

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/26/2025
NAME OF PROVIDER OR SUPPLIER  Legend Oaks Healthcare and Rehabilitation - Fort		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 2 of 5 residents (Resident #1 and Resident #2) reviewed for abuse.</p> <p>The facility failed to ensure Resident #1 was free from abuse when Resident #2 pulled Resident #1 out of bed and hit him on 01/30/25.</p> <p>The noncompliance was identified as past noncompliance. The noncompliance began on 01/30/25 and ended on 01/30/25. The facility had corrected the noncompliance before the investigation began.</p> <p>This failure could place residents at risk of being abused.</p> <p>Findings included:</p> <p>Record review of Resident #1's quarterly MDS, dated [DATE], reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included heart failure, diabetes, stroke, and respiratory failure. The resident had a BIMS of 8, which indicated his cognition was moderately impaired. The MDS further reflected Resident #1 did not have any physical or verbal behaviors.</p> <p>Record review of Resident #1's care plan, revised on 08/08/24, reflected the resident had the potential to demonstrate verbally abusive behaviors related to dementia, ineffective coping skills, poor impulse control, and mental illness. Interventions included to analyze key times, places, circumstances, triggers, and what de-escalates behaviors.</p> <p>Record review of Resident #2's quarterly MDS, dated [DATE], reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included end stage renal disease, Huntington's disease (a progressive, inherited neurodegenerative disorder that affects the brain), pain in left leg and cognitive communication deficit. The resident had a BIMS of 13, which indicated his cognition was intact. The MDS further reflected the resident did not have physical or verbal behaviors.</p> <p>Record review of Resident #2's care plan, initiated on 05/07/24, reflected he had the potential to demonstrate physical behaviors resisting treatments and assistance related to anger, and poor impulse control. Interventions included to document observed behaviors and attempted interventions.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's Provider Investigation Report, dated 02/06/25, reflected the following:</p> <p>[Resident 2] and [Resident #1] were roommates in [room]. At approx. 2:10 a.m. [Resident #1] was yelling at resident [Resident #3] to stop 'snotting around' and making all that noise. Apparently this triggered resident [Resident #2] who then became physically aggressive with [Resident #1] pulling him out of the bed while hitting and slapping him. [Resident #1] then engaged physically in the altercation hitting [Resident #2]. Head to toe assessment conducted on both residents-minor lacerations present on [Resident #1]. Treated provided in house. No injuries [sic] notes to [Resident #2]. [Resident #1] then requested to be sent to [hospital] for evaluation of right knee and head pain-No major injuries noted. [Resident #1] returned with no new order. Residents continue to be separated with [Resident #2] being located to a private room No history of prior incident for either resident.</p> <p>Record review of Resident #1's incident report, dated 01/30/25 , documented by LVN A reflected the following:</p> <p>Incident Description</p> <p>This nurse was charting at nurses' station and noticed resident's call light going off. Upon hearing banging coming from the room, I got up to answer the light. I heard both residents yelling and began to jog towards the room. Upon entering, resident was laying on his right side on the floor Resident stated that his roommate attacked him. I asked the roommate if this was true. He was pacing around on his side of the room. He stated 'did! I was fed up with him.' I called to the other nurses and CNAs to assist me in getting him cleaned up and back in bed. 'All day and night he's being doing snot stuff. So I said 'stop doing that nasty stuff.' He came over and started grabbing on my arms swinging at me. He got a hold of one of my arms and pulled me onto the floor. When I was on the floor he was slapping me so I punched him back. He finally backed off</p> <p>.Injuries Observed at Time of Incident</p> <p>Laceration: right lower leg, forehead, left side of neck, right knee, left lower leg, right forearm</p> <p>Record review of the facility's incident/accident report from November 2024 to February 2025 reflected there were no incidents between Resident #1 and Resident #2.</p> <p>Record review of Resident #1 and Resident #2's progress notes from 04/2024 to January 2025 reflected there were no incidents or disagreements between the resident while they were roommates.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 02/26/25 at 10:55 AM revealed Resident #1 was in bed watching his tablet, and he did not have a roommate at the time. There appeared to be some small scabbed areas to his chest, and one on each arm. The resident said he did not get along with his roommate [Resident #2] because he had a habit of having terrible drainage and would not blow his nose and then swallow it. Resident #1 said he would always tell Resident #2 to either blow his nose to stop making those sounds and Resident #2 would go to his side of the bed and says fuck you old man. The night of the incident Resident #1 said he got tired of listening to Resident #2 make his sounds so again he told Resident #2 to blow his nose. Resident #2 then went around to Resident #1's bed and began to threaten him and Resident #1 told Resident #2 to shut the hell up. At that time, Resident #2 began to try to hit him (Resident #1) but he ended up being scratched. Resident #1 said Resident #2 grabbed his right arm and pulled him down to the floor off the bed and when he was on the floor, Resident #1 was able to hit Resident #2 back and that was when Resident #2 said stop stop and he walked over to his side of the room. Resident #1 further stated he began to yell for help and that was when LVN A and other staff entered the room to help him back into bed. Resident #1 further stated he had some scratches on his chest, both arms, and his left shoulder.</p> <p>Observation and interview on 02/26/25 at 3:08 PM of Resident #2 revealed he was in a room by himself on another hall separate from Resident #1. Resident #2 said the staff were very good to him and he liked to be a loner. The resident recalled the incident between him and Resident #1 and he said Resident #1 was complaining saying he (Resident #2) was snoring, which was not true and he got tired of Resident #1 calling him a boy. Resident #2 said he had enough so he went over to Resident #1 and pulled him out of his bed and that was all. Resident #2 said he never told anyone at the facility Resident #1 was calling him a boy.</p> <p>Interview on 02/26/25 at 11:28 AM with RN B revealed she worked with both Residents #1 and #2 and to her knowledge it appeared as both residents got along and neither resident complained to her they did not like each other. RN B said Resident #2 was very quiet and usually stayed to himself and watched TV in the room. RN B said she never heard them argue or threaten each other.</p> <p>Interview on 02/26/25 at 11:31 AM with MA C revealed she passed medications to both Residents #1 and #2 when they were roommates. MA C said both residents stayed to themselves and did not really talk to each other and Resident #2 stayed in the room and watched TV. The MA said she never heard them argue and neither resident ever complained about the other.</p> <p>Interview on 02/26/25 at 11:35 AM with CNA C described Resident #2 as being very calm and not having any behaviors towards others. CNA C said Residents #1 and #2 did not have any issues with each other that she was aware nor did she ever hear them argue. CNA C said Resident #2 told her he was tired of Resident #1 referring to him a boy when he would ask that he turn the TV down. Regarding the incident, CNA C stated Resident #2 said he had enough, so he went over to Resident #1's bed and pulled him down and out of his bed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/26/25 at 1:42 PM with LVN A revealed she was at the nurses' station when she saw the call light on to Resident #1 and #2's room and heard banging. She stated upon entering the room Resident #1 was on the floor, and Resident #2 was standing on his side of the room pacing. She stated Resident #2 appeared to be upset. Resident #1 said he had been attacked by Resident #2. She stated Resident #2 interrupted and said he had enough of being called a little boy, so he went to confront Resident #1. Resident #2 told LVN A Resident #1 swung at him first, so he retaliated and pulled Resident #1 to the floor. LVN A said she noticed Resident #1 had a couple of lacerations on his legs and arms, which looked like he had been scratched. She said some of the scratches had bled a little, but Resident #1 did not want them treated because he was upset. Resident #1 was sent to the hospital to be evaluated because he mentioned he hit his head. She revealed Resident #1 did not have any head injuries after being evaluated at the hospital. LVN A said both residents had been roommates for over 6 months. She stated she recalled a couple months prior they had bickered with each other because Resident #1 said Resident #2 made noises. LVN A stated that was the only time they had a disagreement, but they had not been yelling or cursing and it did not happen again after that. She also said neither resident stated they wanted to change rooms, nor did they say they did not like each other.</p> <p>Interview on 02/26/25 at 1:42 PM with CNA E revealed she cared for Residents #1 and #2 the night of the incident, and she had not noticed anything out of the ordinary between the residents. CNA E said she provided care to Resident #1 and shortly after leaving their room, she was called back into the room because she was told Resident #1 was on the floor because he had been pulled down by Resident #2. She stated upon entering the room both residents had already been separated and Resident #2 was taken to another room. CNA E said she recalled seeing some scratches on Resident #1's legs and one on his nose. CNA E stated she assisted LVN A in getting Resident #1 off the floor and back into bed. CNA A stated during the time she had worked with both residents, she was not aware they did not like each other or that they had ever yelled or cursed at each other.</p> <p>Interview on 02/26/25 at 2:25 PM with CNA F revealed she worked the night of the incident between Residents #1 and #2, and she happened to pass by their room when she noticed a commotion, so she stepped inside to see if the staff already in the room needed help. She was told Resident #2 pulled Resident #1 out of bed, so she went ahead and took Resident #2 to another room. CNA F said she was not able to see any injuries on Resident #1 because there were other staff around him. CNA F further stated she was not aware if Residents #1 and #2 had a history with each other. CNA F said she requested not to care for Resident #1 because he had been very rude to her in the past during care.</p> <p>Interview on 02/26/25 at 2:44 PM with the Social Worker revealed she was told there was an altercation between Residents #1 and #2 because Resident #2 was making some noises Resident #1 did not like, so Resident #2 pulled Resident #1 out of bed. The Social Worker said both residents were roommates for months, and they never had any incidents in the past, so she thought they were doing well. She stated if she had been aware the residents were no getting along she would have looked into moving one to another room. The Social Worker said neither resident complained to her about the other. She stated when she went to check on Resident #1, he was no longer upset and said he was able to defend himself against Resident #2. The Social Worker further stated neither resident was in any distress after the incident and neither resident had a history of physical aggression towards others.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/26/25 at 4:07 PM with the ADON revealed she was not aware there were any issues between Resident #1 and Resident #2, and both residents stayed to themselves on their side of the room with the privacy curtain pulled in between. The ADON stated neither resident had ever mentioned to her that they had problems with each other. She stated if they had been made aware, they would have discussed a room change.</p> <p>Interview on 02/26/25 at 4:13 PM with the DON revealed she was not aware of any roommate issues between Residents #1 and #2 prior to the incident. She stated no one ever mentioned anything to her, and it appeared to be an isolated incident. The DON said she was told about the altercation where Resident #2 pulled Resident #1 out of bed because Resident #2 said Resident #1 called him a boy. She stated both residents were interviewable and would have been able to tell staff if they were unhappy being roommates and nothing was ever mentioned or noticed. The DON further stated Resident #1 sustained some skin tears and scratches from the altercation but nothing that required treatment. After the incident, all staff were re-educated on abuse/neglect and what to do if they witnessed any incidents.</p> <p>Interview on 02/26/25 at 4:22 PM with the Administrator revealed Residents #1 and #2 were roommates for a while. She stated they appeared to get along, and she was surprised when she was told they had an altercation. The Administrator said she was told Resident #1 was calling Resident #2 a boy because Resident #2 was making some kind snot noises, so Resident #2 pulled Resident #1 out bed. She stated staff immediately intervened when they became aware and both residents were separated. The Administrator described Resident #2 as being very quiet. She stated he did not engage much with others. She further stated Resident #1 sustained some scratches on his body and neither resident appeared to be in distress from the incident. After the incident, she stated all staff were re-educated on abuse/neglect to ensure they all knew what to do if they ever witness any types of abuse.</p> <p>Record review of the facility's Abuse: Prevention of and Prohibition Against policy, revised December 2023, reflected the following:</p> <p>Policy</p> <p>It is the policy of the Facility that each resident had the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment</p> <p>Observation on 02/26/25 at 10:55 AM and 3:08 PM revealed Residents #1 and #2 were each in their own room with no current roommate on different halls, so they did not have to cross paths. Neither resident was seen out of their room during the day.</p> <p>Record review of the incident/accident logs from November 2024 to February 2025 reflected there were no other resident to resident altercations.</p> <p>Record review of the in-services dated 01/30/25 reflected 40 staff were educated on resident rights and resident to resident abuse.</p> <p>(continued on next page)</p>

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F 0600  Level of Harm - Actual harm  Residents Affected - Few	Interview on 02/26/25 from 11:28 PM to 4:22 PM with LVN A, RN B, MA C, CNA D, CNA E, CNA F, CNA G, CNA H, LVN I, and the ADON revealed they were in-serviced on the types of abuse, resident rights and resident to resident abuse. They all said all the residents had the right to be free from abuse and neglect, were able to name the different types of abuse. They were able to describe if they saw resident to resident abuse they were to separate them immediately, assess for injuries, and notify the Abuse Coordinator.		