STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676272	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation-Kyle	1640 Fairway Kyle, TX 78640

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for one (Resident #1) of four residents reviewed for abuse. The facility failed on 11/07/24 to protect Resident #1 from physical and emotional abuse by Resident #2. Resident #2 screamed at Resident #1 and grabbed her right arm with the history of nondisplaced fracture of triquetrum [cuneiform] bone of the wrist, caused erythema (redness of skin) that lasted for 4 days. This failure could place residents at risk of serious physical and emotional injury and harm. The findings included: Record review of Resident #1's face sheet on 11/20/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses were, Wedge compression fracture of second lumbar vertebra (back bone at lumbar area), Maxillary (upper jaw) fracture, Fracture of tooth, Repeated falls, Alzheimer's disease, Nondisplaced fracture of triquetrum bone (bone on the wrist), right wrist, Insomnia, Hypertension, Muscle weakness, Unsteadiness on feet, Lack of coordination and Cognitive communication deficit. Record review on 11/20/24 of Resident #1's initial MDS assessment, dated 08/30/24 revealed a BIMS of 03 indicating her cognition was severely impaired. Record review on 11/20/24 of Resident #1's care plan dated 08/28/24 indicated : 1.She was at the risk for impaired cognitive function or impaired thought processes r/t cognitive deficits and relevant intervention was, facilitate her wish as she liked to ambulate via wheelchair throughout the facility and liked to look out the Hall 100 door /windows. 2.Potential for a psychosocial well-being problem r/t 11/7/24 altercation with another resident [Resident #2] and had red discoloration to right arm from that and the relevant intervention was, when conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's face sheet on 11/20/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses were, Dementia, Chronic kidney disease, Hypertension, Chronic pain, Parkinson's disease, Lack of coordination, Anxiety disorder and Cognitive communication deficit. Record review on 11/20/24 of Resident #2's quarterly MDS assessment, dated 08/02/24 revealed a BIMS of 12 indicating her cognition was moderately impaired. Record review on 11/20/24 of Resident #2's care plan dated 08/28/24 indicated she was on an antidepressant medication and the relevant intervention was monitoring for adverse side effects of agitation. Record review of facility investigation report dated 11/08/24 stated it was confirmed that during an incident on 11/07/24 at 3:00pm Resident #2 screamed at Resident #1's face , raised her arm up and grabbed her right arm. During an observation and interview on 11/20/24 at 11.30am Resident #2 was sitting on her bed and playing cards by self. Her room was adjacent to the exit door from hall 100. When asked about the incident that happened on 11/07/24 between her and Resident #1, her mood elevated and became animated . She conversed in a raised voice and stated that Bitch [Resident #1] lived in Hall 400 however wanted to come to hall 100 all the time. Resident #2 stated she was a nuisance and made numerous attempts to get into her room and on few occasions succeeded too. She stated she did not like anyone invading into her privacy. Resident #2 stated, on 11/07/24 in the evening Resident #1 entered her room , stood up on her feet and tried to assault her . Resident #2 stated at that time she pushed her wheelchair away and out of her room. Resident #2 stated she did not touch her body, only the wheelchair. Resident #2 said Resident #1 was in Hall 100 even after the incident and made attempt to enter her room. Resident #2 stated she was on watch for 10 days for a mistake that Resident #1 had done. Resident #2 said she would not hesitate to physically handle anyone as a last resort if anyone intrude into her room. Resident #2 stated she was a rape victim in the past and still had paranoia about intruders as she was not sure about their motives were. During an observation and interview on 11/20/24 at 2:00pm Resident #1 was sitting on her wheelchair, in her room. She was wearing a helmet for fall protection. She appeared as fragile and delicate. She was pleasant and happy in her presentation and interacted in a passionate manner. Resident #1 stated all the staff and residents at the facility were compassionate, friendly, and helpful. When the investigator asked about the incident that occurred between her and Resident #2 on 11/07/24, she stated she did not remember who Resident #2 was or what the incident was. She stated she did not have any complaint about any staff or residents as all of them were lovely people. When asked if she had visited any residents in their room, she stated she did not . She said she liked to look through one of the glass doors at the facility . She said the view from there was very nice and she liked to watch the activities in the nature on that side. She thanked for talking to her and suggested to stay happy and blessed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 1:00 pm the FM of Resident #1 stated he was aware of the incident . He said the incident occurred when Resident #1 tried to enter Resident #2's room. He said the facility provided best services to Resident #1 however unsure if the facility made sure that Resident #1 would not wander into other residents' rooms or any other unsafe places due to her dementia. He stated he hope another incident would not occur from the same resident as Resident #1 still liked to go to the door next Resident #2's room. He stated he was afraid of her safety if she gets into Resident #2's room due to the lack of observation by the staff. During a telephone interview on 11/20/24 at 2:50pm LVN B stated while she was doing her round about at about 3:00pm in the Hall 100, she heard a scream . She stated she saw Resident #2 raised her arm up, grabbing Resident #1's right arm, and yelling at Resident #1. LVN B stated she did not notice at that time what Resident #1's expression or response was. She said when she arrived at the incident site CNA C was already there trying to deescalate the situation. She stated MD also rushed to the incident site at that time. On 11/20/24 at 3:00pm made a phone call to CNA C and kept a voice message to call back. There was no response as on 11/20/24 at 6:00pm. During a telephone interview on 11/20/24 at 2:40pm MD stated she was in the Hall 100 while the incident occurred. She stated she was rushing to the incident site and saw Resident #1 was pushed out of Resident #2's room by Resident #2 . MD stated Resident #2 was furious and grabbed Resident #1's arm as if she wanted to hurt her . MD stated she observed Resident #1 was upset and was visibly shaking from the commotion. MD stated the situation was deescalated by staff by removing Resident #1 from the incident site. MD stated she visited Resident #1 in her room after about 20 minutes. MD said Resident #1 was resting in her room quietly and appeared peaceful. MD said she examined Resident #1's right arm, the area Resident #2 had grabbed, and it was reddish in color without any open skin. During an interview on 11/20/24 at 1:30pm ADON stated she was the one completed the facility investigation . She stated she and ADM watched the video footage of the incident during the investigation. She stated contrary to what they thought, Resident #1 had not entered Resident #2's room. She said ,on the video it was showed Resident #2 came out of her room yelling and screaming while Resident #1 was attempting to enter her room by opening the door. She stated she also had observed in the video that Resident #2 was grabbing Resident #1's right arm . ADON stated Resident #2 had behavioral concerns and the facility tried to refer her to behavioral health service however Resident #2 and her family declined the referral. ADON stated Resident #1 was a sweet person with no behavioral concerns. She said Resident #1 liked to sit at the exit door at Hall100 and observe the nature outside. ADON stated there was something fascinating for Resident #1 on that side so much so that she wanted to spend good amount of time there. During an interview on 11/20/24 at 4:10pm the ADM stated he watched the video of the incident, and it was showing that Resident #2 grabbing Resident #1's hand during the incident. ADM stated, until watched the video footage, the impression was Resident #1 intruded into Resident #2's room .He said it was clearly shown that Resident #1 did not enter the room however tried to enter the room by pulling the door handle. ADM stated he believed the facility taken all the measures to deescalate the situation and ensuring safety of Resident #1. ADM stated he did not think Resident #1 was physically and emotionally hurt from the incident as the staff intervened at the right time. ADM stated the video was not available as on 11/20/24 as it was overridden by new recordings. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the skin assessment dated [DATE] at 4:17pm reflected : re: altercation- skin intact, red discoloration noted to right arm. Record review of the skin assessment dated [DATE] at 5:36pm reflected : . noted slight discoloration to right arm, no other injuries noted. Record review of the skin assessment dated [DATE] at 6:11pm reflected : Continues with slight discoloration to right arm, denies pain or discomfort. Record review of the skin assessment dated [DATE] at 1:02pm reflected : . noted slight discoloration to right arm, no other injuries noted from recent incident. Record review on 11/20/24 of in-services records since August 2024 revealed there were in-services on 'abuse and neglect' on 08/01/24 and 11/08/24. On 11/08/24 there were in- services conducted on How to responds to resident altercations and identify triggers and what to do when you see residents wanders. Record review of facility's undated policy Investigations of Abuse and Neglect Allegations reflected: .The facility staff will ensure the resident is protected from potential future abuse and neglect while the investigation is being conducted.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 2 of 4 residents (Residents #3 and Resident #4) reviewed for infection control, as indicated by: MA A did not clean and disinfect the blood pressure monitor while using it on Resident #3 and Resident #4 and failed to keep away opened personal drinks from the med cart , on 11/20/24 at 10:25am . This failure could place the residents at risk of transmission of disease and infection. Findings included: Record review of Resident #3's face sheet on 11/20/24 revealed an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses were, Orthostatic hypotension, Type 2 diabetes, Hypertension, Lack of coordination, Muscle weakness, Dementia and Cognitive communication deficit. Record review on 11/20/24 of Resident #3's quarterly MDS assessment, dated 09/19/24 revealed a BIMS of 06 indicating his cognition was severely impaired. Record review on 11/20/24 of Resident #3's care plan dated 11/20/24 indicated resident has orthostatic hypotension and hypertension and relevant intervention was monitoring blood pressure daily. Record review of Resident #4's face sheet on 11/20/24 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses were, ,Type 2 diabetes, Chronic pain, Presence of cardiac pacemaker, Lack of coordination, Hypertension, Muscle weakness, Dementia and Cognitive communication deficit. Record review on 11/20/24 of Resident #4's quarterly MDS assessment, dated 10/31/24 revealed a BIMS of 08 indicating his cognition was severely impaired. Record review on 11/20/24 of Resident #3's care plan dated 11/20/24 indicated Resident #3 had blood pressure and it had to be monitored daily. An observation on 11/20/24 at 10:25am , revealed MA A failed to sanitize the blood pressure monitor before using it on Resident #3, in between Resident #3 and Resident #4 and after Resident #4. MA A took the blood pressure monitor from the top of the med cart and without sanitizing it she took the blood pressure of Resident #3. MA A then moved on to Resident #4 and took his blood pressure with the same blood pressure monitor without sanitizing it. After completing the measurement on Resident #4, without cleaning the blood pressure monitor, she kept it on the top of the med cart. Observation of the med cart revealed there was an opened energy drink and a water bottle at the top of the cart. It was observed MA A taking sip from the bottles while she was administering medications to residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/24 at 10:50am , MA A stated she was working at the facility more than a year and started working as MA recently. She said it was essential to minimize the risk of spreading contagious diseases by sanitizing the blood pressure cuff in between the residents . MA A stated she was aware of the facility policy of should not have personal food items and drinks on the med cart. She said she did not know why staff should not keep food and drinks on the med cart and use it while administering medications. MA A stated she received in services on infection control however did not remember the exact date. Review of facility policy 'Infection Prevention and Control program revised in December ,2023 reflected : The infection prevention and control program is comprehensive in that it addresses detection, prevention and control of infections among residents and personnel. (Personnel covers staff, volunteers, visitors, and other individuals providing services under a contractual agreement). 2. Process Surveillance is the review of practices by staff directly related to resident care. Some considerations for this process may Include, but are not limited to: a. Hand hygiene b. Appropriate use of personal protective equipment (PPE) . e. Infection control practices during the provision of resident care and treatments f. Managing bloodborne pathogen exposure g. Cleaning and disinfection production and procedures for environmental surfaces and equipment h. Appropriate use of transmission-based precautions.