STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455351	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a baseline care plan that included instructions needed to provide effective and person-centered care of the residents, for 1 of 4 residents (Resident #1) reviewed for baseline care plans. The facility failed to ensure a baseline care plan was completed within 48 hours of admission that addressed the care needs of newly admitted Resident #1. This failure could place residents at risk of not receiving necessary care and services. The findings included: Record Review of Resident #1's face sheet dated 02/05/2026 reflected a [AGE] year-old female admitted on [DATE] with the following diagnoses frontal lobe and executive function deficit following cerebral infarction (damage in the brain's frontal region, causing impairments with planning, organizing, initiating tasks, decision-making, emotional control, and behaviors), PSOAS- a long, ribbon-shaped muscle in your back- abscess (a rare, severe collection of pus within the muscle compartment, often causing fever, back, hip, and thigh pain.), and aphasia (a language disorder caused by brain damage (often from a stroke or head injury) that impairs the ability to speak, understand, read, or write, affecting communication skills but not intelligence).Review of Resident #1's MDS assessment dated [DATE]indicate the assessment was incomplete.Review of Resident #1's EMR for a base line care plan on 02/05/2026 reflected no base line care plan was completed.In an interview on 02/05/2026 at 8:55 am the DON stated, there should be a baseline care plan completed within 48 hours after a resident is admitted to the facility. She stated the MDS Coordinator was responsible for completing baseline care plans. The DON stated it was very important for baseline care plan to be completed within 48 hours to ensure the residents received the appropriate care. She stated the information from the baseline care plan was derived to the Kardex for the CNAs to know what type of care to give to the residents. The DON stated Resident #1 did not have a baseline care plan. She stated she did not know at this time why Resident #1's baseline care plan was not completed. In an interview on 02/05/2026 at 1:05 pm the MDS Coordinator LVN A stated she was responsible for baseline care plans. MDS Coordinator LVN A stated a resident could be at risk of not receiving the care needed if the baseline care plan was not completed. She stated the expectations was to complete baseline care plan within 48 hours of the resident's admission to the facility. She stated she did not know why Resident #1's baseline care plan was missed. She stated the baseline care plans are important for staff to follow when there was a new admission. MDS Coordinator LVN A stated if a CNA needed to know the care a resident required, they were expected to ask the nurse supervisor. Review of the facility's policy Care Planning Policy and Procedure not dated reflected To provide a comprehensive plan of care addressing resident's needs, strengths, goals, and approaches.Policy:Each resident's care plan will remain current and inform staff of resident's needs, strengths, goals, andapproaches.Procedure:1. A base line care plan will be completed within 48 hours of admission.

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents who were trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 resident (Resident #2) of 9 residents reviewed for trauma-informed care. The facility failed to ensure Resident #2 had a trauma screening that identified possible triggers when Resident #2 had a history of trauma. This failure could place residents at an increased risk for psychological distress due to re-traumatization and decreased quality of life. Findings included: Review of Resident # 2's Face sheet dated 02/05/2026 at 11:34 AM reflected an [AGE] year-old male, admitted on [DATE] with the following diagnoses: dementia and altered mental status (when a person exhibits symptoms like confusion or disorientation) Review of Resident #2's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 to indicate severe cognitive impairment. Resident Mood interview reflected Resident #2 was feeling down, depressed or hopeless nearly every day. The medication section of the MDS reflects Resident #2 takes an antidepressant medication. Review of Resident #2's care plan printed on 02/04/2026 revealed no focus area or interventions for Resident #2's trauma history, behaviors and triggers. Review of Resident #2's nursing progress note dated 01/31/2026 at 12:50 reflected .Resident displayed inappropriate verbal comments after medication was administered. Review of Resident #2's EMR dated 02/04/2026 revealed Resident #2 did not have a trauma screening assessment in his medical record. Review of Resident #2's social service progress note dated 01/30/2026 at 11:51 AM reflected .Res continues to think other residents are out to get him. Thinks someone has a gun and feels they are following him. Accuses staff of showing him naked old women res. Truly believes these allegations even though none show any credibility. Psych notified. [family member A] states res has been like this a long time. This is not new behavior for him and has often interfered with his personal relationships. Res refused to speak to psychologist. She's tried several times and he is mean to her. Monitor. Review of Resident #2's nursing progress note dated 01/06/2026 at 8:43 PM reflected took CNA with me into room to administer HS meds. again, when he saw this nurse i used to respect you but your wrong in taking my med away at night he continued with how i did certain things on certain days, and i was not working on some of these days. for instance this past weekend, I was off, but he swears i was here and refusing to bring his meds. again i said that i have never not brought his meds. then i quit talking and just let him go on ranting etc. he took his med and again threw the cup against the wall and said do not pick that up, i threw it and I will pick it up. In an interview with Resident # 2 on 02/04/2026 at 4:16 PM, Resident #2 reported that his former roommate threatened to set Resident #2's privacy curtain on fire and repeatedly threatened to kill him. He reported that the facility staff moved the roommate to a room on a different hall three weeks ago. He reported that the former roommate walks down 100 hallway where Resident #2's room was located. He stated, he came here four to five times a day and I don't feel comfortable around him. [DON] made him stop coming down. Resident #2 reported that a little black lady was in another resident's room while Resident #2 was walking down the 100 hallway when allegedly she stated, [Resident #2], I want to show you something. Resident #2 reported that when he looked inside the room where the staff member was, he stated there was a Mexican resident sitting in a chair naked. He denied knowing the name of the staff member. Resident #2 reported a week ago an LVN with colored hair was giving him medication as he sat on the bed. He reported that she pushed him and got on top of him. He stated, I shoved her off of me. He denied that she touched him sexually while on top of him. He reported that DON was aware of (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the incident and stated, she moved her to work on another hallway. He stated the night before the incident, the same LVN told him that she was fond of him. He also alleged that this week as he was walking by the nurse's station with his rolling walker, a male staff member kicked his walker which displaced it out of Resident #2's hands causing injuries to the front of his left shin. He stated that he wrote the incident up and gave it to the DON. He reported an incident with a male, homosexual staff member who allegedly ran his finger across Resident #2's back and stuck his finger in Resident #2's ear. He stated when he became upset about what the male staff member did, another female staff member allegedly referred to Resident #2 as a derogatory name. He stated he reported this incident to the DON. Resident #2 reported that he was assistant warden at a [name] prison and stated, I have seen so many bad things. He reported that he disliked men who hurt or killed women and children. IIn a follow-up interview with Resident #2 on 02/05/2026 at 10:00 AM, he reported that the facility social worker was aware of the alleged incidents between him and his former roommate. He reported knowing the name of the male staff member who ran his finger across his back and put his finger in his ear. He reported knowing the name of the male staff member who he allegedly kicked his wheelchair causing injuries to his left shin. In an interview with the Social Services Director on 02/05/2026 at 1:06 PM, she stated that she has been the social services director for 3 years. She said I have not witnessed any of that happening in regard to alleged incidents by Resident #2. She reported when Resident #2 and his former roommate were not getting along, Resident #2 was referred to a psychologist. She stated that Resident #2 would not cooperate with the psychologist. She reported that his [family member A] is a trigger for him. She reported that his [Family member A] will drop things off for Resident #2 in his room while he was not in there. She stated if Resident #2 saw his [Family member A], an argument occurs. She stated the resident's family would not allow Resident #2 to visit his [Family member B] prior to her passing about four months ago because they did not want him to start family drama. She stated that Resident #2 does not like anyone telling him what to do. She reported that Resident #2's former roommate was large in stature and had a deep voice. She stated he was bossy to Resident #2. She stated Resident #2 was fearful of people having guns and believed his former roommate had a gun. She reported that on Thanksgiving Day, Resident #2 and his former roommate had an argument. She reported that his roommate was moved to a room on Hall 200. She reported that Resident #2 told her the former roommate threatens him by going down Resident #2's hallway. She stated she asked the former roommate to avoid Resident #2 by not walking down Hall 100. She stated that resident behaviors are typically put on the care plan. She stated it was necessary to put a resident's behaviors and triggers on a care plan so the team knows about it and can monitor the effectiveness of the interventions. She stated they can check for improvement and try other goals. She stated not having Resident #2's behaviors and triggers addressed in the care plan could make it difficult to monitor progress. She stated staff who were unfamiliar with Resident #2 would not know about his behaviors and triggers. In an interview with MDS Coordinator LPN A on 02/05/2026 at 3:14 PM, she stated she has worked in the MDS Coordinator role since the second week of August 2025. She stated a resident with a history of making allegations against staff and other residents should have the behavior on the care plan. She stated that a resident's triggers should definitely be on the care plan. She stated the way the resident communicates was put on the care plan. She reported the nursing staff have access to the resident care plans. She reported that CNAs typically learn information about the residents by word of mouth or by looking at the Kardex. She reported the Kardex should have the resident's behaviors and triggers on it. She stated that CNAs report resident information that needs to be on the care plan to the nurses. In an interview with MDS Coordinator LPN B on 02/05/2026 at 3:21 PM, she (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she has worked in the MDS Coordinator role since the middle of October 2025. She reported that the nursing admission assessment triggers things on the care plan. She stated the IDT meets to discuss the residents and their care plans. She reported staff from multiple departments make up the IDT including dietary, social services, MDS, nursing, therapy, and laundry services. She stated that auxiliary staff report behaviors and triggers to the social workers and/or nurses. She reported that a resident's behaviors and triggers should be in the care plan so staff will know what to do when they occur. In an interview with the DON on 02/05/2026 at 10:48 AM, she reported a history of Resident #2 making false allegations against staff and other residents. She reported Resident #2 writes things down and reports it to her. She reported that Resident #2 has been moved to different rooms several times due to him not getting along with his roommates. She stated that his former roommate who he alleged threatened him was relocated to another room on a different hall and denied threatening Resident #2. She stated Resident #2 will be housed in a room without a roommate from now on. She reported that anytime he has a problem with a staff member, they will have a different staff member work his hallway. She reported that he alleged a nurse who worked the nightshift was coming on to him. She stated the nurse would bring another employee with her if she interacted with him. The DON stated Resident #2 did not report to her that anyone pushed him or put their hands on him. She reported that he was evaluated by a psychologist but Resident #2 refused to see the psychologist after the evaluation. She stated the male staff member who he allegedly ran his finger across Resident #2's back was a part-time agency CNA who had long hair. She questioned the staff member about the alleged incident, but he did not remember the incident. She stated, he did not even know who I was talking about. She stated she took the staff member off the agency call list anyway. She denied any knowledge or report of the alleged incident regarding the staff member who he alleged told him she wanted to show him something causing him to see an unclothed resident. The DON stated Resident #2's history of making allegations against staff and other residents as well as his fears and triggers should absolutely be in his care plan. She stated that putting these things in his care plan will make other staff members aware of his behavior and triggers. Review of the facility's policy Care Planning Policy and Procedure (not rated) reflected a purpose To provide a comprehensive plan of care addressing resident's needs, strengths, goals, and approaches. Policy: Each resident's care plan will remain current and inform staff of resident's needs, strengths, goals, and approaches. Procedure: 2. A Comprehensive Care plan will be completed according to the RAI manual upon admission, annual, significant change and as needed. 3. Resident's care plan will be updated quarterly and as needed. 4. Resident's care plan will be reviewed with resident, responsible party and interdisciplinary teamquarterly and as needed.