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	12/19/2024

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, and record review, the facility failed to ensure that residents who received nutrition by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 2 residents (Resident #101) reviewed for enteral feeding. The facility failed to follow physician orders for Resident #101's enteral feeding tube to be flushed with 175 cc (mL) of water every 4 hours. This failure placed residents at risk of dehydration, aspiration pneumonia, and metabolic abnormalities. Findings included: Record review of Resident #101's Admission Record dated 12/19/24 reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #101's quarterly MDS assessment dated [DATE] reflected his diagnoses included non-traumatic intracerebral hemorrhage in brain stem (brain bleed), respiratory failure, dysphasia (difficulty speaking) following other cerebrovascular disease (stroke), aphasia (language disorder), paraplegia (loss muscle function in the lower half of the body), and gastro-esophageal (acid reflux) reflux disease without esophagitis (inflammation). Resident #101 BIMS score was not completed due to resident was rarely/never understood. The MDS further revealed Section K - Swallowing/Nutritional Status indicated resident nutritional approach was feeding tube. Record review of Resident #101's care plan dated 09/17/24 reflected: Requires tube feeding r/t Dysphagia following CVA. Goal: Will maintain adequate nutritional and hydration status aeb weight stable, no s/sx of malnutrition or dehydration through review date. Interventions: Is dependent with tube feeding and water flushes. See MD orders for current feeding orders. Record review of Resident #101's physician orders dated 10/11/24 reflected an order for the resident's feeding tube to be flushed with 175 cc of water every 4 hours. Record review of Resident #101's physician orders dated 10/24/24 reflected an order for the resident to receive Jevity 1.5 at 60 mL per hour for 22 hours a day. (continued on next page)

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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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/17/24 at 10:41 AM revealed Resident #101 lying in bed. He could not answer questions. Resident #101 was connected to his feeding pump, and the feeding rate was set at 60 mL/hr and the water flush rate was set at 145 mL every 4 hours. The Jevity formula bag was dated 12/17/24 at a rate 60 mL/hr. The water bag was dated 12/17/24 at a rate 145 ml/4 hrs. Observation on 12/17/24 at 2:18 PM revealed Resident #101 lying in bed with his feeding pump connected. The feeding rate was set at 60 mL per hour, and the water flush rate was set at 145 mL every 4 hours. Interview on 12/17/24 at 2:39 PM with RN A revealed she was the nurse assigned to Resident #101. She stated she changed Resident #101's formula bag and water bag. She stated Resident #101's water flush rate was set for 145 mL every 4 hours. She stated when she placed the new formula and water bag, she just turned on the feeding machine. She stated the feeding machine rate amount was already set, and all they had to do was turn it on. RN A reviewed Resident #101's physician orders and stated she was not aware resident water flush order was for 175 mL every 4 hours. She stated she failed to review Resident #101's orders prior to connecting the resident. RN A stated she was unsure how long Resident #101 had been receiving water flushes of 145 mL. She stated the potential risk of not providing Resident #101 with the correct water amount could lead to dehydration. Interview on 12/18/24 at 1:27 PM with the ADON revealed she was made aware of Resident #101 not receiving the correct water flushes. She stated the feeding pump did not have the correct flush amount. She stated her expectation was for the nurses to check physician orders prior to connecting the resident. She stated it was her responsibility to complete spot checks on residents who were on g-tubes to ensure the formula bags were labeled, dated, and the amount rates were correct. She stated the potential risk if nursing staff were not checking physician orders was that it could lead to residents receiving too much or too little water intake and if to little could lead to dehydration. Interview on 12/19/24 at 2:40 PM with the DON revealed she was made aware that Resident #101's feeding pump was set with the incorrect water flush rate amount. She stated her expectation was for her nursing staff to review orders prior to starting the resident feeding. She stated it was the responsibility of all nursing staff to ensure residents received the correct amount. She stated the risk of not receiving the correct amount was that it could lead to weight loss or dehydration. Review of the facility's Quality of Care policy, revised December 2023, reflected the following: It is the policy of this facility to provide proper care and maintenance of gastrostomy tubes. .10. Flushing the Tube: a. To reduce the risk of tube clogs, always flush with lukewarm water. - Every four (4) hours if feeding is continuous, or per physician orders. b. The amount of water used for tube flushing depend on the individual physician orders.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice for 1 of 2 residents (Resident #56) reviewed for intravenous fluids. 1. The facility failed to change and maintain the integrity of Resident #56's PICC/central line dressing per professional standards. 2. The facility failed to have physician orders to change Resident #56's PICC/central line dressing, flushing, and to monitor for infection infiltration. These failures could affect residents by placing them at risk for infections and cross-contamination. Findings included: Record review of Resident #56's Admission Record dated 12/19/24 reflected the resident was a [AGE] year-old male who readmitted to the facility on [DATE]. His diagnoses included hemiplegia and hemiparesis (paralysis on one side of the body) following cerebral infraction (stroke) affecting left non-dominant side, non-pressure chronic ulcer of left ankle with necrosis of bone, and peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #56's clinical record reflected an MDS Assessment had not yet been completed for the resident. Record review of Resident #56's care plan dated 12/12/24 reflected: Focus: Has a Urinary Tract Infection. Goal: Urinary tract infection will resolve without complications by the review date. Interventions: Change IV set as ordered. Flush PICC Line as ordered. Give antibiotic therapy as ordered. Monitor/document for side effects and effectiveness. PICC Line dressing as ordered. Record review of Resident #56's physician order dated 12/10/24 reflected the following order for IV antibiotic therapy: Meropenem Intravenous Solution Reconstituted 1 gm (Meropenem) Use 1000 mg intravenously every 12 hours for bacteremia for 13 Days. There was no order to change the PICC/central line dressing using sterile technique every 7 days, and as needed, no orders for flushing and to monitor for infection and infiltration. Observation and interview on 12/17/24 at 10:45 AM revealed Resident #56's PICC/central ling dressing was not dated on his right upper chest. The PICC/central line insertion site was not open to air, and the dressing was still clean and intact. The site had no obvious signs of infection. Resident #56 stated he admitted to the facility about a week ago. He stated his dressing had not been changed since being admitted . Resident #56 denied any discomfort or pain. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/17/24 at 1:37 PM with RN A revealed she was the nurse assigned to Resident #56. She stated Resident #56 had a PICC line and had orders for antibiotics every 12 hours. RN A observed Resident #56's PICC line dressing and stated there was no date on the dressing. She stated the dressing should have a date on it. RN A reviewed Resident #56's physician orders and stated Resident #56 did not have orders to have his PICC/central line dressing changed every 7 days or as needed. Also, Resident #56 did not have orders for flushing the line of for monitoring for infection. She stated the PICC line should be flushed before and after antibiotics were given. She stated the admitting nurse should have called the doctor to obtain orders and should have obtained report from the hospital of when the PICC line dressing was placed. She stated the PICC line dressing should be dated and then changed within 7 days or PRN if the dressing got soiled. She stated the potential risk of not dating the dressing was that it could lead to not knowing when the dressing was last changed and was a risk for infection. She stated it was the responsibility of all nursing staff to ensure orders were obtained. She stated the potential risk of not having physician orders was that it could lead to the PICC line clogging. Interview on 12/18/24 at 1:23 PM with the ADON revealed all staff were expected to obtain physician orders from the doctor that addressed PICC line dressing changes and flushing. She stated she was made aware Resident #56 did not have orders for the PICC line dressing change and flushing. She stated the admitting nurse was responsible for reviewing orders and putting them in the system. She stated if the resident did not have orders, the admitting nurse was responsible for contacting the doctor and obtaining physician orders. She stated during morning meeting she and the DON were responsible for reviewing orders and ensuring orders were obtained. She stated the potential risk would be the PICC line getting occluded (clogged) and infected. She stated the PICC line dressing should always be dated so staff were aware of when the last time the dressing was changed. Interview on 12/19/24 at 2:35 PM with the DON revealed when a resident admitted to the facility with a PICC line, the admitting nurse should complete a full skin assessment, review physician orders, and notify the doctor if any orders were missing. She stated PICC line dressings should be dated, so the nursing staff knew how long the dressing had been on and when it needed to be changed. She stated Resident #56 should have orders for dressing changes, flushes, and monitoring for infection. She stated her nursing staff were flushing Resident #56's PICC line without physician orders. She stated it was the responsibility of the ADON to ensure orders were obtained, and the clinical management team would check if the orders were in place. She stated the potential risk of not dating the PICC line dressing was that it would lead to infection if the dressing was not changed. She stated the potential risk of not having orders to monitor or flush the PICC line was that it could lead to the PICC line clogging. Review of the facility's Physician Orders policy revised October 2022 reflected the following: It is the policy of this facility that drugs and treatments shall be administered/carried out upon the order of a person duly licensed and authorized to prescribe such drugs and treatments. - No drugs or biologicals shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illnesses. - All drug and biological orders shall be dated and signed by the person lawfully authorized to give such an order. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Verbal orders must be recorded in the resident's chart by the person receiving the order and must include the date and times of the order. - Orders for medications much include: o Name and strength of the drug; o Quantity or specific duration of therapy o Dosage frequency of administration; o Route of administration if other than oral; and o Reason or problem for which given. Review of the facility's PICC Line Dressing Change policy revised July 2023 reflected the following: Central Vascular Access Device - Peripherally Inserted Central Catheter (PICC) Dressing Change Policy: The transparent dressing are changed every 7 days and sooner when it becomes loosened to the point of compromising sterility or presents a risk of accidental dislodgment of the catheter. An accumulation of moisture, fluid, blood, or exudate could also be a criteria for a dressing change .M. Label dressing and discard used supplies appropriately.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, for 1 of 2 residents (Resident #260) reviewed for dialysis. The facility failed to ensure pre- and post-dialysis assessments were completed for Resident #260. This failure could place residents at risk of inadequate post-dialysis care. Findings included: Record review of Resident #260's Admission Record dated 12/19/24 reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE] and discharged home on 12/18/24. Record review of Resident #260's Admission MDS assessment dated [DATE] reflected his diagnoses included encounter for orthopedic aftercare following surgical amputation, end-stage renal disease (kidney failure), diabetes mellitus (high blood glucose) and hypertension (high blood pressure). Resident #206 had a BIMS score of 14 indicating resident was cognitively intact. The MDS reflected the resident received dialysis. Record review of Resident #260's care plan dated 12/01/24 reflected: Focus: Needs hemodialysis r/t ESRD Dialysis MWF @ [Dialysis Location] Chair Time 6 AM. Goal: Will have no s/sx of complications from dialysis through the review date. Interventions: Check arteriovenous fistula [surgically created connection between an artery and vein used for hemodialysis treatments] every day for bruit [sound heard using a stethoscope often indicating turbulent blood flow] and thrill [a vibration felt on the skin overlaying an area with turbulent blood flow]. Obtain vital signs and weight. Report significant changes in pulse, respirations and BP immediately. Record review of Resident #260's physician order dated 12/02/24 reflected an order for Resident #260 to receive dialysis every Monday, Wednesday, and Friday at 6:00 AM. Record review of Resident #260's physician order dated 12/03/24 reflected the following order: DIALYSIS EVERY M-W-F 5AM. Please send Dialysis Flow Sheet with a full set of vitals in the morning every Mon, Wed, Fri .Please send full set of vitals. Record review of Resident #260's physician order dated 12/02/24 reflected the following: Dialysis communication form to be completed and filed/scanned in chart on dialysis days every day shift every Mon, Wed, Fri. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #260's Nursing Dialysis Communication Record forms dated 12/02/24, 12/04/24, 12/09/24 reflected there was no information documented on the resident assessment and observation post-dialysis sections. The form dated 12/11/24 had no documented information on the resident assessment and observation or pre-dialysis sections. The facility did not have a form for Resident #260 for Friday, 12/13/24. Interview on 12/17/24 at 11:24 AM with Resident #260 revealed he was a dialysis patient and would go to dialysis three times a week on Monday, Wednesday, and Fridays. He stated his chair time was at 6:00 AM. Resident #260 stated he never missed a treatment. He stated he was provided with a binder when he went to dialysis. He stated staff would check his vitals in the morning before leaving to dialysis treatment, but it was rare for his vitals to be taken when he returned to the facility from dialysis. Interview on 12/19/24 at 12:24 PM with RN B stated when a resident went to dialysis it was the responsibility of the assigned nurse to provide the resident with a dialysis communication form and complete the pre-assessment prior to the resident going to dialysis. He stated when the resident returned the resident's assessment and observation post-dialysis section needed to be completed. He stated Resident #260 received dialysis, but he could not recall if he ever worked with Resident #260 on his dialysis days. He stated if the pre- and post-dialysis assessments did not have information it was because they were not completed. RN B stated the potential risk of not monitoring or documenting pre- and post-dialysis vitals was that it could lead to not knowing if the resident had a change in condition. Interview on 12/19/24 at 2:03 PM with the ADON revealed nursing staff were expected to complete pre- and post-vitals on residents who received dialysis. She stated she reviewed Resident #260's dialysis communication forms and noticed the forms were not fully completed and could not locate a form for 12/13/24. She stated it was the responsibility of Medical Records to inform them if any forms had missing information. She stated Medical Records had not informed her of any missing forms or missing information. She stated the potential risk would be nursing staff missing a change in condition with the resident, and the resident's vitals being low. Interview on 12/19/24 at 2:12 PM with Medical Records revealed it was the responsibility of the nursing staff to ensure pre- and post-dialysis information was filled out. She stated her role was only to upload the files into the residents' medical charts. Interview on 12/19/24 at 2:42 PM with the DON revealed nursing staff were expected to complete pre- and post-dialysis information. She stated she was not aware Resident #260's dialysis communication forms were not being completed. She stated when residents returned from dialysis, the forms were provided to Medical Records. Once the forms were uploaded, the forms were given to the ADON or DON. She stated it was the responsibility of the ADON to review the dialysis communication forms to make sure they were completed. She stated the potential risk of not completing the pre- and post-assessments was that it could lead to missing a change in condition in the resident's health with vitals being low or high. Record review of the facility's Dialysis (Renal), Pre and Post Care policy revised May 2022, reflected the following: Is it the policy of this facility to: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Assist resident in maintaining homeostasis pre- and post-renal dialysis; - Assess and maintain patency of renal dialysis access; and - Assess resident daily for function related to renal dialysis. Pre Dialysis Care: 1. Assess resident's blood pressure (in non-shunt arm) prior to being transported to the dialysis unit. Post Dialysis Care: 1. Dialysis access should be assessed upon return to the facility for patency, and any unusual redness or swelling. Documentation: 1. Assess care given, and condition of renal dialysis access. 2. All assessments, including daily weights and blood pressure to be put in the clinical records. 3. Compliance with care plan approaches and diet order.