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	10/08/2024

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 0684 Level of Harm - Minimal harm or potential for 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** 43791 Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 4 residents (Resident #1) observed for quality of care. The facility failed to apply Resident #1's compression socks as ordered. This failure could place the resident at risk of developing blood clots in his legs Findings included: Record review of Resident #1's undated Admission Record reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included fusion of the vertebrae of the lower back, diabetes, and high blood pressure. Record review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 15 indicating he was cognitively intact. His Functional Status assessment indicted he required limited assistance with his ADLs. Record review of Resident #1's care plan, dated 09/27/24, reflected the risk for decreased activity related to his spinal surgery was not listed as a focus, and his compression socks were not listed as an intervention. Record review of Resident #1's physician's orders reflected an order, dated 09/26/24, which reflected: apply TED hose in the am, off in the pm, indicating the resident's compression socks were to be applied in the morning and removed overnight. Record review of Resident #1's TAR reflected no order to place the resident's compression socks. Interview on 10/02/24 at 12:00 PM with Resident #1 and his family member revealed his compression socks had not been applied since he was admitted . The family member stated they were present for his admission, and his socks were removed and placed on his dresser. The family member stated the socks had not been moved since they were placed there, and they were present at the facility most of the day every day since admission. The family member stated the socks were to prevent blood clots in the resident's legs due to decreased activity. (continued on next page)

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/02/24 at 12:00 PM revealed Resident #1 was not wearing his compression socks. The socks were located on the resident's dresser. Observation on 10/02/24 at 3:30 PM revealed Resident #1 was not wearing his compression socks, and they remained unmoved on his dresser. Observation on 10/03/24 at 8:30 AM revealed Resident #1 was not wearing his compression socks. Interview on 10/03/24 at 8:30 AM with Resident #1 revealed the CNA had placed his socks on around 4:00 PM on 10/02/24, and they had been removed before bedtime. Observation on 10/03/24 at 10:45 AM revealed Resident #1 was wearing his compression socks. Record review of the facility's investigation report indicated the physician had not completed the order process which resulted in the order not transferring to Resident #1's TAR. The investigation report also had a written statement from CNA A reflecting she had applied Resident #1's compression socks on 09/26/24, 09/27/24, 09/29/24, 10/02/24, and 10/03/24. Interview on 10/03/24 at 11:25 AM with Resident #1 revealed he did not recall anyone applying his compression socks until the previous afternoon. Interview on 10/03/24 at 11:35 AM with CNA A revealed she had placed Resident #1's compression socks on him every day with the exception of one day when he refused them. CNA A stated she knew to apply the socks, even if they were not on the TAR, because the resident's family had told her they needed to be applied. Interview attempts via telephone on 10/02/24 at 3:29 PM and 10/03/24 at 11:49 AM with LVN B, who admitted Resident #1, were unsuccessful. Interview on 10/03/24 at 12:45 PM with the DON revealed the admitting nurse was responsible for ensuring all physician's orders had been placed and initiated. The nurse should check the MAR and TAR to ensure all orders were initiated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 32227 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 2 residents (Resident #2) reviewed for elopement. The facility failed to provide adequate supervision to Resident #2, who was aphasic and had right-sided hemiplegia, when the resident left the faciity on [DATE] without staff knowledge and made it approximately 1. 5 miles from the facility with the assistance of a bystander. The resident was out of the facility for approximately two hours without staff knowledge, and he was located by his family who had placed a tracking device on his shoe. The non-compliance was identified as past non-compliance. The IJ began 09/15/24 and ended on 09/23/24. The facility corrected the non-compliance before surveyor's entrance. This failure placed residents at risk of harm and/or serious injury. Findings included: Record review of Resident #1's admission MDS assessment dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included cancer, hypertension (high blood pressure), aphasia (language disorder that makes it difficult to understand or express language), stroke, and hemiplegia (paralysis or weakness in one side of the body). The MDS further reflected the resident had no speech was but he usually understood others and was also usually understood by others and had memory problems. Record review of Resident #2's care plan created on 06/27/24 reflected the resident was at risk for communication related to aphasia. Interventions included to assist with finding words as needed/appropriate. The care plan further reflected the resident had an ADL deficit performance related to hemiplegia affecting the right dominant side/weakness. Interventions included to monitor/document report to the doctor or as needed of any changes or potential for improvement or declines in function. The care plan did not reflect that Resident #2 was at risk for elopement or wandering. Review of Resident #2's elopement assessments, dated 06/22/24 and 08/03/24, revealed he was a low risk for elopement and wandering. Review of the facility's Provider Investigation Report dated 09/16/24 reflected the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident frequently sits outside daily independently or with family. Prior to this incident there have been no attempts to leave the facility property. [Family member] visited with resident on 09/15/24 after this visit at 2:59 p.m. the resident was observed via camera self propelling his wheelchair off facility property. The resident was located near the neighborhood he previously lived in being pushed by an individual unfamiliar to the facility. At apprx 4:30 p.m. the charge nurse and family located the resident via apple tag (that was placed on resident shoe by family). Resident was returned [sic] him to the facility unharmed. Head to toe assessment and vitals were completed, no injuries or s/s of distress noted Observation and interview on 10/08/24 at 9:16 AM with Resident #2 revealed he was self-propelling his wheelchair out the door to the enclosed courtyard. Resident #2 smiled and greeted the surveyor during the introduction. The resident was not able to complete sentences but was able to answer yes/no questions. The resident was asked if he could write or type his conversation and he shook his head no. Resident #2 was asked if he was doing ok and he said yea and nodded his head. He was asked if he was hurting, and he said no and shook his head. The resident was asked if he sat outside in the front of the building, and he said no and made a circular motion with his hand of the courtyard. He was asked if he only stayed in the courtyard, and he said yes. The resident was asked if he had recently left the facility and he began to laugh and said yes. The resident was asked where he was going but was not able to answer the question and only pointed up. Observation on 10/08/24 at 9:00 AM of the facility revealed there was a shaded patio that extended over the driveway in front of the front entrance. There was a sidewalk that extended around the facility without having to go into the parking lot. Interview on 10/08/24 at 9:39 AM with Resident #2's family member [Family Member #3] revealed the resident admitted to the facility post stroke in June 2024. Family Member #3 stated during the resident's time at the facility, he had never made any attempt to leave. The family said he enjoyed being outdoors. They said the day of the incident, the resident's [Family Member #4] had visited and left the facility sometime after lunch. Later after [Family Member #4's] visit, the resident's [Family #3] arrived at the facility to visit and when he was not found in his regular places the staff began to look for the resident. When he was not found at the facility, they contacted the resident's [Family Member #4] who said she had an air tag on the resident, and she was able to locate the resident. The resident's [Family Member #3] and charge nurse drove to the location and the resident was found, uninjured, and being pushed by a young man. Resident #2's family member stated the resident had let them know he was trying to get back home, and he had been found about 5 blocks from his house. [Family Member #4] stated the reason they had an air tag (tracking device) on the resident was because the nursing home situation was new to them, and it let them know where he was at all times even when he was at doctor appointments and they did not know if the facility staff were aware of the air tag. The resident's [Family Member #4] further stated the resident understood he could not leave the facility and he was not to sit outside in front of the facility anymore and if he wanted to be outside, he had to go to the enclosed courtyard. Interview on 10/08/24 at 1:34 PM with the Social Worker revealed it was difficult to complete a BIMS (a short cognitive screening tool used to assess a patient or resident's cognitive abilities) on Resident #2 because he was non-verbal when he admitted . They called the resident's family to assist with the assessment and when they got to the mood assessment questions, Resident #2 took the sheet and read the questions himself and appropriately answered yes or no or gave a thumbs up or thumbs down. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 10/08/24 at 1:07 PM with LVN F revealed the day of the incident, 09/15/24, he passed medications and saw Resident #2 around 2:00 PM and he was in his room. Later around 4:00 PM, the resident's [Family Member #3] asked him if he had seen Resident #2 because he was not at his usual places, so they began to look for him. While they were looking for the resident, the resident's [Family Member #4] was contacted, and she told them the resident had an air tag on and gave them the location of the resident. The LVN said they were not aware the family had placed an air tag on the resident. He and the other charge nurse and Resident #2's [Family Member #3] went to the location the air tag indicated and he was found by a park being pushed by a young teenager. The resident was assessed, and he was not injured and was taken back to the facility. LVN F said Resident #2's family regularly visited and when they were not visiting, he enjoyed sitting out front of the facility people watching. LVN F said the resident was safe to be outside on his own and he had never tried to leave the facility. LVN F further stated Resident #2 was checked on frequently when he was outside just to make sure he was ok. LVN F also said the front door was locked when there was not receptionist at the front entrance. Interview on 10/08/24 at 3:23 PM with RN G revealed he was Resident #2's charge nurse the day of the incident, 09/15/24. He said that day, Resident #1's [Family Member #4] had visited and left the facility at around 1:30 PM. Resident #2 had a routine where he sat outside in front of the facility, and he had never attempted to leave the premises. RN G said the day of the incident he last saw the resident around 2:30 PM at the nurses' station and sometime after 3:00 PM the resident's [Family Member #3] was looking for the resident. At that time, they began to look for the resident and the resident's [Family Member #4] was called who said she had an air tag on the resident and was able to pull the location of the resident. The RN said he was not aware the family had placed an air tag on the resident when he admitted to the facility. He and the other charge nurse drove to the resident's location and found Resident #2 about 2 miles from the facility. Resident #2 was being pushed by a teenager and upon assessment the resident did not have any injuries. RN G said the resident had been at the facility for a few months, and he had never tried to leave and it was unusual for him to have left that day. Normally when Resident #2 sat outside, the staff checked on him frequently to make sure he didn't need anything. Interview on 10/08/24 at 11:52 PM with CNA H revealed she worked with Resident #2, and he was able to self-propel his wheelchair and only used his call light when he needed to be changed. CNA H said the resident was never exit seeking and only left the facility when he was out on pass with family or he usually sat outside in the front of the facility and they would frequently check on him to see if he needed anything because he did not require supervision to be outside. Interview on 10/08/24 at 2:47 PM with LVN I revealed Resident #2 enjoyed sitting outside and looked at the cars and the visitors coming and going. The resident had never attempted to leave the facility or alluded that he wanted to leave. While Resident #2 was outside staff would make sure to check on him frequently and there were no issues or concerns with elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 10/08/24 at 12:40 PM with the Speech Therapist revealed she had been working with Resident #2 with his expressive speech. He was non-verbal but able to make his needs known with choices and yes and no questions. Based on her assessment the Speech Therapist stated Resident #2 was able to make his needs known. She said the resident would sit outside of the facility and had never alluded that he wanted to leave the facility. Prior to the incident, while the resident was outside, staff knew they were to monitor the resident while he was outside to make sure he was ok, but she felt he was safe to stay outside on his own because he knew to stay on the patio and not go into the driveway or parking lot. Since the incident, the resident was told not to go out the front and instructed to go to the enclosed courtyard if he wanted to be outdoors. The Speech Therapist further stated Resident #2 was able to maneuver his wheelchair pretty well even with having deficits on his right side of his body. Interview on 10/08/24 at 1:17 PM with the Physical Therapist revealed Resident #2 was able to maneuver his wheelchair better now than when he first admitted to the facility. She said it could be challenging to communicate with the resident, but the resident was able to understand what was being told to him and was able to follow instructions and commands. The Physical Therapist further stated she felt like the resident was safe to sit outside alone and he had never tried to leave the facility since he had been at the facility. Staff knew to check on Resident #2 when he was outside due to the summer heat, but the resident mainly sat outside under the shaded patio until his family arrived to visit. Interview on 10/08/24 at 3:48 PM with the DON revealed she was made aware Resident #2 had left the faciity on [DATE]. She was told that through an air tag, the family had placed on the resident , without them knowing, had located the resident around his old neighborhood. The nurses told her the resident had been assessed and there were no injuries noted. The DON said Resident #2 always sat outside in the front and never tried to leave. After the incident, the resident was put on 1:1 for 3 days and elopement assessments were done on the residents and there were no residents identified for elopement. They had elopement in-services and drills to make sure staff knew what to do in case they had an elopement. The DON further stated the front doors were being locked on the weekends or when there was not a receptionist at the entrance. Interview on 10/08/24 at 4:00 PM with the Administrator revealed Resident #2 was alert and oriented and had a history of sitting outside in the front of the facility. The resident enjoyed being outside and would wheel himself sidewalk and at no time had he ever expressed he wanted to leave. The Administrator was made aware the resident had left on 09/15/24 when the resident's wife was not able to locate him in the facility. Resident #2 was located through an air tag that had been placed on the resident by the family, that they were not aware of. Per the family, they asked the resident where he was going, and he told him he was going home. The resident was brought back to the facility unharmed, and they placed a WanderGuard on the resident for safety. The Administrator said they were able to get video footage from the library next door and it captured the resident going by there at 3:17 PM and he was brought back to the facility after 4:00 PM. After the incident the family was told the resident would need to wear a WanderGuard for safety and the front doors would remained locked if there was not a receptionist at the front desk. Resident #2 and his family were told the resident could no longer sit outside unsupervised but could continue to go to the enclosed courtyard if he wanted to be outdoors. There were no other residents identified as being an elopement risk during their assessment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 10/08/23 at 10:23 AM revealed Resident #2 was sitting with his wife near the front door, and they were asked to get close to the door to verify the WanderGuard was operating correctly, and the WanderGuard began to beep very loudly, and the front door did not open. Record review of the in-services dated 09/15/24 through 09/20/24 reflected staff had been in-serviced on elopements, and instructed the front doors would remain locked unless there was a receptionist at the front entrance. Record review of the facility elopement drills revealed they were conducted on 09/16/24, 09/22/24, and 09/30/24 with all facility staff of various shifts to include dietary, nursing, housekeeping, and therapy. Record review of the elopement assessment dated [DATE] reflected Resident #2 remained at a low risk of elopement. Record review of Resident #2's one-to-one monitoring revealed he was being checked on every 15 minutes and initialed by staff from 09/15/24 through 09/18/24. Record review of Resident #2's care plan revealed it had been updated after the incident on 09/15/24 to reflect the following: Elopement risk/wanderer related to history of attempts to leave the facility unattended. Impaired safety awareness. The resident enjoys sitting in the front portico area on warm days. Interventions included to document wandering behavior, monitor the wanderguard to the left ankle and staff will check on the resident if he wished to sit outside. Interviews on 10/08/24 from 10:27 AM to 3:48 PM with the DON, Housekeeping Supervisor, LVN F, RN G, CNA H, LVN I, and LVN J, who worked various shifts, revealed they were all aware Resident #2 was only allowed in the enclosed courtyard and could not be alone in the front patio unattended. Record review of the facility's Elopement/Unsafe Wandering policy, revised December 2003, reflected the following: Policy It is the policy to provide a safe environment, as free of accidents as possible, for all residents through appropriate assessment, interventions, and adequate supervision to prevent accidents related to unsafe wandering or elopement while maintaining the least restrictive manner for those at risk for elopement.