STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676426	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - Fort	4240 Golden Triangle Boulevard Keller, TX 76244

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** 44937 Based on observation, interview and record review, the facility failed to ensure the resident's right to receive services in the facility with reasonable accommodation of resident needs and preferences for 5 of 10 residents (Residents #2, #3, #4, #5, and #6) observed for accommodation of needs. The facility failed to ensure Residents #2, #3, #4, #5, and #6 had call lights within reach. This failure could place the residents at risk of not being able to request assistance when needed. Findings included: 1. Review of Resident #2's Admission Record dated 06/06/24 revealed the resident was a [AGE] year-old male who had been admitted to the facility on [DATE]. Review of Resident #2's annual MDS, dated [DATE], revealed a BIMS score of 00, indicating score not calculated with diagnoses that included seizure disorder, anxiety disorder, cognitive communication deficit, lack of coordination, general weakness. Functional abilities indicated Resident was dependent on staff for all activities of daily living. Review of Resident #2's care plan revealed he had self-care performance deficit. Goal revealed she will safely perform bed mobility, transfers, eating, dressing and personal hygiene along with other daily living skills. Intervention included encouragement to use bell to call for assistance. Resident was at risk for falls. Goal revealed resident will not sustain serious injury. Intervention included to be sure call light was within reach and encourage use. Ensure safe environment: working and reachable call light, low bed, clear floor path. 2. Review of Resident #3's Admission Record dated 06/06/24 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. Review of Resident #3's quarterly MDS, dated [DATE], revealed a BIMS score of 00, indicating score not calculated with diagnoses that included seizure disorder, depression, chronic pain due to trauma, stroke. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's care plan revealed alteration in musculoskeletal status related to pain. Goals included resident will remain free from pain or at a level of comfort acceptable. Intervention included to anticipate and meet needs. Be sure call light within reach and respond promptly to all request for assistance. 3. Review of Resident #4's Admission Record dated 06/06/24 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #4's yearly MDS, dated [DATE], revealed a BIMS score of 15 indicating her cognition intact with diagnoses that included anxiety disorder, bipolar disorder, respiratory failure, developmental disorder of speech and language, tracheostomy status, stroke. Her Functional Status indicated she required set up or clean up assistance with her ADLs. Review of Resident #4's care plan revealed she had tracheostomy related to impaired breathing mechanics. Goal included to have clear and equal breath sounds bilaterally. Interventions included to keep call light or alternate call system within reach. Resident is a fall risk, Goal to be free from falls. Intervention included a safe environment with low bed, reachable call light. 4. Review of Resident #5's Admission Record dated 06/06/24 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Review of Resident #5's quarterly MDS, dated [DATE], revealed a BIMS score not calculated with diagnoses of depression, contracture of right knee, generalized weakness, cognitive communication deficit. Functional Status was not indicated. Review of Resident #5's care plan revealed she was at risk for falls related to left knee pain, bedbound status and weakness. Goals included not to sustain injuries. Interventions included to be sure call light was withing reach at all times and encourage use of call light for assistance as needed. Safe environment low bed, call light in reach, personal items within reach, floor free from clutter. 5. Review of Resident #6's Admission Record dated 06/06/24 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] and readmitted [DATE]. Review of Resident #6's MDS revealed a BIMS score of 10 indicating cognition moderately impaired with diagnoses that included high blood pressure, anxiety disorder, depression, repeated falls, abnormal gait and mobility, muscle weakness. Her Functional Status indicated he required set up and clean up assistance with eating, toileting and personal hygiene, supervision with oral hygiene, showering, and dressing. Review of Resident #6's care plan revealed she had self-care performance deficit. Goal revealed she will safely perform bed mobility, transfers, eating, dressing and personal hygiene along with other daily living skills. Intervention included encouragement to use bell to call for assistance. Resident was at risk for falls. Goal revealed resident will not sustain serious injury. Intervention included to be sure call light was within reach and encourage use. Ensure safe environment: working and reachable call light, low bed, clear floor path. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Review of Resident #7's Admission Record dated 06/06/24 revealed the resident was an [AGE] year-old male who had been admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #7's annual MDS, dated [DATE], revealed a BIMS score of 2, indicating severe cognitive impairment with diagnoses that included cognitive communication deficient, lack of coordination, repeat falls, stroke. Review of Resident #7's care plan revealed he was at risk for decreased communication skills related to deficit related to Dementia. Goals included Resident #2 making basic needs known on a daily basis. Interventions included to ensure/provide a safe environment: Call light in reach, adequate low glare light, bed in lowest position and wheels locked, Avoid isolation. Observation on 06/06/24 at 11:12 AM revealed Resident #2's call light was on the floor under his bed not within reach. Observation on 06/06/24 at 11:15 AM revealed Resident #3's call light was laying on the floor underneath Resident #3's bed. Observation on 06/06/24 at 11:19 AM revealed Resident #4's call light was on the far side of Resident #4's bed between her bed and the wall, not within Resident #4's reach. Observation on 06/06/24 at 11:20 AM revealed Resident #5's call light was hanging of the bed, on the floor near Resident #5's bed not within Resident #5's reach. Observation on 06/06/24 at 11:31 AM revealed Resident #6's call light was behind the bed, on the floor near Resident #6's headboard not within Resident #6's reach. Observation on 06/06/24 at 2:45 PM revealed Resident #7's call light was on the floor behine Resident #7's night stand not within Resident #7's reach. Observation and interview on 06/06/24 at 2:45 PM with CNA A stated the reason call lights were not within was because the residents were not using them. CNA A stated nursing staff were responsible for ensuring call lights were within reach at all times. CNA A stated she was aware of the facility policy to have the call lights within reach. CNA A stated not having call lights within the reach of residents placed residents at risk of not having their needs met. Interview on 06/06/24 at 4:17 PM with the ADON revealed she was not aware call lights on 200 hall not being within residents' reach. The ADON stated nursing staff should be ensuring resident call lights were near and within residents reach at all times and during their rounds. The ADON stated call lights on the floor was an issue because it placed residents at risk of not having their needs met. The ADON stated this was an intervention to help resident communicate their needs and facility policy that should be followed at all times. Interview on 06/06/24 at 5:20 PM with the DON revealed call lights were required to be placed within reach of the resident, even if the resident was believed incapable of using the call light. The DON stated the nursing team was responsible for ensuring call lights were within reach of each resident. The DON stated family and other staff needed to be able to easily call for help if they were in the room. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Call Light Bell policy, revised October 2022, reflected: .It is the policy of the facility to provide the resident a means of communication with nursing staff. .4.Leave resident comfortable. Place the call light within resident reach before leaving room. If call light/bell deficit immediately report to unit supervisor .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on obsrevation, interview and record review, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASRR) program to the maximum extent practicable to avoid duplicate testing and effort, which include incorporating the recommendation from the PASRR level II determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care for one (Resident #1) of two residents reviewed for PASRR assessments. The facility failed to submit a completed a request for Nursing Facility Specialized Services (NFSS) in the LTC Online Portal within 20 business days of Resident #1's IDT meeting. This could place residents at risk of not receiving specialized services to help prevent skin breakdown and pressure sore development. Findings included: Record review of Resident #1's face sheet revealed the resident was a [AGE] year-old male, who readmitted to the facility on [DATE], and had an original admitted [DATE]. Record review of Resident #1's Quarterly MDS dated [DATE] revealed his diagnoses included anemia, coronary artery disease, heart failure, and hypertension. Record review of Resident #1's initial IDT meeting revealed it was held on 02/20/24, and a customized wheelchair was recommended by the Habilitation Coordinator. Record review of Resident #1's PASRR evaluation on 02/16/24 revealed the resident was PASRR level II positive related to his diagnoses of unspecified intellectual disabilities on admission. Record review of Resident #1's Care Plan dated 06/06/24 revealed the resident had been identified as having PASRR positive status related to his developmental disabilities. Interview on 06/06/24 at 12:14 PM with Resident #1 revealed it took him longer to maneuver around the facility in the facility wheelchair due to his size and physical disabilities. Interview on 06/5/24 at 2:37 PM with the PASRR Habilitation Coordinator revealed the initial IDT meeting for Resident #1 was on 02/20/24. He stated at the initial IDT meeting he explained to everyone present that the facility had 20 days to request NFSS in the LTC Online Portal for the request for a customized wheelchair for Resident #1. He stated when he went to the quarterly IDT meeting on 05/07/24, the facility still had not begun the initial process of requesting the customized wheelchair for the resident through the online portal as required within the 20 business days of the initial IDT meeting. Interview on 06/06/24 at 11:12 AM with the facility Social Worker revealed she did not submit the NFSS form into the LTC Online portal. She stated it was therapy's responsibility to put in the request for the customized wheelchair in the LTC Online portal. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/06/24 at 11:32 AM with the Director of Rehabilitation revealed she contacted a wheelchair vendor. She stated the vendor came and did a limited assessment and never returned. She stated she knew she had not completed the NFSS form in the LTC portal within the required 20 days. Interview on 06/06/24 at 4:57 PM with the MDS Coordinator revealed she was at the quarterly IDT meeting for Resident #1. She stated the Director of Rehabilitation was responsible for uploading the NFSS form. She stated after the quarterly IDT meeting for Resident #1 on 05/07/24, she asked the Director of Rehabilitation if the NFSS form had been completed since the initial IDT meeting on 02/20/24. The MDS Coordinator stated the Director of Rehabilitation informed her the NFSS form had not been submitted. Record review of facility's policy flowchart dated 11/29/17 and titled Pre-Admission Screening and Resident Review, revealed if specialized services were required, the facility would initiate specialized services by submitting the request to the LTC Online Portal within 20 business days after the date of the Initial IDT.