area just beneath her kneecap on the outside left portion of the upper shin area. After the injury occurred, CNA P got Resident #162 to the bed, seated outward from the bed at the 3 o'clock position facing the window. The resident confirmed the blood stain on the floor was 8-12 inches from the outline of the bed at the 3 o'clock position.</p> <p>Record review of the facility's Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment Policy, dated 10/2022, reflected it was the right of each resident be free from neglect and mistreatment. Neglect was the failure of the facility to have provided goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress. Mistreatment was inappropriate treatment of a resident. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility was supposed to have reported to the state agency immediately, but no later than 2 hours after the allegations was made.</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772</p> <p>Based on observations, interviews, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 9 Residents (Resident #162) reviewed for quality of care.</p> <p>The facility failed to ensure Resident #162 made follow up appointment with a wound care specialist.</p> <p>This failure placed residents at risk of condition exacerbation, psychosocial harm, and infection.</p> <p>Findings included:</p> <p>Record review of an intake, dated 11/7/2024 at 8:21 AM, reflected a complaint made by a responsible party on behalf of Resident #162. The intake alleged on 11/2/2024 a staff attempted to transfer Resident #162 from her wheelchair to her bed. The complainant alleged Resident #162 required 2 people to transfer her, but only 1 staff member was present. The complainant alleged Resident #162 received a wound, a huge gash to her leg. Resident #162 was rushed to the hospital where she received a blood transfusion. Upon her release, Resident #162 was supposed to have returned to see the wound care doctor on 11/6/2024, but the facility allegedly did not read the discharge papers and did not get her to the appointment. The Responsible parties for Resident #162 were extremely worried about the lack of care.</p> <p>Record review of Resident #162's AR, dated 11/13/2024, reflected a [AGE] year-old-woman who was admitted to the facility on [DATE]. She was diagnosed with muscle weakness, need for assistance with personal care (which was a diagnosed medical classification influenced by health status and needed support with health services), unsteadiness on feet, other reduced mobility, unspecified lack of coordination, other abnormalities of gait (manner of walking) and mobility, unspecified abnormalities of gait and mobility, Parkinson's disease (which was progressive disorder that affected the nervous system and the parts of the body controlled by the nerves), other lack of coordination, body mass index 36.0-36.9-Adult , generalized anxiety disorder (which was a mental heal condition marked by heightened responses (worry) to certain situations and stimuli), and other recurrent depressive disorders (which was a mental condition characterized by depressed mood, loss of pleasure, or interest in life).</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #162's Quarterly MDS Assessment, dated 8/13/2024, reflected the resident had a BIMS Score of 15. A BIMS Score of 15 indicated the resident had no cognitive impairment. The resident had no impairment in either upper extremity (shoulder, elbow, wrist, and hand;) Resident had no impairment in either lower extremity (hip, knee, ankle, and foot.) The resident utilized a wheelchair and a walker for mobility. The resident required partial/moderate assistance for eating, oral hygiene, and personal hygiene (which meant the helper provided less than half the effort while the resident completed the greater portion of the activity). The resident was dependent upon staff for toileting hygiene, showering/bathing self, and putting on/taking off shoes (which meant the helper provided all the effort of the activity). The resident received substantial/maximal assistance with upper body dressing (which meant the helper provided more than half the effort while the resident completed the lesser portion of the activity). Lower body dressing: not applicable, not attempted, and the resident did not perform this activity prior. The resident required substantial/maximum assistance with roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer (which meant the helper provided more than half the effort while the resident completed the lesser portion of the activity).</p> <p>Record review of Resident #162's CCP reflected a Focus area for skin tear to left knee, initiated 11/2/2024, R/T transferring. The Goal, initiated on 11/5/2024, indicated the skin tear on the left knee would heal and the resident would be free from skin tears. The Intervention, initiated on 11/2/2024, delegated nursing facility staff to identify potential causative factors, notify Med. Dir., and family, of skin tears occur, prevent skin tears, monitor location, size, and treatment of skin tear, and use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces; a Focus area for potential/actual skin impairment to skin integrity, initiated 11/02/2024, R/T laceration to the left lower leg with sutures in place. Follow up with Physician at hospital on 11/12/2024. Enhanced Barrier Precautions ordered. An addition goal, initiated on 11/8/2024, indicated the resident would not have any complications R/T skin in jury type. The Interventions, initiated on 11/2/2024, delegated nursing facility staff to monitor location, size, and treatment of skin tear, and use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces.</p> <p>Record review of a facility communication for Resident #162, dated 11/2/2024, indicated Resident #162 experienced a change in condition on 11/2/2022 due to a skin laceration, puncture, or wound. The condition was a new condition and the resident experienced pain at the degree of 8 out of 10. At the time of the assessment, the skin wound, or ulcer, progress was unable to be determined. The resident was on anticoagulant therapy (blood thinner).</p> <p>Record review of a nursing home to hospital; transfer form, dated 11/2/2024, indicated Resident #162 transferred from the nursing home to a local hospital on 1/2/2024 for a skin wound, or ulcer. Blood pressure was 202/104. ADLs, such as bathing, dressing, transfers, toileting, and eating required assistance. Additional relevant information was resident saying laceration was received to the lower left leg during a transfer from the bed to wheelchair. Pressure bandage applied, 911 called, nurse practitioner, notified family, family visiting when accident occurred. (Form Incorrect-Transfer was from the wheelchair to the bed.)</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #162's hospital discharge paperwork reflected Resident #162 presented to the emergency department from a local nursing home on 11/2/2024 at 8:50 PM with an acute left lower extremity bleeding from a wound that occurred today just prior to arrival. Height was 5 feet 6 inches; Weight was 183 pounds. Large lower extremity wound oozing blood. [NAME] blood cell counts on 11/2/2024 were first recorded at 5:38 PM results with 7.7 and again at 7:22 PM results 11.7. Principle Problem: Acute blood loss, anemia</p> <p>Secondary to left lower extremity injury.</p> <p>*Presented with acute onset bleeding from left lower extremity wound after injury at nursing home, currently on dual antiplatelet therapy.</p> <p>*Hypotensive with blood pressure in 80s/60s, status post (experienced a medical event) fluid bolus with improvement.</p> <p>*Hemoglobin 11.4 to 10.3</p> <p>* Status post pressure dressing with Tranexamic Acid (medication to prevent bleeding) and lidocaine with epinephrine impregnated quick clot, achieving adequate hemostasis; status post 1 unit packed red blood cells emergently.</p> <p>*No overt signs of continued blood loss at this time.</p> <p>*Monitor Hereditary Hemochromatosis (a genetic disorder that causes iron to build up in organs) every 12 hours, transfuse if Red Blood Cells are less than 7, or active bleeding</p> <p>*Patient also requested wound care referral to wound care physician on discharge.</p> <p>*Blood pressure low on arrival; hold high blood pressure medications at this time in light of acute bleeding. Monitor blood pressure.</p> <p>*Resident admitted to the hospital from the emergency roiaognom on [DATE] at 7:24 PM for monitoring.</p> <p>*Handwritten, on the last page of the hospital discharge paperwork, dated 11/4/2024 indicated resident received 13 stitches to her left leg below the knee.</p> <p>*1 unit of blood.</p> <p>*Wound care order follow-up clinic on 11/6/2024 at 2:30 PM.</p> <p>*Do not bend knee for 1 week; not to be in wheelchair for more than 4 hours; keep leg straight.</p> <p>*Blood pressure was 150/70 at 11:30 AM 11/4/2024.</p> <p>* Resident discharged from the hospital to the nursing facility on 11/4/2024 at 1:48 PM</p> <p>*Resident was transported by a local transport company to the nursing facility on 11/4/2024.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #162's PN, dated 11/4/2024 at 3:19 PM, reflected Resident #162 had a follow-up visit on 11/6/2024 at 2:30 PM. Entered by LVN O.</p> <p>Record review of Resident #162's Skin Evaluation, dated 11/4/2024 at 4:46 PM, reflected the Resident had a laceration to the left lower leg at 8 CM x2.5 CM x0.5 CM with sutures in place. Left and right leg with some swelling observed with a moderate indentation left in the skin after applying pressure to both legs. Entered by ADON</p> <p>Record review of Resident #162's TAR, dated 11/2024, reflected Resident #162 received Wound care treatment described in the resident's order summary report on 11/5/2024, 11/6/2024, 11/8/2024, 11/10/2024, 11/12/2024, and 11/15/2024.</p> <p>Record review of Resident #162's appointment request form. Appointment request form initiated on 11/6/2024 with a scheduled appointment for 11/12/2024 at 1:00 PM with wound care clinic off site from the facility.</p> <p>Record review of Resident #162's infection surveillance assessment, dated 11/10/2024 at 2:21 PM reflected Resident #162 developed an infection to her skin, soft tissue, and mucus membrane. Resident #162 was prescribed Doxycycline 100 MG 2 times a day for 7 days. Started 11/10/2024. Entered by LVN O. Wound care continued per order.</p> <p>Record review of Resident #162's PN, dated 11/10/2024 at 2:16 PM reflected an order for Resident #162 to start Doxycycline 100 MG 2 times a day for 7 days R/T wound infection. Entered by LVN O.</p> <p>Record review of Resident #162's Skin Evaluation, dated 11/10/2024 at 3:57 PM, reflected the Resident had a laceration to the left lower leg at 8 CM x2.5 CM x0.5 CM with sutures in place. Left and right leg with some swelling observed with a moderate indentation left in the skin after applying pressure to both legs. Doxycycline 100 MG 2 times a day for 7 days for infection. Entered by LVN C.</p> <p>Record review of Resident #162's MAR, dated 11/2024, reflected Resident #162 received Doxycycline 100 MG 2 times a day for 7 days. The first dose was on 11/10/2024 at 4:00 PM. The medication continued through 11/15/2024 and was due to run the course on 11/17/2024 at 8:00 AM.</p> <p>Record review of the facility's transport schedule, dated 11/12/2024, reflected Resident #162 had an off-site appointment, with the wound care clinic, on 11/12/2024 at 1:00 PM.</p> <p>Record review of the facility's schedule book for 11/12/2024 reflected Resident #162 was transported to an off-site appointment, with the wound care clinic, on 11/12/2024 at 1:00 PM.</p> <p>Record review of a photo revealed the facility's appointment request box. The appointment request box was attached to the wall, just outside of the transporter's office.</p> <p>Record review of a blank appointment request form revealed spaces for a name of person completing form, date, specialty, reason for appointment, date, time, physician, address, city, state, zip code, contact number, required labs/x-rays/medications, resident name, room, and date of birth.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's appointment reminder flier was taped to the wall in the room of Resident #162. The appointment reminder was for an off-site appointment, with the wound care clinic, on 11/19/2024 at 2:00 PM.</p> <p>Observation and interview on 11/12/24 at 4:34 PM with Resident #162 revealed the resident in her room sitting in her wheelchair watching television. The resident was well groomed and in good spirits. She made appropriate eye contact and was easy to engage. The room was free from odors but was slightly cluttered. The interview revealed she was expecting a visit from someone from the complaint department. The resident explained that on 11/2/2024, she was helped in a transfer from her wheelchair to her bed by CNA P. During the transfer, the CNA was not able to hold her up and she hit her leg against a part of the bed that caused a tear in her skin. The mobility support bar, which was on the side of the bed where the transfer occurred, was unlocked from the vertical position to the horizontal position. She explained she was rushed to the hospital, where she stayed for about 2 days. While there, she received pain medication, an infusion of blood, and several stitches. She made mention she had just come back from the wound care doctor earlier that same day but was supposed to have seen the wound care doctor on 11/6/2024. When she asked staff why she did not get to her appointment, staff stated something about the transporter not getting the appointment information. Interview, observation, and record review on 11/13/2024 at 4:40 PM with Resident #162 and RP #1000, in Resident #162's room, revealed RP #1000 was concerned about the skin tear Resident #162 suffered, on 11/2/2024, and Resident #162 having missed her follow-up wound care appointment, on 11/6/2024. Record review of photos, provided by RP #1000, reflected the injury to Resident #162's lower left extremity. Looking at the photo, the picture of the left leg was viewed from the vantage point of the resident looking down at their leg. The left kneecap was at the 6 o'clock position, the left outer side of her left kneecap was at the 9 o'clock position, the left shin was at the 12 o'clock position, and the right inner side of her left kneecap was at the 3 o'clock position. The photos reflected a straight tear in the skin beginning just beneath, or at the same level, of Resident #162's left kneecap area (Spot A.) The tear began at the 3 o'clock position of the left kneecap area. The tear extended across the entire left kneecap area towards the 9 o'clock position for an approximate 2-3 inches. At the 2-3-inch mark, the skin tear curved towards the shin in the shape of the letter {C} for 2-3 inches in distance. At the bottom of the C shaped curve, the tear continued at a downward 45-degree angle for 2-3 inches towards the 1 o'clock position of the inner portion of the resident's left shin (Spot B.) The skin was still connected to the resident's lower extremity at Spot A and at Spot B leaving a loose flap of skin.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/15/2024 at 11:58 PM with the former VDT revealed she used to be the transporter and had an extensive knowledge of the procedures to learn of, and make, appointments for residents. The current VDT was out on runs and was not available for interview. When a resident returned from the hospital, or an encounter with an off-site entity, the resident usually returned with some form of documentation. The nursing staff were supposed to review the documentation and enter required information into the resident's medical record. Based on the documentation, if a follow up appointment was to be made, the nursing staff were supposed to complete an appointment request for the resident and provide the request form to the VDT. The VDT would make the appointment, added it to the schedule, and placed a reminder in the resident's room. It was not the responsibility for the VDT to review medical records to look for appointment information. The former VDT was not aware Resident #162 missed an appointment on 11/6/2024, but was able to confirm by the schedule, and the appointment request form, there was an appointment for Resident #162 scheduled on 11/6/2024 for 11/12/2024. Record review of the files, or available information, in the VDT office did not reveal an appointment request for an appointment for Resident #162 that was supposed to have occurred on 11/6/2024. A safeguard in place to ensure the residents got appointments scheduled, was the VDT making a convenience copy of the documentation and reviewing it for clarity.</p> <p>Interview on 11/15/24 at 12:56 PM with Resident #162 revealed she knew, on 11/4/2024, she had an appointment on 11/6/2024 for a follow up with the wound care clinic. When 11/6/2024 came, the appointment did not happen. She spoke to a member of the nursing staff (specific name unknown) who was unable to confirm, or deny, the existence of an appointment. The VDT was not at the facility and could not elaborate on the issue with the appointment. She was not in pain on the day of the missed appointment, and she had not developed an infection. She stated she was concerned about her leg and was disappointed the facility did not get her to her appointment. She had moments of anxiety about the condition of her leg and her concern had grown to worry. The next day, 11/7/2024 or 11/8/2024, she learned she had a new follow up appointment on 11/12/2024 with the wound care doctor. The news of the upcoming appointment, which was several days away, did not reduce her worry about the condition of her leg. In fact, her worry intensified. She stated she was irritated and aggravated the facility did not make her appointment. On 11/8/2024 or 11/10/2024, she received wound care from the facility. During wound care, the nurse noticed an odor emitting from the resident's wound. Resident #162 was prescribed an antibiotic. After she learned of the infection, she hypothesized it would not have gotten infected if she had made her appointment on 11/6/2024. Having to wait a few days more for her appointment, on top of a new infection, made her angry. She made it to the doctor on 11/12/2024 for wound care and feels much better now. She has a weekly appointment for wound care, and her next appointment was scheduled for 11/19/2024.</p> <p>Interview on 11/15/2024 at 3:16 PM with LVN Q revealed the nursing staff reviewed the DC papers from the residents and coordinated with the VDT using an appointment request and submission to the appointment request box. The nursing staff could enter a progress note in the resident's medical record, as an option to remember, because papers get lost. If a nursing staff member entered an appointment into the medical record, they should have initiated the appointment request form. Follow up appointments for residents were important because residents obviously needed to have a health care provider follow up for a condition that needed further treatment. A resident's medical condition that needed further treatment but did not get further treatment due to a missed appointment, risked exacerbation, possible infection, or possible pain. Residents who missed an appointment for a medical treatment, were at risk of psychosocial harm, such as depression, anxiety, worry, or anger. A Safeguards in place to make sure residents got to their future appointments was documentation review and communication between nursing staff and the VDT for confirmation.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/15/24 at 4:47 PM with the DON revealed the facility followed physician orders that described treatment on any resident's DC order. These recommendations were read by the nursing staff and then the appointment request was provided to the VDT to make the appointment. The orders for Resident #162, upon DC on 11/4/2024, indicated a follow-up appointment for wound care at an off-site entity on 11/6/2024. The resident did not get to her appointment. The DON was unable to confirm if the facility called the doctor for any new orders based on the resident missing her appointment on 11/6/2024. Wound care continued like it was ordered on 11/4/2024. The DON stated the follow-up appointments were important because of continuity of care. The Resident's, who missed appointments, risked interrupted continuity of care and the health risk varied depending upon the medical concern. The DON stated that Resident #162 was ordered [wound care orders] upon her return on 11/4/2024; [Do not bend left knee] and [Follow up appointment 11-6-2024] and [Not to be in wheelchair greater than 4 hours.] The Resident received orders to clean and pat wound dry and orders to treat every other day. On 11/10/2024, which was 4 days later then the missed appointment, the resident developed an infection in the wound. The resident was prescribed Doxycycline 100 MG BID for 7 days. The resident had her rescheduled follow up appointment on 11/12/2024. The DON could not state, as a matter of fact, that the delay in getting the resident to the physician's follow-up appointment caused her leg to get infected. She said the leg could have gotten infected at any point along the way, even if she did make the follow-up appointment on 11/6/2024. The DON stated she spoke to Resident #162 after she returned from the hospital, on 11/4/2024, for the skin tear. She stated Resident #162 had been scared due to the amount of blood, and its loss. She had not heard of any complaints from Resident #162's heightened anxiety for either the skin tear or missing her follow-up appointment.</p> <p>Interview on 11/15/2024 at 6:08 PM with ADM A revealed there was a disciplinary approach in place for residents to get to their follow-up appointments. The approach consisted of medical records review and any appointment requests were provided to the VDT. A safeguard in place, to ensure accurate appointment setting, was that the nursing staff checked the scheduling book to make sure appointments matched the orders, did not conflict with others, and could be provided. The ADONs followed up with the transporter to make sure the appointments were set per the physician order. It was important for residents to attend their follow up appointments because it was the physician request to follow up. Some negative outcomes for a resident missing a follow up appointment depended on the details for the appointment.</p> <p>Record review of the facility's Physician Orders policy, dated 7/2022, reflected it was the policy of the facility to accurately implement orders upon the written order of a person duly licensed and authorized to do so in accordance with the resident's plan of care.</p> <p>Record review of the facility's Transportation to Appointment Policy, dated 05/2027, reflected it was the policy of the facility to assist residents in arranging transportation to and from appointments when necessary.</p> <p>Record review of the facility's ADL policy, in the Quality-of-Care Section; dated 7/2020, reflected it was the policy of the facility that residents were given the appropriate treatment and services to attain, or maintain, the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care.</p>		

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

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772</p> <p>Based on observations, interviews, and record review, the facility failed to ensure residents' environments remained as free from accident hazards as possible for 1 of 9 Residents (Resident #162) reviewed for environmental accidents.</p> <p>The facility failed to ensure Resident #162 was free from environmental hazards and accidents during a 1 person transfer from a wheelchair to a bed.</p> <p>This failure placed residents at risk of physical and psychosocial harm.</p> <p>Findings included:</p> <p>Record review of an intake, dated 11/7/2024 at 8:21 AM, reflected a complaint made by a responsible party on behalf of Resident #162. The intake alleged on 11/2/2024 a staff attempted to transfer Resident #162 from her wheelchair to her bed. The complainant alleged Resident #162 required 2 people to transfer her, but only 1 staff member was present. The complainant alleged Resident #162 received a wound, a huge gash to her leg. Resident #162 was rushed to the hospital where she received a blood transfusion. Upon her release, Resident #162 was supposed to have returned to see the wound care doctor on 11/6/2024, but the facility allegedly did not read the discharge papers and did not get her to the appointment. The Responsible parties for Resident #162 were extremely worried about the lack of care.</p> <p>Record review of Resident #162's AR, dated 11/13/2024, reflected a [AGE] year-old-woman who was admitted to the facility on [DATE]. She was diagnosed with muscle weakness, need for assistance with personal care (which was a diagnosed medical classification influenced by health status and needed support with health services), unsteadiness on feet, other reduced mobility, unspecified lack of coordination, other abnormalities of gait (manner of walking) and mobility, unspecified abnormalities of gait and mobility, Parkinson's disease (which was progressive disorder that affected the nervous system and the parts of the body controlled by the nerves), other lack of coordination, body mass index 36.0-36.9- adult , generalized anxiety disorder (which was a mental heal condition marked by heightened responses (worry) to certain situations and stimuli), and other recurrent depressive disorders (which was a mental condition characterized by depressed mood, loss of pleasure, or interest in life).</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #162's Quarterly MDS Assessment, dated 8/13/2024, reflected the resident had a BIMS Score of 15. A BIMS Score of 15 indicated the resident had no cognitive impairment. The resident had no impairment in either upper extremity (shoulder, elbow, wrist, and hand;) Resident had no impairment in either lower extremity (hip, knee, ankle, and foot.) The resident utilized a wheelchair and a walker for mobility. The resident required partial/moderate assistance for eating, oral hygiene, and personal hygiene (which meant the helper provided less than half the effort while the resident completed the greater portion of the activity). The resident was dependent upon staff for toileting hygiene, showering/bathing self, and putting on/taking off shoes (which meant the helper provided all the effort of the activity). The resident received substantial/maximal assistance with upper body dressing (which meant the helper provided more than half the effort while the resident completed the lesser portion of the activity). Lower body dressing: not applicable, not attempted, and the resident did not perform this activity prior. The resident required substantial/maximum assistance with roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer (which meant the helper provided more than half the effort while the resident completed the lesser portion of the activity).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #162's CCP reflected a Focus area for Parkinson's Disease, created on 8/20/2022. The Goal, created on 8/20/2022, indicated the resident would be free from complications related to Parkinson's Disease. The Intervention, initiated 8/20/2022, delegated nursing facility staff to monitor and report resident's poor balance, poor coordination, gait disturbance, muscle cramps or rigidity, decline in range of motion, and changes in mood; a Focus area for ADL Self Care performance deficit, revised on 3/29/2024, R/T limited mobility for Parkinson's Disease. The Goal, revised on 7/11/2024, indicated resident would maintain current level in bed mobility, transfers, eating, dressing, grooming, toilet use, and personal hygiene. The Intervention, created on 8/1/2022, delegated nursing facility staff to provide 1 staff limited assist for toilet use and 1 person contact guard for transfers; a Focus are for falls, revised on 10/10/2023, R/T weakness, Parkinson's Disease, and Anxiety. The Goal, revised on 7/11/2024, indicated the resident would not sustain serious injury. The Intervention, initiated on 9/27/2023, delegated nursing facility staff to educated resident on locking wheelchair wheels before transfers and have bed in the lowest position; a Focus area for antidepressant medication use, initiated on 12/24/2021, /T depression. The Goal, initiated on 12/24/2021, indicated the resident would show decreased episodes of depression. The Intervention, initiated 12/24/2024, delegated nursing facility staff to give antidepressant medications as ordered and to monitor for muscle tremor, agitation, depression, sadness, irritability, anger, crying, worthlessness, slowed movements, lethargy, fear of being alone, concern with body functions, anxiety, and the need for constant reassurances; a FOCUS area for anti-anxiety medication, initiated on 12/24/2021, R/T anxiety. The Goal, initiated on 12/24/2021, indicated the resident would show decreased anxiety. The Intervention, initiated on 12/24/2024, delegated nursing facility staff to give anti-anxiety medications as ordered. Monitor for clumsiness, slow reflexes, confusion, disorientation, depression, dizziness, light-headedness; a Focus are for skin tear to left knee, initiated 11/2/2024, R/T transferring. The Goal, initiated on 11/5/2024, indicated the skin tear on the left knee would heal and the resident would be free from skin tears. The Intervention, initiated on 11/2/2024, delegated nursing facility staff to identify potential causative factors, notify Med. Dir., and family, of skin tears occur, prevent skin tears, monitor location, size, and treatment of skin tear, and use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces; a Focus area for potential/actual skin impairment to skin integrity, initiated 11/02/2024, R/T laceration to the left lower leg with sutures in place. Follow up with Physician at hospital on 11/12/2024. Enhanced Barrier Precautions ordered. An addition goal, initiated on 11/8/2024, indicated the resident would not have any complications R/T skin in jury type. The Interventions, initiated on 11/2/2024, delegated nursing facility staff to monitor location, size, and treatment of skin tear, and use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces.</p> <p>Record review of Resident #162's Order Summary Report reflected orders for:</p> <ol style="list-style-type: none"> 1. Change of condition for: (add what the Change of Condition) Provider notified: Med. Dir.; resident sent to emergency room for laceration to lower left extremity; family visiting at time of incident. <p>Every shift for 3 Days, started 11/3/2024.</p> <ol style="list-style-type: none"> 2. Clean left knee with wound cleanser pat dry then use xeroform gauze on stiches line to keep moist, <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>cover with 4-inch x4 inch gauze and (dressing) pad and wrap with kerlix (gauze) and ace once a day and as needed. Left knee should not be bend for at least a week and patient should not be in a wheelchair for more than 4 hours a day. Each day shift for secondary to trauma, started 11/5/2024.</p> <p>Record review of a facility communication for Resident #162, dated 11/2/2024, indicated Resident #162 experienced a change in condition on 11/2/2022 due to a skin laceration, puncture, or wound. The condition was a new condition and the resident experienced pain at the degree of 8 out of 10. At the time of the assessment, the skin wound, or ulcer, progress was unable to be determined. The resident was on anticoagulant therapy (blood thinner).</p> <p>Record review of a nursing home to hospital; transfer form, dated 11/2/2024, indicated Resident #162 transferred from the nursing home to a local hospital on 1/2/2024 for a skin wound, or ulcer. Blood pressure was 202/104. ADLs, such as bathing, dressing, transfers, toileting, and eating required assistance. Additional relevant information was resident saying laceration was received to the lower left leg during a transfer from the bed to wheelchair. Pressure bandage applied, 911 called, nurse practitioner, notified family, family visiting when accident occurred. (Form Incorrect-Transfer was from the wheelchair to the bed.)</p> <p>Record review of Resident #162's medication order reflected Resident #162 received 50 Micrograms/Milliliters Fentanyl injection (pain medication) once on 11/2/2024 at 10:23 PM.</p> <p>Record review of Resident #162's hospital discharge paperwork reflected Resident #162 presented to the emergency department from a local nursing home on 11/2/2024 at 8:50 PM with an acute left lower extremity bleeding from a wound that occurred today just prior to arrival. Height was 5 feet 6 inches; Weight was 183 pounds. Large lower extremity wound oozing blood. [NAME] blood cell counts on 11/2/2024 were first recorded at 5:38 PM results with 7.7 and again at 7:22 PM results 11.7. Principle Problem: Acute blood loss, anemia</p> <p>Secondary to left lower extremity injury.</p> <p>*Presented with acute onset bleeding from left lower extremity wound after injury at nursing home, currently on dual antiplatelet therapy.</p> <p>*Hypotensive with blood pressure in 80s/60s, status post (experienced a medical event) fluid bolus with improvement.</p> <p>*Hemoglobin 11.4 to 10.3</p> <p>* Status post pressure dressing with Tranexamic Acid (medication to prevent bleeding) and lidocaine with epinephrine impregnated quick clot, achieving adequate hemostasis; status post 1 unit packed red blood cells emergently.</p> <p>*No overt signs of continued blood loss at this time.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*Monitor Hereditary Hemochromatosis (a genetic disorder that causes iron to build up in organs) every 12 hours, transfuse if Red Blood Cells are less than 7, or active bleeding</p> <p>*Patient also requested wound care referral to wound care physician on discharge.</p> <p>*Blood pressure low on arrival; hold high blood pressure medications at this time in light of acute bleeding. Monitor blood pressure.</p> <p>*Resident admitted to the hospital from the emergency rodiagnom on [DATE] at 7:24 PM for monitoring.</p> <p>*Handwritten, on the last page of the hospital discharge paperwork, dated 11/4/2024 indicated resident received 13 stitches to her left leg below the knee.</p> <p>*1 unit of blood.</p> <p>*Wound care order follow-up clinic on 11/6/2024 at 2:30 PM.</p> <p>*Do not bend knee for 1 week; not to be in wheelchair for more than 4 hours; keep leg straight.</p> <p>*Blood pressure was 150/70 at 11:30 AM 11/4/2024.</p> <p>* Resident discharged from the hospital to the nursing facility on 11/4/2024 at 1:48 PM</p> <p>*Resident was transported by a local transport company to the nursing facility on 11/4/2024.</p> <p>Record review of Resident #162's Skin Evaluation, dated 11/4/2024 at 4:46 PM, reflected the Resident had a laceration to the left lower leg at 8 CM x2.5 CM x0.5 CM with sutures in place. Left and right leg with some swelling observed with a moderate indentation left in the skin after applying pressure to both legs. Entered by ADON</p> <p>Record review of Resident #162's TAR, dated 11/2024, reflected Resident #162 received Wound care treatment described in the resident's order summary report on 11/5/2024, 11/6/2024, 11/8/2024, 11/10/2024, 11/12/2024, and 11/15/2024.</p> <p>Record review of Resident #162's infection surveillance assessment, dated 11/10/2024 at 2:21 PM reflected Resident #162 developed an infection to her skin, soft tissue, and mucus membrane. Resident #162 was prescribed Doxycycline 100 MG 2 times a day for 7 days. Started 11/10/2024. Entered by LVN O. Wound care continued per order.</p> <p>Record review of Resident #162's PN, dated 11/10/2024 at 2:16 PM reflected an order for Resident #162 to start Doxycycline 100 MG 2 times a day for 7 days R/T wound infection. Entered by LVN O.</p> <p>Record review of Resident #162's Skin Evaluation, dated 11/10/2024 at 3:57 PM, reflected the Resident had a laceration to the left lower leg at 8 CM x2.5 CM x0.5 CM with sutures in place. Left and right leg with some swelling observed with a moderate indentation left in the skin after applying pressure to both legs. Doxycycline 100 MG 2 times a day for 7 days for infection. Entered by LVN C.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #162's MAR, dated 11/2024, reflected Resident #162 received Doxycycline 100 MG 2 times a day for 7 days. The first dose was on 11/10/2024 at 4:00 PM. The medication continued through 11/15/2024 and was due to run the course on 11/17/2024 at 8:00 AM.</p> <p>Record review of Resident #162's PN, dated 11/12/2024 at 4:27 PM, reflected Resident #162 reported a pain level at a severity of a 3 out of 10. Pain medication administered as needed/ effective. Entered by LVN C.</p> <p>Observation and interview on 11/12/24 at 4:34 PM with Resident #162 revealed the resident in her room sitting in her wheelchair watching television. The resident was well groomed and in good spirits. She made appropriate eye contact and was easy to engage. The room was free from odors but was slightly cluttered. The interview revealed she was expecting a visit from someone from the complaint department. The resident explained that on 11/2/2024, she was helped in a transfer from her wheelchair to her bed by CNA P. During the transfer, the CNA was not able to hold her up and she hit her leg against a part of the bed that caused a tear in her skin. The mobility support bar, which was on the side of the bed where the transfer occurred, was unlocked from the vertical position to the horizontal position. She explained she was rushed to the hospital, where she stayed for about 2 days. While there, she received pain medication, an infusion of blood, and several stitches. She made mention she had just come back from the wound care doctor earlier that same day but was supposed to have seen the wound care doctor on 11/6/2024. When she asked staff why she did not get to her appointment, staff stated something about the transporter not getting the appointment information.</p> <p>Interview and observation on 11/13/24 at 3:03 PM with the MNTD revealed Resident #162's bed mobility support bars were attached to the bed, on each side, with three bolts. The mobility bar was a slender, upside-down U-shaped bar, about 36 to 42 inches long. The top end of the slender upside-down U-shaped bar extended in the direction of the ceiling. The bottom of the slender upside-down U-shaped bar extended in the direction of the floor. The bottom 6-8 inches of the slender upside-down U-shaped bar had a welded junction box. The welded junction box was the location of the mobility bar where the three attachment bolts were housed. The 6-8-inch welded junction box section was the point where the slender upside-down U-shaped bar was attached to the bed. The slender upside-down U-shaped bar was hollow and each of the hollow ends, at the bottom of the welded junction box, were covered with smooth ended round black safety caps. Slightly higher than the center point of the welded junction box, was a black knob. To change the slender upside-down U-shaped bar from the vertical to horizontal position, the black knob was pulled outwards to release a stabilizing pin. When the stabilizing pin was disengaged, the slender upside-down U-shaped bar rotated from the vertical to horizontal position. When rotated, the top of the slender upside-down U-shaped bar pivoted 90 degrees towards the head of the bed; the bottom of the slender upside-down U-shaped bar, which was welded junction box and the two plastic capped ends, rotated 90 degrees towards the foot of the bed. The MNTD touted years of experience with the facility's mobility bars and did not know how the resident could have torn her skin on any part, or configuration, of the bed's mobility bar. The MNTD stated there were no sharp edges on the mobility bar; no sharp edges on the sides on the rounded bar; no sharp edges on the welded junction box; and no sharp edges on the smooth ended round black safety caps. Observations of the MNTD in Resident #162's room, revealed the MNTD running his fingers along the curved bar that extended vertically from the side of the bed, the welded junction box, and the 2 smooth ended round black safety caps. His inspection revealed no edges that could have contributed to Resident #162's skin tear. He said there was no way the resident hurt herself on the mobility bar.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Group interview, observation, and record review on 11/13/2024 at 4:40 PM with Resident #162 and RP #1000, in Resident #162's room, revealed RP #1000 was concerned about the skin tear Resident #162 suffered, on 11/2/2024. RP #1000 was not present at the time of the accident. RP #1000 pointed out a bouquet of flowers CNA P sent the resident. RP #1000 did not think the CNA P meant to hurt the resident; furthermore, RP #1000 felt the accident was just that, an accident. RP #1000 did question the size, height, and weight of CNA P, who performed the transfer, and described how her Resident #162 towered over CNA P. Observations of the room revealed Resident #162's bed. The foot of the bed was at the 6 o'clock position, the head of the bed was at the 12 o'clock position, the side of the bed closest to the window was at the 3 o'clock position, and the side of the bed closest to the bathroom was at the 9 o'clock position. Resident #162 described the wheelchair to bed transfer at the time of the accident. Resident #162 stated CNA P came to the room to help her from the wheelchair to the bed. Resident #162 was at the 4 o'clock position in her wheelchair facing the bed at a 45-degree angle (the portion of the left armrest, where the left hand of the resident would have been, was closest to the bed.) CNA P locked the wheels on the wheelchair and started to perform the transfer. At the beginning of the transfer, Resident #162 asked CNA P to stop because her legs were not in the correct position. CNA P continued with the transfer. During the transfer, the resident was lifted and shifted to their left slightly more than 90 degrees to place her buttocks on the side of the bed at the 3 o'clock position. During the transfer, and before Resident #162 realized what was happening, the accident had occurred. She stated her left leg struck something hard and the accident occurred. Measurements were taken from the top height of the mattress (6 inches in thickness) at the 3 o'clock position to the floor. The distance was 25 inches. Three hard surfaces existed between the mattress and the floor. One hard surface between the top of the mattress and the floor was a metal mattress support structure (Surface A.) Surface A was at 2 inches in vertical length and located just beneath the mattress. A second hard surface was a middle metal support rail with an information plate on it (Surface B.) Surface B was at 2 inches beneath Surface A and Surface B was at 3 inches in vertical length. A third hard surface was the lowest metal support rail closest to the floor (Surface C.) Surface C was at 2 inches in vertical length and directly beneath Surface B; Surface C was recessed inwards under the bed. When rubbing a finger against the bottom edge of Surface B, there was a straight and prominent 90-degree edge. There was a dark circular stain on the floor. The stain was 8-12 inches in distance from the outline of the bed, just to the left, while facing the window at the 3 o'clock position (2:45 position.) The stain was described by Resident #162 as a blood stain left by the accident. The size of the stain was slightly larger than the diameter of a softball. Measurements were taken of the distance between Resident #162's left knee to left ankle. The distance was 15 inches. The resident's left leg and left ankle were thickly wrapped with ace bandages at the time of the interview, so the distance from the ankle to the bottom of the foot was estimated to be an additional 2 inches. At the time of the transfer on 11/2/2024, the resident was not wearing any shoes. The bed's mobility bar, the slender upside-down U-shaped bar, was attached to the bed at the 1:45 position of the bed. It was attached by 3 bolts on the welded junction box, 6-8 inches in vertical length, at the height of Surface B. After disengaging the stabilizing pin by pulling the black knob, the slender upside-down U-shaped bar rotated 90 degrees; the curved end at the top rotated towards the head of the bed; and the welded junction box rotated in the direction of the foot of the bed. The welded junction box, which was at the bottom of the slender upside-down U-shaped bar, had no parts extending its length, but the 2 smooth ended round black safety caps. The welded junction box was the point of a 90-degree rotation. Since there were no parts extending its length downward, except the smooth ended round black safety caps, the rotation did not extend any of its parts towards the foot of the bed, but the smooth ended round safety caps. The mobility bar, in the horizontal position, was parallel in direction, and the same heights of Surface B. RP #1000 observed the inspection of Resident #162's bed and mobility bar and stated, there was no way Resident #162 could have hurt her leg on the mobility bar in the horizontal position. Record review of photos, provided by RP #1000, reflected the injury to Resident #162's lower left extremity. Looking at the photo, the picture of the left leg was viewed from the vantage point of the resident looking down at their leg. The left kneecap was at the 6 o'clock position, the left outer side of her left kneecap was at the 9 o'clock position, the left shin was at the 12 o'clock position, and the right inner side of her left kneecap was at the 3 o'clock position. The photos reflected a straight tear in the skin beginning just beneath, or at the same level, of Resident #162's left kneecap area (Spot A.) The tear began at the 3 o'clock position</p>

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NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation - Waxaha		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and observation 11/13/24 at 5:16 PM with RP #3000 revealed she was at the facility on 11/2/2024 at the time Resident #162 had the injury to her left lower leg. Just before the injury occurred, CNA P came to the room to transfer Resident #162 from her wheelchair to her bed. RP #3000 was asked to leave the room, by the resident, while she was being transferred. While outside of the room, the door was open; curtain was not drawn. RP #3000 was standing across the hall from the resident's door; the door was at RP #3000's 11:00 position; and the resident's bed was 20 feet away, to her front. In RP #3000's line of sight to her the resident, was staff with a medication cart. The medication cart staff had her back to the inside of the resident's room with objects in their hands. The medication staff was not making any noises. After a span of 1-2 minutes, RP #3000 heard Resident #162 protesting the method CNA P was attempting to transfer her (exact words not remembered.) About a minute after the protest, Resident #162 was heard emitting a cry out in pain. After the cry of pain, she clearly heard CNA P cry out, oh no. After the CNA cried out oh no, the staff member at the medication cart turned around and went in to assess the situation. RP #3000 stated the facility responded, called 911, and got her to the hospital. RP #3000 did not observe, nor had she looked for, the resident with a gait belt (a cloth strap used to help life a resident) around her waist. She did not think the size, height, and weight of CNA P was appropriate to transfer someone with the size, height, and weight of Resident #162, since she was transferring Resident #162 alone.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/13/24 at 6:04 PM with CNA P revealed she was the CNA who transferred Resident #162 from her wheelchair to her bed on 11/2/2024. She explained how she transferred the resident by placing the wheelchair next to the bed. The foot of the bed was at the 6 o'clock position, the head of the bed was at the 12 o'clock position, the side of the bed closest to the window was at the 3 o'clock position, and the side of the bed closest to the bathroom was at the 9 o'clock position. The resident's wheelchair was at about a 45-degree angle to the bed close to the 4 o'clock position. The opening of the wheelchair was facing towards the bed. The resident was seated in the wheelchair with her legs stretched outwards to the front. The wheels were locked; the bed was in the lowest position. CNA P was standing in front of the resident, facing her, with her legs inside of the positioning of the resident's legs. The resident wrapped her arms around the CNA's waist. The CNA put her arms under the resident's armpits (inside the resident's grip around the CNA's waist) and laced her left hand over right wrist; her right hand was in a fist. Before they started the transfer, the CNA stated Resident #162's legs were pointed straight out. She stated she moved the resident's legs in a manner to move them away from the bed, so she did not hit them during the transfer. When trying to move the resident's legs prior to performing the transfer, the resident stopped her and stated, No No No , don't do that, watch my legs. The CNA stated she stopped at that moment thinking she needed more support. She stated she grabbed a gait belt and wrapped it around the resident's upper abdomen area, just under her breasts. CNA P was standing in front of the resident, facing her, with her legs inside of the positioning of the resident's legs. The resident wrapped her arms around the CNA's waist. The CNA put her arms under the resident's armpits (inside the resident's grip around the CNA's waist) and grabbed onto the gait belt. The resident's legs were still straight out. She stated the resident would not let the CNA bend them. When the CNA lifted and turned the resident, the CNA pivoted to her right; while the resident pivoted to her left to be placed on the bed. At the time of the lifting, CNA P stated the resident's legs were at an approximate 45-degree angle from the resident's hips to the ground; both legs were on the outside of the CNA's legs. Resident #162's legs were angled downwards and away from the bed pointing towards the 3 o'clock position. When Resident #162's buttocks came to rest on the mattress, her legs were straight at a downward 45-degree towards the floor still directed towards the 3 o'clock position. It was at that moment when the resident stated ouch, ouch, my leg. CNA and the resident looked down at the same time and noticed the tear of the skin on her lower left leg, two or three inches under the knee. CNA stated she stated, OMG, I am so sorry, and yelled out for help. The resident handed the CNA a brief, and she applied direct pressure. The nursing staff arrived and called 911. Resident #162 went to the hospital. When asked how CNA P thought the injury occurred, she mentioned it could have been the bottom of the mobility bar and the two black buttons on the bottom. When asked, she stated she was not sure if the resident's legs were as straight as they were described earlier; furthermore, it was possible the resident's side of her left shin was up against the bed frame during the transfer.</p> <p>Interview and observation on 11/13/2024 at 6:55 PM with ADM B revealed the possible source of Resident #162's left lower leg injury could have been Surface B's prominent edge on her bed. ADM B was observed looking at a bed, which was not being used. She stated she would look at the bed in further detail with the maintenance director.</p> <p>Interview and observation on 11/14/2024 at 2:30 PM with CNA P revealed the use of a gait belt had not been discussed in any interview prior to her interview on 11/13/2024 at 6:04 PM. When asked for clarity, CNA P stated she did stop the transfer and apply a gait belt to continue the transfer. CNA P's size, height, and weight were observed as petite.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/15/24 at 4:47 PM with the DON revealed Resident #162's skin tear was not reported to the state because the resident, who had a high BIMS Score, was able to explain what happened during the transfer. The facility did not feel the skin tear was the result of neglect or mistreatment; therefore, it did not meet the criteria for reporting. The DON stated that Resident #162 was ordered [wound care orders] upon her return on 11/4/2024; [Do not bend left knee] and [Follow up appointment 11-6-2024] and [Not to be in wheelchair greater than 4 hours.] The Resident received orders to clean and pat wound dry and orders to treat every other day. The DON stated she spoke to Resident #162 after she returned from the hospital, on 11/4/2024, for the skin tear. She stated Resident #162 had been scared due to the amount of blood, and its loss. She had not heard of any complaints from Resident #162's heightened anxiety for either the skin tear.</p> <p>Interview on 11/20/2024 at 11:13 AM with Resident #162 revealed the initial objection, where she cautioned the way CNA P was transferring her, was at the start of the transfer. Resident #162 told CNA P that her leg was caught on the bed. CNA P did not pause. CNA P did not stop and apply a gait belt. CNA P continued with the transfer. The resident stated the portion of her left leg, which was caught on the bed, was the area just beneath her kneecap on the outside left portion of the upper shin area. After the injury occurred, CNA P got Resident #162 to the bed, seated outward from the bed at the 3 o'clock position facing the window. The resident confirmed the blood stain on the floor was 8-12 inches from the outline of the bed at the 3'oclock position.</p> <p>Record review of the facility's Incident and Accident Policy, dated 5/2018, reflected any accident that required reporting would be completed to the state's standard.</p> <p>Record review of the facility's Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment Policy, dated 10/2022, reflected it was the right of each resident be free from neglect and mistreatment. Neglect was the failure of the facility to have provided</p>		