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	11/15/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on observations, interviews, and record review, the facility failed to ensure residents could receive services with reasonable accommodation of resident's needs and preferences for 1 of 9 Residents (Resident #23) reviewed for accommodation of needs. The facility failed to place Resident #23's call light paddle (which was a white, 0.5 inch by 2.5-inch diameter plastic circular paddle, used to call staff for resident assistance) in a place the resident could reach or activate. This failure placed the residents at risk of having their medical needs unmet and to have experienced psychosocial harm. Findings included: Record review or Resident #23's AR, dated 11/15/2024, reflected an [AGE] year-old-man who admitted to the facility on [DATE]. He was diagnosed with Parkinson's Disease (which was progressive disorder that affected the nervous system and the parts of the body controlled by the nerves), need for assistance with personal care (which was a diagnosed medical classification influenced by health status and needed support with health services), and other lack of coordination. Record review of Resident #23's Quarterly MDS Assessment, dated 7/21/2024, reflected the resident had a BIMS Score of 11. A BIMS Score of 11 indicated the resident had moderate cognitive impairment. The resident had impairment on both sides of their upper extremities (shoulder, elbow, wrist, and hand). The resident had impairment on both sides of their lower extremities (hip, knee, ankle, and foot). The resident utilized a wheelchair, and a geriatric-chair (a large padded reclining chair with wheels that people with limited mobility) for mobility. The resident was dependent upon staff (which meant the helper provided all the effort of the activity) for eating, oral hygiene, toileting hygiene, showering/bathing self, upper body dressing, lower body dressing, putting on/taking off shoes, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer, walking 10 feet, walking 50 feet (with 2 turns), and walking 150 feet. The resident was always incontinence of bowel and bladder. (continued on next page)

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #23's CCP reflected an area of Focus area of risk of falls, initiated on revised on 12/12/2022, R/T weakness and balance. The Goal, initiated on 12/12/2022, indicated the resident would not sustain serious injury. The Intervention, initiated on 12/12/2022, delegated nursing facility staff to ensure the resident's call light was within reach and encourage resident to use it to call for assistance as needed; and, a Focus area of pressure ulcer development, initiated on revised on 3/5/2024, R/T disease process and immobility. The Goal, revised on 2/6/2024, indicated the resident would have intact skin and show no signs of pressure ulcer progression of infection. The Intervention, initiated on 2/6/2024, delegated nursing facility staff to ensure the resident's call light was within reach. Record review of Resident #23's Order Summary Report reflected an order, started on 1/24/2024, for Tramadol Oral Tablet, 5 MG, by mouth 3 times a day for pain; an order for Morphine Sulfate Oral Solution 20 MG, .25 ML to 1 ML, every hour as needed for pain. Observations and interview on 11/12/24 at 10:17 AM revealed Resident #23 was in his bed resting. The head of the resident's bed was at a 45-degree angle. Both resident's arms were beneath his top sheet. The resident had a call paddle instead of a call light button (which was a white, life saver sized, handheld mechanism with a red button at one end used to call staff for help). The call paddle was placed near the top outer edge of his right shoulder, and it was not touching his body. He tried to demonstrate, with his right arm, how he could activate the call system in place to call for staff. He did not know the location of the call light paddle; he was told it was located near the top of his right shoulder. He could not free his right arm from the covers to reach, or activate, the call light paddle. He was unable to reach across his body, with his left arm, to reach or activate the call light paddle either. Observations revealed the resident had a limited range of motion in both left and right arms. He stated he could not call for help when he needed it and was at the mercy of staff checking on him. Since he could not reach the call paddle, he felt helpless. Observations and interview on 11/13/24 at 10:05 AM revealed Resident #23 was in his bed watching the television. The head of the resident's bed was at a 45-degree angle. The call paddle was placed near the top outer edge of his right shoulder, and it was not touching his body. He tried to demonstrate, with his right arm, how he could activate the call system in place to call for staff. He did not know the location of the call light paddle; he was told it was located near the top of his right shoulder. He tried to activate the call paddle with his right arm but was unable to raise his right arm to reach to his shoulder area. He was unable to reach across with his left arm to activate the call light paddle either. Again, he felt like he was at the mercy of staff to come and check on him and he still felt helpless. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/15/24 at 2:55 PM with LVN N revealed the residents use their call light to get staff help with emergencies, assistance with eating, help being changed, to drink water, or help with a general care concern. To use a call light button, a resident must have the physical ability to move an extremity to reach it. The resident must have the ability to grasp the call light button in their hand and use a digit to press the red button. For residents, who did not have the physical ability to use a call light button, there was the option of a call light paddle. A call light paddle was a small flat round device a resident could touch, or move, to call for staff. A resident could use any extremity to call for help. Residents, who were given a call light paddle based on their physical limitations, should have had the call light paddle positioned near their body in an accessible spot, and educated how to use it. Some negative outcomes for a resident, who could not call for help, were toileting accidents, falls, linen entanglements, issues with dignity, anxiety, or fear. Safeguards to ensure residents had access to their call lights were regular room rounds, as needed room rounds, and confirmation the call light was in the correct place for the resident upon having left the room. Interview on 11/15/24 at 4:33 PM with CNA M revealed call lights were provided to residents to use to get help from staff with their needs. One of the call light devices, a call light button, was a lifesaver sized device, the handle, with a red button at the end. The other was a round paddle that was activated by movement. To use the button, you had to be physically able to hold the device and press the button. The paddle required only to be moved or bumped. Some residents did not have the ability to use the call light button, because of contractures and had to use the paddle. CNA M stated Resident #23 utilized a call light paddle. She stated, I place the call light paddle on his chest, described as the sweet spot. The resident could not move their arms much and the paddle needed to be close. Negative outcomes for residents who could not call for help were thirst, hunger, sat in wet clothes, anger, or felt ignored. The staff were trained to make sure the call light buttons, or paddles, were always in the resident's reach. Safeguards in place to ensure residents always had access to their call lights consisted of room checks every 2 hours and to make sure the call light was within reach upon leaving the room. Observation and interview on 11/15/2024 at 5:15 PM with RP #4000 revealed him, and Resident #23 , moving throughout the facility in a geriatric-chair (a large padded reclining chair with wheels that people with limited mobility.) RP #4000 stated he was not that impressed with the care the facility provided. He explained how he visited Resident #23 recently and the resident was very thirsty. He explained the resident consumed a large cup of water in one act of consumption. When RP #4000 was informed about the call light paddle inaccessibility, he voiced frustration and mentioned the resident did not have the physical ability to call for help. He did not like having heard Resident #23 was unable to call for help and at the mercy of staff coming to his room to check on him. Interview on 11/15/24 at 5:46 PM with the DON revealed residents who could not use the traditional call light button were provided with a call paddle. The resident's ability to use the traditional call light button required a physical grasp and the ability to press the red button on top. Resident #23, who had contractures, was provided a paddle. The call light paddle was sensitive, as long as they could touch or move it, the paddle would initiate a call for help to staff. Safeguards in place to make sure the call light paddle was close enough to a resident to activate were clipped, to ensure proximity, angel rounds, and spot checks. Negative outcomes for a resident, who was not able to call staff for help, would having resulted in the resident's need not being met. A resident, who could not call staff for help, would be at the mercy of a staff member making a room round. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/15/24 at 6:01 PM with ADM A revealed she had her staff trained to follow the call light policy. Staff were trained to determine which was the best call light apparatus to provide for the resident and to make sure it was always in reach. Residents that were not able to call for help risked the opportunity to receive staff's help. Record review of the facility's Call Light Policy, dated 8/3/2021, reflected instruction to answer the call light/bell within a reasonable time; listen to the resident's request; responds to the request; and leave the resident comfortable having placed the call device within the resident's reach before leaving the room. Record review of the facility's Rounds, Licensed and Certified Staff Policy, dated 05/2007, reflected instruction to place all call lights within the resident's reach.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 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. The facility failed to report an incident of neglect after a failed resident transfer, which resulted in an injury and a 2 day hospitalization . This failure placed residents at risk of continued incidents of neglect. Findings included: 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. 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). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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). 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. Record review of Resident #162's Order Summary Report reflected orders for: 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 stiches line to keep moist, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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). 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.) 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 Secondary to left lower extremity injury. *Presented with acute onset bleeding from left lower extremity wound after injury at nursing home, currently on dual antiplatelet therapy. *Hypotensive with blood pressure in 80s/60s, status post (experienced a medical event) fluid bolus with improvement. *Hemoglobin 11.4 to 10.3 * 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. *No overt signs of continued blood loss at this time. *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 *Patient also requested wound care referral to wound care physician on discharge. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Blood pressure low on arrival; hold high blood pressure medications at this time in light of acute bleeding. Monitor blood pressure. *Resident admitted to the hospital from the emergency roiagnom on [DATE] at 7:24 PM for monitoring. *Written by hand, 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. *1 unit of blood. *Wound care order follow-up clinic on 11/6/2024 at 2:30 PM. *Do not bend knee for 1 week; not to be in wheelchair for more than 4 hours; keep leg straight. *Blood pressure was 150/70 at 11:30 AM 11/4/2024. * Resident discharged from the hospital to the nursing facility on 11/4/2024 at 1:48 PM *Resident was transported by a local transport company to the nursing facility on 11/4/2024. 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 indention left in the skin after applying pressure to both legs. Entered by ADON 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. 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. 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. 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 indention 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. 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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review or 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. 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 say. 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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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

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	676421	A. Building B. Wing	11/15/2024

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47172 Based on observations, interviews, and record review the facility failed to ensure the resident assessment accurately reflected the resident's status for 2 of 6 residents (Resident #18 and Resident #58) who were reviewed for accuracy of assessments. Resident #18's most recent MDS was coded as resident having clear speech, when observations revealed the resident was only able to make sounds and did not have the ability to carry a conversation. Resident #58's most recent MDS was coded as resident having clear speech, when observations revealed the resident was unable to move her mouth in order to speak. This failure placed residents at risk of incorrect care and services necessary for their physical, mental, and psychosocial well-being. Findings included: Record review of Resident #18's undated face sheet indicated Resident #18 was a [AGE] year-old female, who was admitted to the facility on [DATE]. She was diagnosed with Parkinson's Disease (a movement disorder of the nervous system that worsens over time), epilepsy with status epilepticus (continuous seizure or multiple seizures without enough time to recover between them), personal history of transient ischemic attack (minor stroke), cerebral infarction without residual deficits (temporary disruption of blood flow to the brain), aphasia (inability to speak well), and dysphagia (difficulty swallowing). Record review of Resident #18's Quarterly MDS, dated [DATE], reflected in Section B Speech Clarity that Resident #18 had unclear speech-slurred or mumbled words. Record review of Resident #18's Quarterly MDS, dated [DATE], reflected in Section B Speech Clarity that Resident #18 had clear speech-distinct intelligible words. Record review of Resident #18's care plan dated 09/22/2024 reflected resident has alteration in communication related to aphasia, impaired ability to make self-understood. The interventions listed included for staff to anticipate and meet needs, monitor/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed, refer to speech therapy for evaluation and treatment as ordered, and validate messages by repeating aloud. Observation on 11/12/2024 at 10:07 a.m., revealed resident #18 sitting in her wheelchair in her room watching television. When the resident was being asked by the state surveyor about her stay at the facility, the food, and her daily activities, she responded with unarticulated sounds, and was unable to form words. She enhanced her communication with hand movements, head nods, and other gestures. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/13/2024 at 9:15 a.m., revealed resident #18 in the same position as the previous observation. When asked if she had already eaten breakfast Resident #18 shook her head in a yes motion and then used her hand to motion to the window and made unarticulated sounds to try and communicate back to the state surveyor. Interview on 11/14/2024 at 09:31 a.m., with the LVN E revealed she had worked at the facility off and on for roughly three months. The LVN E stated that the way in which Resident #18 communicated was by rolling up to staff in her wheelchair and would tug on their clothes if she needed their attention, knock on the medicine cart if she needed pain medication, tap the water cart if she needed assistance with water, and used other gestures to communicate her needs. The resident also utilized her call light, shook her head yes or no, and attended activities when they interested her. Interview on 11/14/2024 at 10:03 a.m., with the ST revealed she had worked at the facility since 04/2018. The ST stated that Resident #18 was last evaluated on 01/25/2024 for speech therapy services. The resident was on speech therapy services three times a week from June to October of 2020 when she first admitted to the facility. The resident only showed a little bit of improvement in speech at that time, she already had her own ways of communicating and did not want to continue speech therapy, and she refused a communication board or other devices at that time due to her already formed coping strategies. Record review of Resident #58's undated face sheet indicated Resident #58 was a [AGE] year-old female, who admitted to the facility on [DATE]. She was diagnosed with dementia (decline in mental ability that interferes with daily life), cognitive communication deficit, dysphagia (difficulty swallowing, aphasia (inability to speak well), Parkinson's Disease (a movement disorder of the nervous system that worsens over time), cerebral infarction (lack of blood flow to the brain), dysarthria (motor-speech disorder that makes it difficult to form and pronounce words), and anarthria (a severe form of dysarthria). Record review of Resident #58's Quarterly MDS, significant change dated 05/01/2022 reflected in Section B Speech Clarity that Resident #58 had unclear speech-unclear or mumbled words. Record review of Resident #58's Quarterly MDS, dated [DATE] reflected in Section B Speech Clarity that Resident #58 had clear speech-distinct intelligible words. Record review of Resident #58's care plan dated revised on 09/24/2023 reflected resident has Parkinson's Disease and was at risk for decline in all aspects due to her natural disease process. The interventions listed included to allow sufficient time for speech/communication. Follow ST recommendations to assist resident with communication. The care plan also reflected that the resident was at risk for communication problems related to aphasia. The interventions listed include to anticipate and meet residents needs and to validate the message by repeating aloud, dated revised on 04/22/2024. Observation on 11/12/2024 at 10:25 AM revealed Resident #58 lying in bed with her mouth open wide, eyes half open with gaze towards the ceiling, and her hands contracted in her lap. When the state surveyor introduced themselves to the resident, she did not respond with words, sounds, or a gaze in their direction. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/13/2024 at 09:22 AM revealed Resident #58 in the same position as the previous observation with headphones on her ears. When prompted with questions from the state surveyor, the resident gave no response and did not look in their direction. Interview on 11/13/2024 at 09:22 AM with LVN D revealed she had worked at the facility since 06/2019. LVN D stated that hospice came in the mornings between the hours of 6 AM and 8 AM to visit with Resident #58. She further explained that Resident #58 was changed positions every 2 hours, her tube feedings were changed every 24 hours, and to alleviate Resident 58's contractures she was given a towel for comfort. Interview on 11/14/2024 at 01:04 p.m., with ADM B revealed that around 2 years ago she was the Social Worker for the facility and was familiar with Resident #58. The Social Worker is responsible for completing Section B-Hearing, Speech, and Vision of the MDS assessment. She stated that Resident #58 was aphasic, has not recently been on therapy services, and she cannot speak due to her progression in diagnosis. Interview on 11/14/2024 at 02:13 PM with ST revealed she had worked at the facility since 04/2018. The ST stated that Resident #58 was admitted to the facility in 2020 and had some speaking impairments but was able to communicate. The most recent SLUMS assessment conducted by the ST was conducted on Resident #58 on 09/18/2023 in which the resident scored 0's (meaning severe impairment). Resident #58 was discharged from speech therapy services on 02/28/2024 due to transferring to hospice care . The assessments conducted would lead to therapies residents received to maintain their highest practicable standard of life. Record review on 11/15/2024 of the facility's Resident Assessment and Associated Processes Policy, dated 12.2023 indicated, It is the policy of this facility that resident's will be assessed, and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified. Procedure: Comprehensive Assessment: includes the completion of the MDS (Minimum Data Set} as well as the CAA (Care Area Assessment} process, followed by development and/or review of the comprehensive care plan. Comprehensive MDS assessments include Admission, Annual, Significant Change in Status Assessment, and Significant Correction to Prior Comprehensive Assessment. An accurate Comprehensive Assessment will be made of the resident's needs, strengths, goals, life history and preferences, using the RAI and will include at least the following: Cognitive patterns Communication Mood and behavior patterns Physical functioning and structural problems (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Disease diagnosis and health conditions Special Treatments and procedures Documentation of summary information regarding additional assessment performed on the care areas triggered by the completion of the MDS Documentation of resident participation in the assessment process. 3. Comprehensive assessments will be conducted within 14 days of admission, when there is a significant change in the resident's status and not less than once every 12 months (within 366 days of the previous comprehensive assessment). a. Significant Change: is a major decline or improvement in a resident's status that: i. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; the decline is not considered self-limiting (note: self limiting is when the condition will normally resolve itself without further intervention or by staff implementing standard clinical interventions to resolve the condition.) b. Significant Change in Status Assessment: is a comprehensive assessment that must be completed when the Interdisciplinary Team (IDT) has determined that a residents meets the significant change guidelines for either major improvement or decline. The assessment will be completed within 14 days of identification and the clinical health record will contain information related to when the determination was made.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on observations, interviews, and record review, the facility failed to implement a comprehensive care plan to meet the resident's highest practicable physical, mental, and psychosocial well-being of 2 (Resident #34 and Resident #82) of eleven residents reviewed for care plans. The facility failed to update the comprehensive person-centered care plan for Resident #34's transfer status for use of the Mechanical lift. The facility failed to implement a comprehensive person-centered care plan for Resident #82 that included Enhanced Barrier Precautions as ordered. These failures could place residents at risk for not receiving appropriate care and treatment. Findings included: Resident #34 Record review of Resident #34's Face Sheet reflected an [AGE] year-old male who was admitted on [DATE] with a diagnosis of type 2 diabetes mellitus (elevated blood sugars), spastic hemiplegia affecting unspecified side (paralysis with muscle spasms of an arm or leg), muscle weakness, and cognitive communication deficit. Record review of Resident #34's care plan initiated 10/10/2024 reflected Resident #34 had an ADL self-care performance deficit related to hemiplegia, reduced mobility, weakness, and generalized pain., Resident #34's goal was to safely perform bed mobility, transfers, eating, and grooming through the review date. Interventions included on the care plan were staff to perform ADLs as needed. Interventions on the care plans did not indicate how much assistance was needed. The care plan did not indicate the use of the mechanical lift for transfers. Record review of Resident #34's Admission MDS dated [DATE], reflected a BIMs score of 04 indicating resident #34 was cognitively impaired. The MDS also reflected that Resident #34 had lower extremity impairments, used a wheelchair for mobility, and had a goal to be substantial maximal assistance with transfers. Record review of Resident #34's Visual Bedside Kardex (a smaller version of the comprehensive care plan indicating ADL needs) report dated 11/13/24 reflected staff were to assist with ADLs as needed. Interventions on the Kardex did not indicate how much assistance was needed or the use of the Mechanical Lift. Record review of Resident #34's Documentation Survey Report (a detailed report of how much staff assistance the resident required within a period of time) dated 11/15/2024 reflected Resident #34 was total dependence for transfers with assistance of 1-2 staff members. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 11/12/24 at 12:36 PM Resident #34 was sitting up in his wheelchair with a blue lift sling behind him. He was dressed, groomed, and did not appear in any distress. He did not answer questions just nodded his head up and down when asked if he was ok. In an interview and observation on 11/15/24 at 11:11 AM CNA B stated transfer status could be found on the plan of care. CNA B was able to pull up the plan of care for Resident #34 but was unable to verify mechanical lift transfer status. She stated if she were unsure of how to transfer a resident, she would ask the nurse for clarification. CNA B stated she had been educated on transferring a resident safely using a mechanical lift. She stated the risk for not transferring a resident correctly could be injury or falls possibly. In an interview on 11/15/24 at 12:15 PM ADM Stated mechanical lift should be within the care plan. She stated therapy would do initial evaluation and establish transfer status. The interdisciplinary team were responsible for adding transfer status to the care plan. ADM A stated the risk for not care planning mechanical lifts could be that the resident could get improperly transferred. In an interview on 11/15/24 at 12:50 PM LVN C stated Resident #34 was new to her hall. She stated if she were unclear about a transfer, she would refer to the therapy department. She stated the CNAs needed to see transfer status. LVN C stated not having a transfer status clear on the plan of care could lead to unsafe transfers and falls. LVN C stated it was the responsibility of the nurse to make sure Resident #34's transfer status was correct to ensure safety. In an interview on 11/15/24 at 12:56 PM the DON stated if the nurse aides were unsure of transfer status, they were to use the safest mechanism of transfer and that would be a mechanical lift with the assistance of two staff members. She stated if staff were not sure of transfer status, they couldn ' t ' t always talk to the nurse or therapist. If the staff used the mechanical lift, there would not be a risk to the resident because it was the safest route of transferring a resident. Record review of facility undated policy titled Mechanical Lift and Slings reflected the facility will provide for the safety needs of a resident requiring the use of a mechanical lift for transfers. Transfer status / mechanical lift will be maintained in the resident's medical record. Review of Resident #82's admission record on November 15, 2024, revealed that Resident #82 was a [AGE] year-old male resident who was admitted and re-entered the facility on September 2, 2022, with diagnoses that included: acute kidney failure, personal history of COVID-19, muscle weakness (generalized), need for assistance with personal care, and elevated white blood cell count. Resident #82's advanced directive was Full Code. Enhanced Barrier Precautions (EBP) were required for for high resident contact care activities. Indication: wounds, indwelling medical device, infection and/or MDRO status. Review of Resident #82's Comprehensive Minimum Data Set (MDS) Resident Care and Screening assessment dated [DATE], indicated the resident's Brief Interview for Mental Status (BIMS) score to be twelve out of a possible 15, thus indicating the resident was cognitive and able to make decisions. The same MDS indicated that the resident required set-up or clean-up assistance with most of the resident's functional abilities and goals, except the resident required supervision or touching assistance with tub/shower transfers, and partial/moderate assistance with walking ten feet. The MDS revealed the resident had an indwelling catheter. The MDS revealed the resident had a skin condition that required the application of ointments/medications other than to feet . (continued on next page)

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	676421	A. Building B. Wing	11/15/2024

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #82's Order Summary Report as of 11/15/2024 revealed an active order which read, ENHANCED BARRIER PRECAUTIONS: PPE required for high resident contact care activities. Indication: wounds, indwelling medical device, infection and/or MDRO status every shift. The order status was active, order date: 4/17/2024, and start date: 4/17/2024. Review of Resident #82's care plan did not indicate the need to use Enhanced Barrier Precautions during high contact care activities, although this was ordered. In an interview with the DON on November 15, 2024, at 1 PM, the DON stated that she ensured EBP were implemented and communicated with all staff by making rounds and doing spot checks. The DON stated that staff were educated on which residents required the utilization of EBP, but also there was a gold star or flower [sticker] on the name of each resident who required EBP. The DON stated there was no set determination by the facility as to where PPE was to be placed. The DON stated that staff should always refer to the care plan for an indication such as EBP . In an interview with LVN D on November 15, 2024, at approximately 1:45 PM, it was stated that LVN D learned of residents' conditions through shift reports and referencing treatment records and care plans, as changes occur regularly and often . Record review of facility policy titled Comprehensive Person-Centered Care Planning dated 11/2016 and revised 12/2023 reflected It is the policy of this facility that the interdisciplinary team shall develop a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet the residents medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment .

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 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. The facility failed to ensure Resident #162 made follow up appointment with a wound care specialist. This failure placed residents at risk of condition exacerbation, psychosocial harm, and infection. Findings included: 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. 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). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	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 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). 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. 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). 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.) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	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 Secondary to left lower extremity injury. *Presented with acute onset bleeding from left lower extremity wound after injury at nursing home, currently on dual antiplatelet therapy. *Hypotensive with blood pressure in 80s/60s, status post (experienced a medical event) fluid bolus with improvement. *Hemoglobin 11.4 to 10.3 * 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. *No overt signs of continued blood loss at this time. *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 *Patient also requested wound care referral to wound care physician on discharge. *Blood pressure low on arrival; hold high blood pressure medications at this time in light of acute bleeding. Monitor blood pressure. *Resident admitted to the hospital from the emergency roiagnom on [DATE] at 7:24 PM for monitoring. *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. *1 unit of blood. *Wound care order follow-up clinic on 11/6/2024 at 2:30 PM. *Do not bend knee for 1 week; not to be in wheelchair for more than 4 hours; keep leg straight. *Blood pressure was 150/70 at 11:30 AM 11/4/2024. * Resident discharged from the hospital to the nursing facility on 11/4/2024 at 1:48 PM *Resident was transported by a local transport company to the nursing facility on 11/4/2024. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	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. 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 indention left in the skin after applying pressure to both legs. Entered by ADON 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. 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. 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. 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. 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 indention 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. 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. 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. 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. 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. 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. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	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. 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 say 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. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	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 11/12/2014. 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. 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. 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. 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. 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.

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	676421	A. Building B. Wing	11/15/2024

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 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. 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. This failure placed residents at risk of physical and psychosocial harm. Findings included: 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. 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). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 Fosus 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. Record review of Resident #162's Order Summary Report reflected orders for: 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 stiches line to keep moist, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. 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). 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.) 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. 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 Secondary to left lower extremity injury. *Presented with acute onset bleeding from left lower extremity wound after injury at nursing home, currently on dual antiplatelet therapy. *Hypotensive with blood pressure in 80s/60s, status post (experienced a medical event) fluid bolus with improvement. *Hemoglobin 11.4 to 10.3 * 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. *No overt signs of continued blood loss at this time. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*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 *Patient also requested wound care referral to wound care physician on discharge. *Blood pressure low on arrival; hold high blood pressure medications at this time in light of acute bleeding. Monitor blood pressure. *Resident admitted to the hospital from the emergency roiagnom on [DATE] at 7:24 PM for monitoring. *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. *1 unit of blood. *Wound care order follow-up clinic on 11/6/2024 at 2:30 PM. *Do not bend knee for 1 week; not to be in wheelchair for more than 4 hours; keep leg straight. *Blood pressure was 150/70 at 11:30 AM 11/4/2024. * Resident discharged from the hospital to the nursing facility on 11/4/2024 at 1:48 PM *Resident was transported by a local transport company to the nursing facility on 11/4/2024. 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 indention left in the skin after applying pressure to both legs. Entered by ADON 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. 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. 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. 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 indention 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. Record review or 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. 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 say 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 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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. 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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on interviews and record review, the facility failed to ensure residents' drug regimen was adequately monitored and free from unnecessary drugs for 1 (Resident #96) of 6 residents reviewed for pharmacy services. The facility failed to monitor Resident #96 for side effects/adverse reactions for the use of Apixaban (an anticoagulant medication- blood thinner). These failures could place residents at risk of bruising, and bleeding. Findings included: Resident #96 Record review of undated face sheet reflected Resident #96 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #96 had the following diagnoses of muscle weakness, hyperlipidemia (elevated cholesterol), abnormalities of gait, and hypertension (elevated blood pressure). Record review of the Quarterly MDS dated [DATE] reflected Resident #96 was given an Anticoagulant (blood thinner) medication during the prior 7 days to the MDS assessment reference date of 09/18/2024. Record review of Physicians Order Summary Report dated 11/13/2024 for Resident #96 reflected an order for Apixaban (a blood thinner) to be given daily. Record review of the Order Summary also reflected there was no order for side effect monitoring of the Apixaban. Record review of Medication Administration Record (MAR) for the month of November reflected resident #96 had received Apixaban twice daily routinely. The MAR also reflected there was no monitoring for side effects in place related to the use of the Apixaban. In an interview 11/12/24 at 09:48 AM Resident #96 stated she would like to have more choices with her food. She had no complaints related to care. In an interview on 11/15/24 at 12:15 PM ADM A stated she would have to refer to policy, but yes blood thinner side effects should have been monitored. She stated the interdisciplinary team (a team of department heads within the nursing home) review treatment records to ensure monitoring for side effects of medications such as a blood thinner were in place. ADM A stated she was not familiar with what the general risk to a resident would have been for not monitoring for side effects of a blood thinner. She stated she would have to refer to policy . In an interview on 11/15/24 at 12:56 PM the DON stated when the floor nurse gets an order for a blood thinner, they should also put in the order to monitor for side effects at the same time of that medication. The ADON's monitor the charts and follow up after the floor nurses to ensure the anticoagulant (blood thinner) monitoring was in place. The DON stated risk for residents receiving blood thinners that were not monitored would be bleeding or bruising that was unnoticed. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled Pharmacy Services dated 08/2017 and revised 01/2022 reflected The MRR includes identification of irregularities, medications-related errors, adverse consequences, and use of unnecessary drugs. Unnecessary drug is defined as medication ordered: Without adequate monitoring.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50042 Based on observations and interviews, the facility failed to prepare food that was at an appetizing temperature for one of five residents sampled: 1. The facility served Resident #13 cold or lukewarm food throughout the resident's stay and refused the resident's requests to reheat food items, stating that federal and state regulations did not allow for this. This failure could have placed residents at risk of not being satisfied with their food, decreased food intake, unintended weight loss, hunger, poor nutrition, impeded recovery from illness and injury, and diminished quality of life. Findings included: Record review of Resident #13's admission record revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE], with diagnoses that included: neuromyelitis optica [devic], need for assistance with personal care, paraplegia, legal blindness, gastro-esophageal reflux disease without esophagitis, and irritable bowel syndrome with diarrhea. The resident's advance directive was full code: use AED with CPR during sudden cardiac arrest . In an interview with Resident #13 on [DATE], at 10:02 AM, the resident stated that often her meals were served cold. The resident stated that she was served all meals in her room and by the time they get to her, they were not at a preferred temperature. The resident stated that requests for food items to be reheated were met with reluctance or denial. For example, the resident stated that scrambled eggs were served lukewarm or cold on the inside. The resident stated that toast was often served cold, and butter cannot be spread because of the temperature of the toast. The resident stated that staff's response to food temperature complaints was that they could not control the temperature of the food served on hall trays. The resident stated that staff have also refused to reheat outside food items brought in by the resident's family. In a follow up interview with Resident #13 on [DATE], at approximately 2:30 PM, the resident stated the temperature of the food has improved this week while state surveyors have been in the building. The resident stated that staff would refuse to reheat food items to her preference often during the early days of her admission,. but recently their refusal was less often. The resident stated that she estimated staff's current refusal to be ,d+[DATE] times a week. The resident stated that this concern was reported to the facility and the ombudsman with little but some improvement. The resident stated that she has spent $478.23 on outside food and delivery service due to the quality, taste, and temperature of the food being served at the facility. In an interview with LVN D on [DATE], at approximately 1:45 PM, regarding reheating food items at the request of the resident, LVN D stated staff do not reheat food. LVN D stated their procedure was to get the resident a whole new tray. LVN D stated if a resident had a complaint regarding the temperature of the food, staff would do what they needed to resolve the resident's complaint . (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy/procedure titled Resident/Personal Food Storage/Rethermalization-Microwaving/Hot Liquids revised on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and ,d+[DATE], stated the following in part: If rethermalization/microwaving is needed, all rethermalization/microwaving will be done in the kitchen, by kitchen staff only during kitchen hours .For time and temperature control for safety foods (perishables), cook to a temperature of 165F. Food will remain above 135F prior to serving .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 2 (Resident #52 and Resident #82) of eleven residents reviewed for infection control. 1. CNA #A failed to change gloves or wash her hands while performing perineal care when removing a soiled brief and applying a clean brief for Resident #52. 2. The facility failed to ensure staff and others were aware that Resident #82 required the use of Enhanced Barrier Precautions. 3. The facility failed to ensure Personal Protective Equipment (PPE) was readily accessible for the care and treatment of Resident #82, who was on Enhanced Barrier Precautions. 4. The facility failed to provide proper environmental cleaning and disinfection of Resident #82's room. This failure could place residents at risk for healthcare associated cross contamination which could result in infections or illness. Findings included: Resident #52 Record review of Resident #52's Face Sheet reflected a [AGE] year-old female who was admitted on [DATE] with diagnosis of chronic obstructive pulmonary disease (a group of diseases affecting the lungs and breathing), atrial fibrillation (an irregular heart rate and rhythm), pneumonia, shortness of breath, and unsteadiness on feet. Record review of Resident #52's care plan initiated 05/21/2024 reflected a care plan for bladder incontinence. Resident #52s goal was to remain free from skin breakdown due to use of incontinence briefs through the review date. The care plan included interventions to check as required for incontinence. Wash, rinse, and dry perineum. Monitor/document for signs and symptoms of UTI (Urinary Tract Infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Record review of Resident #52's Quarterly MDS dated [DATE], reflected she was always incontinent of bowel and bladder. The MDS reflected Resident #52 was not assessed for her ADL assistance needed or her cognitive function. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation on 11/12/2204 at 09:42 AM Resident#52 was observed in her bed. She has no complaints related to care, stated she was receiving her showers and staff were kind. Observation of Perineal Care for Resident #52 on 11/13/2024 at 1:24PM revealed CNA A performed peri care cleansing from front to back, using new wet wipe with each pass across the perineal area. Resident #52 was rolled over and the backside cleansed again using clean wipes with each pass from the front to back. CNA A removed a soiled brief and did not wash hands or use alcohol-based hand sanitizer between gloving from dirty to clean brief. CNA A completed peri care, covered resident up, and gave her the call light. In an interview with CNA A on 11/13/2024 at 1:45 PM she stated staff were instructed to wash hands between all glove changes. CNA A stated she just forgot to wash her hands. She stated the negative effects on the residents for not washing hands would be spreading bacteria. In an Interview on 11/15/2024 at 12:15 PM ADM A stated it was expected that staff follow policy protocols for infection control. She stated the staff were instructed on infection control upon hire, annually, and with any concerns for infection control. ADM A stated the risk to the resident for not cleaning hands between glove changes would be urinary tract infections or bacterial infections. In an interview on 11/15/2024 at 12:56 PM the DON stated staff were expected to wash their hands before and after putting on gloves. The DON stated staff were instructed on infection control at least monthly and as needed. She stated she was responsible for training the staff. The DON stated the risk for residents for staff not washing their hands included spreading of infections. Record review of the facility's Policy and procedure titled Hand Hygiene dated 05/2007 and updated in 10/2022 reflected: Use an alcohol-based hand rub containing at least 62% alcohol or alternatively soap and water for the following situations -after removing gloves. Review of Resident #82's admission record on November 15, 2024, revealed that Resident #82 was a [AGE] year-old male resident who was admitted and re-entered the facility on September 2, 2022, with diagnoses that included: acute kidney failure, personal history of COVID-19, muscle weakness (generalized), need for assistance with personal care, and elevated white blood cell count. Resident #82's advanced directive was Full Code. Review of Resident #82's Comprehensive Minimum Data Set (MDS) Resident Care and Screening assessment dated [DATE], indicated the resident's Brief Interview for Mental Status (BIMS) score to be twelve out of a possible 15, thus indicating the resident was cognitive and able to make decisions. The same MDS indicated that the resident required set-up or clean-up assistance with most of the resident's functional abilities and goals, except the resident required supervision or touching assistance with tub/shower transfers, and partial/moderate assistance with walking ten feet. The MDS revealed the resident had an indwelling catheter. The MDS revealed the resident had a skin condition that required the application of ointments/medications other than to feet. Review of Resident #82's Order Summary Report as of 11/15/2024 revealed an active order which read, ENHANCED BARRIER PRECAUTIONS: PPE required for high resident contact care activities. Indication: wounds, indwelling medical device, infection and/or MDRO status every shift. The order status was active, order date: 4/17/2024, and start date: 4/17/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #82's care plan initiated on July 23, 2024, and created on September 23, 2024, revealed the resident was resistive to care and treatments and refused to allow staff to remove dirty linens, insisting on washing and drying it himself. However, no goals or interventions were indicated for this focus area that would appropriately address the dangers this would present . Observation of Resident #82's room on November 12, 2024, at 12:04 PM, revealed no Enhanced Barrier Precautions signage or indication outside of the resident's room in reference to Enhanced Barrier Precautions that should be utilized. Observation of Resident #82's room on November 12, 2024, revealed no PPE immediately available outside or inside of the resident's room. Observation of Resident #82's room on November 12, 2024, revealed a foul odor emitting inside of the room, and at least 10-12 soiled towels draped along furniture and other items in the room and piled behind the door of the resident's room. The towels were soiled with a yellowish substance. As were the bed and linens in the resident's room. In an interview with Resident #82 on November 12, 2024, at 12:04 PM, the resident revealed that his legs were leaking fluid which required his use of multiple towels to soak up and clean up the leaked fluid. The resident stated that he was afraid that he would not be provided with enough towels needed to clean up the fluid, so he preferred to rinse the dirty towels himself and hang them to dry throughout his room, so they were readily available. Observation of Resident #82's room on November 13, 2024, at 10:07 AM, revealed no Enhanced Barrier Precautions signage or indication outside of the resident's room to indicate Enhanced Barrier Precautions should be utilized. Also, on this date and time, no available PPE was observed immediately outside of the resident's room . In an interview with the DON on November 15, 2024, at 1 PM, the DON stated that she ensured EBP were implemented and communicated with all staff by making rounds and doing spot checks. The DON stated that staff were educated on which residents required the utilization of EBP, but also there was a gold star or flower [sticker] on the name of each resident who require EBP. The DON stated there was no set determination by the facility as to where PPE was to be placed. The DON stated that staff should always refer to the care plan for an indication such as EBP . In an interview with LVN D on November 15, 2024, at approximately 1:45 PM, it was stated that LVN D learned of residents' conditions through shift reports and referencing treatment records and care plans, as changes occur regularly and often . Observation of Resident #82's room on November 15, 2024, at approximately 2 PM, revealed no Enhanced Barrier Precautions signage or indication outside of the resident's room, including the presence of a gold star or flower [sticker]. Record review the facility's policy titled Infection Prevention and Control Program-Linens dated 8/29/2017 states, Soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled IPCP Standard and Transmission-Based Precautions, which originated on 6/2021 and revised on 7/2022 and 10/2022, states in part the following: 3. Enhanced Barrier Precautions (EBP): expand the use of PPE and refer to the use of gown and gloves during high contact resident care activities . 6. Implementation: a. The facility will implement a system to alert staff, residents, and visitors that a resident is on TBP. i. Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and require PPE (e.g., gown and gloves) ii. For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. b. Make PPE, including gowns and gloves, available immediately outside of the resident room.