

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/15/2026
NAME OF PROVIDER OR SUPPLIER  Legacy Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to ensure that each resident received adequate supervision to prevent accidents for 1 of 3 residents (Resident #1) reviewed. The facility failed to ensure that Resident #1 received sufficient supervision to avoid the right femur fracture and subsequent hospitalization on 01/11/26. This failure could place the residents at risk for accidents. Findings included: Review of Resident #1's Face Sheet dated 01/15/26 revealed she was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included unspecified fracture of left femur, aftercare following joint replacement surgery, presence of left artificial hip joint, dementia, iron deficiency, hypotension (low blood pressure) and pain. Review of Resident #1's quarterly MDS dated [DATE] revealed her BIMS score was 01 indicating her cognition was severely impaired. The MDS also indicate Resident #1 needed moderate assistance to roll left and right, Sit to lying and Lying to sitting on side of bed. She needed maximum assistance in sitting, standing and Chair/bed-to-chair transfer. It was noted that Resident #1 was fully dependent on toilet transfer and incontinent care. Review of Resident #1's Comprehensive Care Plan dated 01/15/26 revealed Resident #1 was experiencing pain related to a hip fracture with surgical repair. The relevant intervention was administering the pain medication as ordered and observing the worsening of the pain symptoms and report to physician. Record review of the FRI dated 01/12/26 indicated that, on 01/11/26, Resident #1 was transferred to the ER by the NP's order for evaluation of the swelling on the right thigh. Record review of the hospital record dated 01/12/26 reflected Resident #1 had distal Right femur fracture from unwitnessed ground level fall at nursing facility. The radiology results revealed that a Dynamic Hip Crew (DHS) ( an orthopedic implant used for internal fixation of proximal femur fractures ) was present on the right femur and there was a midshaft comminuted impacted angulated spiral fracture (a severe injury where a bone is twisted and shattered into multiple pieces, with fragments driven into one another and bent out of alignment) , that occurred below the DHS. Record review of the EHR on 01/15/26 revealed there was no documentation of the pain and assessment that Resident #1 had when moving her right leg, on 01/08/26. Record review of the January 2026 MAR reflected Resident's pain level on 01/08/26 and 01/11/26 were 5 and 7 respectively on a pain scale of 1 to 10 where 10 was the highest and Acetaminophen Tablet 650 MG was administered on both of the occasions. Her pain level on 01/09/26 in the day shift was 2. It indicated that her pain level was 0 on rest of the days. During an observation conducted on 01/15/26 at 3:30 p.m., Resident #1 was observed lying in bed. An interview was not possible due to her poor cognitive ability. During a telephone interview on 01/15/26 at 2:15 p.m., the RP for Resident #1 reported that on 01/11/26 at 7:36 p.m. she received a call from the facility indicating that Resident #1 required transfer by EMS to a nearby hospital due to significant swelling of the right lower extremity extending from the thigh to the ankle, with an unknown cause. The RP stated that hospital staff indicated the injury might have</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 455351	If continuation sheet Page 1 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/15/2026
NAME OF PROVIDER OR SUPPLIER  Legacy Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>occurred several hours prior to its discovery based on the extent of swelling. She further reported that Resident #1 was diagnosed with a right femoral fracture requiring surgical intervention. The RP added that the resident had a prior left hip replacement following a fall in October 2025. She stated that facility staff were unable to provide a definitive explanation for the injury and expressed her belief that the fracture might have resulted from a stress injury during repositioning or care. During a telephone interview on 01/15/26 at 3:16 p.m., CNA G stated she provided care to Resident #1 on the afternoon shifts of 01/09/26, 01/10/26, and 01/11/26. She reported no swelling or pain on 01/09/26 and 01/10/26. However, on 01/11/26 at about 4:30pm, she observed the resident moaning and grimacing in severe pain, with significant swelling of the right leg. She stated she immediately reported these findings to LVN H. When the investigator asked her if she was aware Resident #1 had experienced pain on 01/08/26 when moving her right leg, she responded that she did not know about it. On 01/15/26 at 2:45 p.m., a voicemail message was left for LVN H requesting a return call; no response was received. Review of a progress note dated 01/11/26, authored by LVN H, documented that CNA G reported Resident #1 to be in severe pain with significant swelling of the right upper leg between the hip and knee. Assessment revealed marked edema, warmth, and pain with palpation and movement. Tylenol was administered immediately, and the resident was transferred to the emergency department, as per the physician's order. She stated RN D reported to her about the pain Resident #1 had in the afternoon and was under observation. During an interview on 01/15/26 at 12:05 p.m., RN D stated that she worked the day shifts on 01/09/26, 01/10/26, and 01/11/26 and was not aware of Resident #1's complaint of right leg pain on 01/08/26, as the information was not communicated. She stated no pain complaints were reported on 01/09/26 or 01/10/26 though she had not assessed for pain specifically on her right leg. However, on 01/11/26 at approximately 4:30 p.m., CNA E reported that Resident #1 was shivering. Upon assessment, RN D observed signs of pain in the right leg, but no swelling or deformity observed. She administered Tylenol 650 mg as needed, after which the resident stopped shaking and exhibited no further signs of pain. RN D reported that she communicated this information to the oncoming nurse, LVN H, prior to the end of her shift at 6:00pm. During an interview on 01/15/26 at 3:01 p.m., CNA E stated that she worked with Resident #1 on the afternoon shift of 01/08/26 and observed no swelling or pain during incontinence care. She stated that she worked at the facility on 01/10/26 and 01/11/26, however she had not worked with Resident #1 on 01/09/26 or 01/10/26. On 01/11/26, she observed Resident #1 shivering in pain during lunch, while serving lunch to the residents and reported it to RN D. She said later that day she came to know that the resident had been noted to have pain on 01/08/26 through somebody else (unable to remember who that was). During a telephone interview on 01/15/26 at 1:55 p.m., CNA B stated that while working the day shift on 01/08/26, Resident #1 exhibited pain when her right leg was moved during incontinence care. CNA B reported that although the resident was sometimes combative, on that day she was quiet. CNA B stated she informed LVN A of the change in condition; LVN A assessed the resident and administered pain medication. CNA B further stated that later the resident was observed in common areas in her wheelchair without apparent signs of pain or discomfort. CNA B stated she worked again on 01/09/26 and reported being cautious when providing care for the right leg, noting no further signs of pain. She did not work on 01/10/26 or 01/11/26. During a telephone interview on 01/15/26 at 2:05 p.m., LVN A reported that on the morning of 01/08/26, CNA B informed her that Resident #1 complained of pain from her right leg during perineal care. LVN A stated she completed an assessment and noted no abnormalities, deformities, swelling, or redness of the bilateral lower extremities. However, when perineal care was attempted again, the resident moaned when her right leg was grasped. She stated Resident #1 did not have the cognitive ability to</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/15/2026
NAME OF PROVIDER OR SUPPLIER  Legacy Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>express her pain verbally. LVN A stated she specifically assessed the right leg again and found no visible abnormalities. She administered Acetaminophen (Tylenol)325 mg, two tablets, as needed for pain, and the resident did not complain of pain for the remainder of the day. LVN A stated she was not sure if she had communicated about the incident to the incoming nurse, LVN C, during the shift change. She said she did not report the issue to the NP and forgot to document the incident in the EHR. She stated she should have documented the incident as well as report it to NP and LVN C to ensure monitoring and continuity of care. During an interview on 01/15/26 at 2:17 p.m., LVN C stated that he worked the night shift on 01/08/26 and was not informed of Resident #1's complaint of right leg pain during the change of shift by LVN A. He indicated that he did not perform a focused assessment of the right leg during his shift as he was not aware of the issue with Resident #1's right leg. During an interview on 01/15/26 at 2:30 p.m., CNA I stated that she worked the morning shifts on 01/10/26 and 01/11/26 (6:00 a.m. to 2:00 p.m.). She stated she was not aware of the pain from the right leg of Resident #1 with movements and did not find any signs of pain, swelling, or redness in Resident #1's lower extremities while changing her briefs. Resident #1 was combative sometimes and had not checked for any sign of pain while changing her briefs on these days. She stated if she was aware of the concern with her right leg, she would have observed the resident closely for pain with the movements of the affected leg. During an interview on 01/15/26 at 4:15 p.m., the NP stated she received a call on 01/11/26 regarding swelling and pain in Resident #1's right leg and ordered transfer to the emergency department. She reported she was not aware of the pain episode on 01/08/26. The NP stated the resident had a history of left hip fracture and was prescribed Tylenol as needed, with order for pain assessment each shift. She identified severe pain, swelling, deformity, and redness as possible indicators of fracture and stated she could not determine the exact timeframe for the onset of swelling following a fracture. The NP stated she was not sure if the complaint of pain in the right leg of Resident #1 on 01/08/26 was related to the fracture as there was no swelling or deformity observed at that time. She stated that, considering the age and condition of Resident #1, the finding on 01/08/26 should have been communicated with her and continue to assess and monitor Resident #1 for the pain and change of condition originating on the affected leg. During an interview on 01/15/26 at 10:30 a.m., the DON stated that Resident #1 returned from the hospital on [DATE] following surgical repair of the right femur fracture after being admitted to hospital with swelling on her right leg and pain. The DON reported that on 01/08/26 at approximately 9:00 a.m., CNA B noted the resident moaning and grimacing in pain when her right leg was moved and reported this to LVN A, who assessed the resident and administered Tylenol. The DON stated it was unclear whether this information was communicated to subsequent shifts, however there were no reports of pain or swelling until 01/11/26. She stated there was no information available if Resident #1 was assessed for pain from her right leg. Upon review of the incident, the DON said there was no evidence of follow-up assessment or communication regarding Resident #1's pain until the evening of 01/11/26. The DON stated that the exact timing of the fracture could not be determined. She stated Resident #1 had no fall episodes in the month of January 2026. She indicated that although pain was noted with movement of the right leg on 01/08/26, there were no visible signs of fracture at that time. She stated staff should have conducted focused pain assessments and observations for change of condition of the affected extremity. She further stated that there was no documentation of continued assessment or observation following the initial complaint on 01/08/26. However, she noted that interviews with CNAs who worked on 01/09/26 and 01/10/26 revealed no observed signs of pain or swelling during care across shifts. Record review of the facility's undated policy 'Abuse prevention and prohibition reflected: . Injuries of Unknown Origin: An</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/15/2026
NAME OF PROVIDER OR SUPPLIER  Legacy Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689  Level of Harm - Actual harm  Residents Affected - Few	injury should be classified as injury of unknown origin whenBoth of the following criteria are met: The source of the injury was not observed by any person, or the source of injury could not be explained by the resident.A licensed professional nurse will examine the resident for signs of injury and notify the resident'sphysician of any injuries noted.		