STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455351	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGACY NURSING AND REHABILITATION	2817 KENT STREET BRYAN, TX 77802

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to promote and facilitate resident self determination through support of resident choice, including but not limited to the right to make choices about aspects of his or her life in the facility that were significant to one (1) of eighteen (18) residents reviewed for self determination. (Resident #180) Resident #180 was observed requesting to be helped to bed for approximately an hour and a half stating he felt weak. Staff failed to respond to his request until after lunch had been served. This failure could place all residents, dependent on staff for transfers, at risk for their needs and preferences not being met. Findings included: Review of Resident #180's Face Sheet reflected a [AGE] year old male admitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #180's Quarterly MDS dated [DATE] reflected a BIMS score of 15 indicating the resident was cognitively intact. Review of Section G, Functional Status reflected Resident #180 required staff supervision and assistance by one staff person for transfers. Section G also reflected Resident #180 was not steady, only able to stabilize with staff assistance when completing a surface to surface transfer. Review of Resident #180's Care Plan dated 1/15/2020 reflected Resident #180 had an ADL self-care performance deficit r/t impaired mobility, weakness, and contractures. Interventions included, Transfer: The resident requires assistance by staff to move between surfaces and as necessary. and Bed Mobility: The resident requires assistance by staff to turn and reposition in bed as necessary. An observation on 3/11/2020 at 10:45 revealed Resident #180 asked to be put to bed. A female voice stated she would return with assistance. In an observation and interview on 3/11/2020 at 11:25 AM Resident #180 was observed to be sitting in his wheelchair, in his room, facing his bed. He stated he just wanted to lay down. When asked if he had requested to lay down he stated yes. In an observation and interview on 3/11/2020 at 11:50 AM Resident #180 was observed to be sitting in his wheelchair, in his room, facing the door to the room. He stated he felt weak and still wanted to lay down. He stated he did not feel like eating lunch, he just wanted to go to bed. In an observation on 3/11/2020 at 1:35 PM Resident #180 was observed to be in his bed, on his side, asleep. In an interview on 3/12/2020 at 10:03 AM LVN D denied Resident #180 asked to be assisted to bed. She stated he had a fever this morning and the doctor had been notified. In an interview on 3/12/2020 at 10:20 AM DON stated denied being aware of Resident #180's request to lay down. Her expectation would be for staff to have assisted him at the time of his request or return as soon as possible if additional staff assistance was needed. In an interview on 3/12/2020 at 10:35 AM CNA A stated she did not receive a request to assist Resident #180 on 3/11/2020. She stated she would not have needed assistance as he is a one person transfer and can assist with transfers. In an interview on 3/12/2020 at 12:01 PM PTA G stated she spoke with Resident #180 at approximately 9:15 AM on 3/11/2020 as she starts gathering residents for therapy right at 9 AM. She stated Resident #180 declined therapy but was not clear in explaining why and seemed confused. She stated she notified LVN D of the residents demur and his refusal to attend therapy. Review of facility's Resident's Rights, undated and a part of their admission packet reflected, Each and every resident in this facility has the right to: . Receive a prompt response to all requests and inquiries. Retire and rise in accordance with reasonable requests. Receive adequate and appropriate health care, medical treatment and protective support services.
F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Based on Record Review and interviews the facility failed to refer 4 of 6 Residents (Residents #54, #60, #65 and #69) reviewed with Mental Illness [DIAGNOSES REDACTED]. The facility failed to re-evaluate Resident #60 when she was diagnosed with [REDACTED].#54 when she was diagnosed with [REDACTED].#65 when she diagnosed with [REDACTED].#69 when she was diagnosed with [REDACTED]. Findings include: Review of Face Sheet for Resident #60 reflected a [AGE] year old female was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the MDS quarterly assessment for Resident #60 dated 2/13/2020 reflected a BIMS score of 00 indicating severe cognitive impairment. Her functional assessment reflected she required limited or one person assistance for most ADLs and extensive assistance for toileting and bathing. Bowel and bladder assessments reflected occasional incontinence of both areas. The assessment reflected Resident #60 received Antidepressant medication 5 of the 7 days reviewed. Review of the Care Plan for Resident #60 dated 2/05/2020 reflected a history of [MEDICAL CONDITION]/Stroke, a history of falls, confusion and dementia. Resident #60's Care Plan reflected interventions to cope with aggressive behavior and resistance to care. Review of physician's orders [REDACTED].#60 reflected she was prescribed no psychoactive medications. Physician orders [REDACTED]. Resident #60's records reflected she was prescribed the antidepressant [MEDICATION NAME], which was discontinued on 2/12/2020. Review of PASRR Records for Resident #60 reflected Level 1 screening dated 8/21/15 was marked negative for MI, ID and DD. The facility was not able to find any other records related to PASRR evaluations or rescreening. Review of Face Sheet for Resident #54 reflected a [AGE] year old female was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #54's Quarterly MDS dated [DATE] reflected a BIMS score of 14 indicating minimal cognitive impairment. Her functional assessment reflected she required extensive assistance for most ADLs. The assessment reflected Resident #54 received Antidepressant and Antipsychotic medications 7 of the 7 days reviewed. Review of Resident #54's Care Plan dated 1/16/2020 reflected She is at risk for complications r/t antidepressant medications r/t Major [MEDICAL CONDITION] with interventions to Administer Antidepressant medications as ordered and monitor/document side effects and effectiveness every shift. (Resident #54) is at risk for complication r/t res uses [MEDICAL CONDITION] medication r/t Disease process with interventions to administer [MEDICAL CONDITION] medications as ordered by physician, consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly and monitor and document behaviors every shift. Review of Resident #54's Physician order [REDACTED]. Resident #54 was to be monitored for side effects of Antidepressant Medication and Antipsychotic Medication. Review of Resident #54's PASRR Records reflected Level 1 screening dated 7/2/2019 was marked negative for MI, ID and DD. The facility was not able to find any other records related to PASRR evaluations or rescreening. The screening was completed by MDS Nurse. Review of Face Sheet for Resident #65 reflected a [AGE] year old female was admitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #65's Quarterly MDS dated [DATE] reflected a BIMS score of 3 indicating severe cognitive impairment. Her functional assessment reflected she required extensive assistance with most ADLs. The assessment reflected Resident #65 received Antidepressant Medication 7 out of 7 days reviewed. Review of Resident #65's Care Plan dated 3/12/2020 reflected she used antidepressant r/t [DIAGNOSES REDACTED]. Also reflected was that Resident had [MEDICAL CONDITION] or an acute confusion episode with interventions to include monitor the residents safety frequently during shift and prn and redirect and provide

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

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.

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F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) gentle reality orientation as required. Also reflected was Resident had potential to be verbally aggressive r/t Dementia, History of verbal aggression and anxiety disorder with interventions to administer medications as ordered and monitor/document for side effects and effectiveness. Review of Resident #65's Physician order [REDACTED]. Review of Resident #65's PASRR Records reflected Level 1 screening dated 7/20/2016 was marked negative for MD, ID and DD. The facility was not able to find any other records related to PASRR evaluations or rescreening. Review of Face Sheet for Resident #69 reflected a [AGE] year old female was admitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #69's Quarterly MDS dated [DATE] reflected a BIMS score of 12 indicating minor cognitive impairment. Her functional assessment reflected she required extensive assistance with most ADLs. The assessment reflected Resident #69 received Antidepressant Medication 7 out of 7 days reviewed. Review of Resident #69's Care Plan dated [DATE] reflected she had impaired cognitive abilities secondary to dementia,[MEDICAL CONDITION](Dementia is not listed as a [DIAGNOSES REDACTED]. Also reflected resident was at risk of fall and injury related to lower extremity weakness, upper/lower extremity contractures, cognitive impairment with interventions to anticipate and meet needs, assure adequate lightening especially at night, fall risk quarterly and prn, place call light and frequently needed objects within patient reach and refer to therapy as needed. Also reflected Resident was at risk for complications r/t res uses antidepressant medication r/t depression in which may cause complications with irritability, tearfulness, restlessness, inability to concentrate and significant mood swings. Interventions included to administer antidepressant medications as ordered by physician and monitor/document side effects and effectiveness every shift. Review of Resident #69's Physicians Orders dated 3/12/2020 reflected she was prescribed [MEDICATION NAME] Oxalate Tablet 10 MG effective 8/23/2019 for Major [MEDICAL CONDITION] Recurrent, Unspecified and [MEDICATION NAME] Tablet 15 MG effective 8/23/2019 for Major [MEDICAL CONDITION], Recurrent, Unspecified. Orders also reflected Depression Monitoring effective 11/25/2019. Review of Resident #69's PASRR Records reflected Level 1 screening dated 8/23/2019 was marked negative for MD, ID and DD. The facility was not able to find any other records related to PASRR evaluations or rescreening. In an interview on 3/12/2020 at 10:45 AM MDS Nurse stated Resident #54 came from another facility where the PASRR had already been completed as negative so she was put in the system that way. In an interview on 3/12/2020 at 11:25 AM DON stated if a resident had a [DIAGNOSES REDACTED]. In an interview on [DATE] at 11:45 AM the MDS Nurse stated she had not assessed Resident #60 with any issues of Depression. The MDS nurse stated she was unsure but the Major Depressive [DIAGNOSES REDACTED]. In an interview on 3/12/2020 at 3:00 PM the DON stated she was not able to locate any PASRR information for Resident #60. She stated a transition to a new computerized record keeping system may have resulted in difficulty locating the assessments. The DON stated she was unsure why Resident #60 was not reassessed when the [DIAGNOSES REDACTED]. In an interview on 3/12/2020 at 3:10 PM the Administrator stated she had not been able to locate any further information on PASRR assessments for Residents #60 and #54. She stated the facility would file to have both Residents reassessed as soon as possible. She stated facility policy was to conduct PASRR assessments on all Residents with MI diagnoses. Review of the Resident review and screening (PASRR) Policy supplied on 3/12/2020 reflected any person should be screened for signs of MI, ID or related conditions. The policy reflected all persons positive in Level 1 screening should be referred to the local authority for Level II screening.
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** Based on interview, observation and record review the facility failed to ensure that based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for one (1) of eighteen (18) residents reviewed for quality of care. (Resident #15) The facility failed to reposition Resident #15 to relieve pressure from his back and bottom. This failure places residents at risk for developing pressure ulcers leading to a decreased quality of life. Findings included: Review of Resident #15's Face Sheet reflected a [AGE] year old male who was admitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #15's Quarterly MDS dated [DATE] reflected a BIMS score of 99 indicating severe cognitive impairment. His functional status reflected he required extensive assistance with all ADLs. Bed mobility required extensive assistance and 2 staff members. Review of Resident #15's Care Plan dated 1/22/2020 reflected he had a self-care performance deficit r/t cognitive impairment, generalized weakness, poor ability to follow direction, contractures and amputation. Interventions included for transfer - the resident uses a mechanical lift with staff for transfers into geri-chair. The plan also reflected he had potential impairment to skin integrity r/t fragile skin and limited mobility. Interventions included - weekly treatment documentation to include measurement to each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. The plan also reflected he had a pressure sore to coccyx r/t immobility that resolved 12/23/19 and reopened 1/13/20. Interventions included - follow facility policies/protocols for prevention/treatment of [REDACTED].#15's Physician order [REDACTED]. Review of facility computerized medical record on 3/11/2020 at 3:00 PM reflected the following dates and times Resident #15 was repositioned. The column title stated Turned q 2 hrs while in bed and chair 3/11/2020 04:18 AM 3/11/2020 12:29 PM 3/10/2020 07:18 AM [DATE]20 07:13 AM 3/8/2020 04:13 AM 3/8/2020 10:15 AM 3/7/2020 05:10 AM 3/7/2020 13:59 PM 3/6/2020 13:59 PM In an interview and observation on 3/11/2020 at 11:21 AM a family member stated Resident #15 was not turned every 2 hours as ordered. She pointed out and it was observed Resident #15 was on his back with his head elevated approximately 30%. An observation on 3/11/2020 at 1:40 PM revealed Resident #15 to be flat on his back with the head of his bed elevated. An observation on 3/11/2020 at 2:49 PM revealed Resident #15 to be flat on his back with the head of his bed elevated. In an interview and observation on 3/12/2020 at 10:03 LVN D stated Resident #15 no longer had a pressure sore that she had viewed it over the weekend and it was close. She stated it was a sheer burn from his bed sheet. When asked how often he was to be repositioned, she stated every 2 hours. Review of facility policy, Prevention of Pressure Ulcers/Injuries dated 2001 Med-Pass, Inc (Revised July 2017) reflected, The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. Mobility/Repositioning . 1. Choose a frequency for repositioning based on the resident's mobility, the support surface in use, skin condition and tolerance, and the resident's stated preferences. 2. At least every hour, reposition residents who are chair-bound or bed bound with the head of the bed elevated 30 degrees or more. 3. At least every two hours, reposition residents who are reclining and dependent on staff for repositioning. 4. Reposition more frequently as needed, based on the condition of the skin and the resident's comfort.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to limit the prescription of a PRN [MEDICAL CONDITION] drug to 14 days without appropriate documentation from the physician for one (1) of five (5) Residents reviewed. (Resident #35) The facility failed to review documentation for a PRN order which appeared in the MAR for Resident #35. The deficient practice affected Resident #35 and could have affected all residents who are prescribed antipsychotic medications within the facility. Findings include: Review of the Face Sheet for Resident #35 reflected a [AGE] year old female admitted on [DATE] with [DIAGNOSES REDACTED].#35 dated 1/24/20 reflected a BIMS score of 12 indicating mild cognitive impairment, Functional status marked as supervision of one person for all ADLs. Bowel and Bladder noted as Resident is always continent. Medications reviewed reflected Antianxiety medications were received 7 of 7 days. Review of physician's orders [REDACTED]. As needed referring to PRN. Both orders were dated as started on 6/15/19. Reviews reflected the PRN order had been included in the regularly scheduled medication for Anxiety disorder. Review of the Care Plan for Resident #35 dated 1/29/2020

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) reflected impaired cognitive function related to aging. Resident #35 was to monitored for effects of Antianxiety medication and chronic pai[DIAGNOSES REDACTED] Record review of MARs for Resident #35 reflected the PRN [MEDICATION NAME] order was active and continued from 2/01/20 to 3/11/20. She received a PRN dose of [MEDICATION NAME] 0.5 mg on 2/07/20 at 11:30 PM. In an interview on 3/12/2020 at 8:15 AM the DON stated the Physician for Resident #35 had discontinued the PRN dose of [MEDICATION NAME] prescribed. The DON provided a Drug Regimen Review dated 7/31/19 which reflected the physician had planned to continue the PRN dose of [MEDICATION NAME] indefinitely. The rationale reflected in the Review was the Resident had benefited from periodic use of [MEDICATION NAME] PRN and benefits outweighed the risks associated with the medication. In an interview on 3/12/2020 at 9:19 AM the RP for Resident #35 (son) stated he had no concerns related to his mother's medication. The RP stated his mother had needed to take [MEDICATION NAME] for Anxiety for years. He stated he visited frequently and had not observed her in a drowsy or sedated state. In an interview on 3/12/2020 at 11:27 AM the Physician for Resident #35 stated he was not aware the order for PRN [MEDICATION NAME] had not been discontinued. He stated he was aware a PRN order could not be given for more than 14 days. He stated he had ordered the PRN dosage of [MEDICATION NAME] stopped as he was in the process of tapering Resident #35 off pain and psychoactive medications. He stated he reviewed Resident #35's Medication orders at least monthly. He stated he had renewed Resident #35's bedtime order for [MEDICATION NAME] 0.5 mg. The physician stated Resident #35 had received the medication for a long time and the single PRN dose given had not resulted in an notable affect. In an interview on 3/12/2020 at 12:07 PM the Administrator stated all PRN medication orders must be discontinued after 14 days or a new order was to be written by the physician with the appropriate rationale. The Administrator stated the computer entry for the [MEDICATION NAME] order was entered incorrectly and all Psychoactive medication orders would be reviewed for accuracy. Review of the Consultant Pharmacist report dated 2/02/2020 reflected no concerns were identified for Resident #35. The report referenced a letter the physician had returned dated 7/31/19. The letter to the physician referenced the end of the 14 day PRN period for the [MEDICATION NAME] order. The Physician response reflected Resident #35 had taken PRN doses of [MEDICATION NAME] intermittently with good effect and benefits outweighed risks associated with the medication. Review of the [MEDICAL CONDITION] Medication Policy dated 2/2020 reflected [MEDICAL CONDITION] medications (scheduled and PRN) should be monitored for effectiveness. PRN orders are limited to 14 days, except if the attending physician documents a rationale in the medical record and indicates the duration of the PRN order.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation, interview, and record review the facility failed to store all drugs and biologicals in locked compartments for one (1) of four (4) medication carts. The medication cart on the 400-hall was observed to be unlocked and facing the hallway. The med cart was located between rooms #403 and #405. These failures placed residents on the 400-hall at risk for residents' not being provided their medication as ordered by their physician. Findings included: Observation on 03/10/2020 at 3:43 PM revealed the medication cart on the 400-hall was left unattended and unlocked until 3:51 PM. Observation on 03/10/2020 at 3:51 PM revealed ADON walked up to the medication cart located on the 400 hall and pushed the lock in. The medication cart was located against the hallway wall between rooms #403 and #405 with the drawers facing the hallway. The medication in the cart was not counted prior to the ADON locking the med cart. In an interview on 03/10/2020 at 3:43 PM CNA C stated the cart was open and she did not know where the nurse was that was responsible for the cart. CNA C stated the cart was to be locked at all times when a nurse is not at the cart. CNA C further stated several minutes had passed prior to when LVN C returned to the cart. In an interview on 03/10/2020 at 3:51 PM ADON stated the med cart should never be left unlocked for any reason. ADON further stated her expectation is the nurse lock the cart prior to walking away from the cart. ADON stated she would locate the nurse responsible for leaving the cart unlocked. ADON locked the med cart but did not count the medication prior to locking the cart. In an interview on 03/10/2020 at 3:58 PM LVN C stated she left the med cart unlocked while she went to check on a resident. LVN C further stated the expectation is the med cart is to be locked when she's away from the med cart. In an interview on 03/10/2020 at 4:12 PM ADM stated the medication cart shouldn't ever be left unlocked and unattended. ADM stated she was made aware of this and she addressed and corrected the problem. Review of the facility's policy Security of Medication Cart reflected Medication cart shall be secured during medication passes. Policy Interpretation and Implementation, Medication carts must be securely locked at all times when out of the nurse's view.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on interview and observation, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for residents receiving meals from the facility's only kitchen. CNA B and ADON were observed on 3/10/2020 removing paper from straws, using their bare hands with the unwrapped straws to stir sugar and/or sugar substitute into tea and leaving the straw in the tea for the residents to drink from. This failure could place all residents in danger of becoming ill from the transmission of communicable diseases. Findings included: An observation on 3/10/2020 at 12:05 PM to 12:15 PM revealed CNA B unwrapping then using residents' straws to stir sugar into her tea. She handled the straw with her bare hands and left the straw in the residents glass. She was observed doing this while assisting two different residents. Both residents were observed drinking from the straw left in the glass. Another CNA (unidentified in gray scrubs) also used a resident's straw to stir sugar into the resident's tea. An observation on 3/10/2020 at 12:27 PM revealed ADON delivering a tray to a resident's room. She was observed unwrapping then using the resident's straw to stir sugar into her tea. She handled the straw with her bare hands and left the straw in the resident's glass. In an interview on 3/10/2020 at 12:29 PM ADON stated yes she used the resident's straw to stir her sweetener into her tea but held it by the sides and did not touch the top of the straw. When asked if a spoon might be better she stated the sweet taste of sugar would mix with the food. She stated the concern had never come up. In an interview on 3/10/2020 at 12:42 PM CNA B stated it would have been better to use a spoon because the residents put the straws into their mouths. In an interview on 3/12/2020 at 10:20 AM DON stated her expectation would be for staff to leave paper on top of the straw to keep protected while stirring or to use a spoon to stir sweetener into the residents' tea.