STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676113	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Center -	2003 W Hutchins Place San Antonio, TX 78224

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for 2 of 8 residents (Residents #1 and #2) reviewed for care plans in that: Resident #1's and Resident #2's comprehensive care plan did not reflect they had dentures. This failure could place residents at risk of receiving inadequate interventions not individualized to their care needs. The findings included: 1. Record review of Resident #1's face sheet dated 03/22/2024 revealed a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included surgical wound, pleural effusion (extra fluid around the lungs), atrial fibrillation, chronic diastolic (congestive) heart failure, and adult failure to thrive. Record review of Resident #1's discharge MDS, dated [DATE], showed Resident #1's cognition was intact. Record review of Resident #1's comprehensive care plan, close date 10/02/2023, revealed, the resident's dentures were not included in the care plan. Record review of Resident #2's face sheet dated 3/14/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus with hyperglycemia, hyperlipidemia (elevated cholesterol levels), dysphagia (a condition with difficulty in swallowing food or liquid), and need for assistance with personal care. Record review of Resident #2's most recent quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills. The MDS also indicated resident #2 was dependent on staff for oral hygiene. Record review of Resident #2's comprehensive care plan, with revision date 2/08/2 revealed 4 the resident's dentures were not included in the care plan. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/22/24 at 5:20 p.m. Resident #2 was sitting in her bed. On her bedside table was a container with dentures. Resident #2 stated those were her dentures and she takes care of her dentures herself the staff had never helped her with them. Resident #2 stated she was seen by a dentist and has no issues. Resident #2 stated she likes to keep her dentures out of her mouth and in the container when she was not eating. During an interview on 03/22/24 at 3:16 p.m., the DON stated both Resident #1 and Resident #2 should have their dentures care planned so staff could have done the interventions for dentures. Record review of a document titled Inventory of Personal Effects, dated 07/20/2023, revealed resident #1 had dentures on admission. Record review of the facility policy and procedure titled, Care Planning, with revision date 05/2007 revealed in part, .It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident .7. The MDS Coordinator and/or Social Services staff will notify the resident, family and/or responsible party, and other interested parties designated by the resident, of the date and time of the care plan conference two (2) week prior to the meeting

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview, and record review, the facility failed to assist residents in obtaining routine dental services to meet the needs of 1 of 2 residents (Resident #1) reviewed for dental services. The facility failed to ensure Resident #1's missing dentures were replaced. This failure could place residents at risk of not receiving needed dental care, difficulty eating, a decreased quality of life, weight loss, and discomfort. Findings included: Record review of a face sheet dated 03/22/2024 indicated Resident #1 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included surgical wound, pleural effusion (extra fluid around the lungs), atrial fibrillation, chronic diastolic (congestive) heart failure, and adult failure to thrive. Record review of Resident #1's discharge MDS, dated [DATE], showed Resident #1's cognition was intact. Record review of Resident #1's care plan, close date 10/02/2023, revealed, the resident's dentures were not included in the care plan. The care plan also revealed Resident #1 had unplanned/unexpected weight loss related to poor food intake, recent hospitalization September -5.0% change [5.4%] initiated on 09/18/2023 with intervention to give supplements, if weight decline persisted to contact the physician and dietician, monitor and report any signs and symptoms of decreased appetite, nausea/vomiting, unexpected weight loss, or complaints of stomach pain. During an interview on 03/20/24 at 11:40 p.m. Resident #1's family member stated Resident #1 left the facility to go to the hospital and left all her belongings including her dentures and some paperwork at the facility. The family member stated when Resident #1 returned to the facility all her belonging were missing. The family member stated it was a weekend and staff told him possibly another staff member who worked during the week has the dentures. The family member stated the facility eventually had her see the facility dentist to see if she could qualify for dentures. The family member stated everyone at the facility knew her denture were missing and they gave him excuses and never replaced them. During an interview on 03/21/24 at 12:13 p.m. the social worker stated the facility did plan to replace Resident #1's missing dentures. The SW also stated she did not include the missing dentures for Resident #1 on the grievance log but she had a journal she could check for notes. The SW returned with a typed document and stated these were notes she had that were not documented on the grievance log. The SW stated the reason the dentures were never ordered for Resident #1 as of 03/21/24 was because the Resident's dentist never sent an invoice for the cost of new dentures. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/22/24 at 8:58 a.m. the DON stated the had a current resident who had missing dentures and they were able to replace them in about 2 weeks. The DON stated Resident #1 had to go to the ER and upon returning they did not know what happened to her dentures but they agreed to replace them. The DON stated they tried to get them covered by the insurance, but it was too soon for the insurance to get a new set. The DON stated they had agreed to pay for the dentures but Resident #1 had discharged and stopped communicating with them. During a follow up interview on 03/22/24 at 9:37 a.m. the SW and Administrator stated Resident #1 and the family refused to use the facility dentist and wanted to use their own dentist. This surveyor pointed out that the handwritten grievance report notes they provided stated the resident wished to try their dentist to see if they would be faster because they were told it would take up to 3 months with the facility dentist. The SW stated she did not try to use the facility dentist again when she was unable to get in touch with the resident's dentist. The SW stated she could not get in touch with Resident #1. The SW stated she tried to call the resident's representative or family member once and they did not answer. During a follow up interview on 03/22/24 at 10:48 a.m. Resident #1's family member stated after Resident #1 was discharged at the end of September 2023 he spoke with staff from the facility several times over the phone about replacing Resident #1' dentures. The family member stated he told the facility her dentures were missing and the facility staff stated they were going to check with the SW because it happened over the weekend. The family member stated when he went to the SW office to speak with her she stated they were still looking for the dentures. The SW stated they would have her see the facility dentist and see if she could qualify for a new set. The family member stated they transported the resident in her wheelchair to another room to be seen by the facility dentist. The family member stated the facility dentist looked at the resident and they talked to the dentist and assistant themselves. The family member stated nothing ever happened with the facility dentist so they took the resident to her dentist she got the dentures from. The family member stated they never told the facility they did not want to use their dentist and were only trying to get the dentures replaced. The family member stated they personally would go to the social workers office and talk to her about the resident having difficulty eating. The family member stated the facility was feeding her a regular diet and she had a hard time eating it without her dentures. The family member filed a complaint in November because they felt the facility was making excuses and did not replace the dentures. The family member stated the Resident passed at the beginning of March and it was very upsetting to them for the resident to have never had her dentures replaced and had to eat only soft foods. Record review of a document titled Inventory of Personal Effects, dated 07/20/2023, revealed Resident #1 had dentures on admission. Record review of the progress notes, dated 03/22/2024, revealed: -On 07/20/23 Resident #1 arrived at the facility with only dentures upon inventory. -On 07/22/23 at 1:30 p.m. Resident #1 had a change in condition with a low blood pressure and the resident refused to go to the hospital. -On 07/22/23 at 3:14 p.m. Resident RP requested the resident be sent to the hospital. -On 07/22/23 at 5:39 p.m. Resident #1 was sent to the hospital. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 08/01/23 at 3:18 p.m. Resident #1 returned from the hospital. -On 08/05/23 at 10:53 a.m. Resident #1 asked about top/bottom dentures, briefs, and medical paper work that was left in the room on previous admission. Note stated the ADONs were aware and the social worker would follow up. -On 08/08/23 at 12:06 p.m. a note from the social worker stated SW met with resident at bedside to discuss discharge plans and goals. Resident recently readmitted to facility from hospital. Resident currently in facility for short term skilled services. Resident wishes to discharge back home after stay. Resident states she lives with family member in a single story home and has dme of wheelchair, walker, cane, shower chair. Resident states her family member would help with ADLs. Resident states her family member would transport her places. Resident wishes to be a full code. SW will continue to monitor and intervene as needed. (The dentures were not mentioned.) -On 08/11/23 at 2:34 p.m. Resident #1 was sent to hospital for seizure activity at approximately 12:30 p.m. -On 08/31/2023 at 6:25 p.m. Resident #1 returned to the facility. -On 09/07/23 at 2:01 p.m. a note from the social worker stated SW met with resident in room. Resident alert and oriented x3 and pleasant to speak with. Resident currently in facility for short term skilled services. Resident wishes to discharge back home after stay. Per resident, she lives with family member in a single story home and has dme of wheelchair, walker, cane, shower chair. Resident states her family member would help with ADLs. Resident states her family member provided transport. Resident wishes to be a full code. SW will continue to monitor and intervene as needed. The dentures were not mentioned. -On 09/24/23 at 12:02 p.m. the resident discharged home with family. (The dentures were not mentioned.) Record review of a document titled Inventory of Personal Effects, dated 08/01/2023, stated No new inventory resident stated she left items here at facility from previous admission. Record review of a document titled Oral Health Screening Form, dated 08/09/23, revealed patient has no natural teeth and a note stated small but adequate ridges patient wants new dentures present dentures lost. The document was signed by the facility's dentist. Record review of August 2023 log provided by the facility did not contain any information about Resident #1's lost dentures. Record review of an untitled and undated document provided by the SW stated: Resident #1 (DOB: .) -9/18/2023 Call to [Resident #1's dentist] No answer and left voicemail -9/19/2023 Call to [Resident #1's dentist] No answer and left voicemail (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-9/20/2023 Call to [Resident #1's dentist] No answer and left voicemail -10/4/2023 Call to Resident #1 No answer and left voicemail -[Resident #1] returned call 10/4/2023 at 4:01pm, and SW provided update that SW unable to talk to anyone at dentist office. SW asked resident to contact her dentist office to inform them that SW would be calling dentist office on behalf of resident. [Resident #1] voiced understanding. -10/7/2023 at 9:15AM Call from [Resident #1] called SW informed SW that she spoke with dentist office and informed them that SW would be calling -10/10/23 at 11:53AM Call [Resident #1's dentist] no answer and SW left voicemail. -10/13/23 at 12:15PM Call to [Resident #1] No answer and SW left voicemail -10/13/23 at 12:16PM Call to [Resident #1] husband No answer and left voicemail -10/27/2023 Call to [Resident #1's dentist] SW called dentist office and able to speak with office. Office states resident received new dentures too recently for insurance to cover. Office states top and bottom dentures will cost $2400. SW informed office invoice would need to be sent to facility so facility could cover. SW provided email address. Pending invoice at this time -11/14/23 9:04AM call to [Resident #1's dentist] SW called dentist office, no answer and left voicemail. -12/4/23 10:40AM call to [Resident #1's dentist] NO answer and SW left voicemail for office requesting return call. -12/8/23 at 11:24AM call to [Resident #1] No answer and SW left voicemail. -2/15/24 1:51PM call to [Resident #1's dentist] No answer and SW left voicemail -2/15/24 1:53PM call to [Resident #1] No answer and SW left voicemail. Record review of a document titled Grievance Resolution Form, dated 08/03/23, contained hand written notes and stated resident #1 returned from hospital and dentures not found in belongings left at facility . person reporting: resident . steps taken to investigate the grievance: search for dentures/ refer to dentist . summary of findings/ conclusion: resident left to hospital and left all personal belongings including dentures at facility. Upon returning dentures unable to be located [Resident #1] referred to [facility's] dentist and seen by dentist for new dentures . seen by [facility] dentist 8/9. [facility dentist] process can take up to three months. Resident states has outside dentist and wishes to see them for possible faster process . (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Missing Items, dated 07/2017, stated Policy: It is the policy of this community to ensure residents belongings are kept safe and secured in room. Procedures: 1. If resident reports missing items a Grievance Form is to be filled out for those items. -Inventory sheets will be reviewed to ensure that item was brought into facility .3. If report involves money or item of value. Administrator is to be notified immediately for further investigation. 4. Resolvement of items missing should be communicated to resident and/or family. Record review of the facility's policy titled Grievances, dated 11/2007, stated Policy: it is the policy of this facility to: 1. Voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment .2. Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior other residents. Purpose: To assure that concerns are quickly and thoroughly evaluated and acted upon in order to resolve issues which affect the quality of life and care for resident in our facility. Procedures: 1. Copies of the Grievance Resolution Form are available from the Social Services Designee or Administrator and at the nursing stations. These forms are to be initiated when concerns or complaints are made. 2. Residents and/or Families are informed of and given copy of the grievance policy during the admission process. General concerns may be voiced at Resident and/or Family Council meetings. 3. When a concern is voiced to a facility employee, the resident, family, guest or fell ow employee is directed to the appropriate department supervisor to evaluate and resolve the issue. If the supervisor is not available, the matter is referred to the administrator. 4. The administrator evaluates and investigates the concern and takes appropriate action to resolve the concern and prevent further occurrences. 5. The administrator/ designee responds to the individual expressing the concern within (3) three working days of the initial concern to acknowledge receipt and describe steps taken towards resolution. If a concern form has not been initiated, it is initiated at this time by the administrator or designee. 6. The administrator/ designee completes the grievance resolution form and contacts all parties with the outcome. Grievance resolution forms are kept as legal confidential documents. They are not discoverable and only the portions completed by the concerned party shall be made available to same .