

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675501	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/01/2026
NAME OF PROVIDER OR SUPPLIER Legacy at Corsicana Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 3300 W 2nd Ave Corsicana, TX 75110	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately for one of seven (Resident #2) Residents reviewed for abuse and neglect. The ADM failed to report an allegation of abuse from Resident #2 on 5/14/2026 to the state agency. This failure placed residents at risk of not being protected from abuse, neglect, or exploitation. Findings include: Review of Resident #2's face sheet dated 6/1/2026 reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: heart disease, muscle wasting, high blood pressure, type 2 diabetes mellitus (blood sugar regulation disorder), hyperlipidemia (high cholesterol), hearing loss, and enlarged heart. Review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS of 4 suggesting severe cognitive impairment. Review of Resident #2's census record in the EMR reflected she was discharged on 5/11/2026. Review of hospice progress note dated 6/1/2026 by HN reflected: 5/14/2026-WHILE AT [facility] VISITING WITH OTHER [agency] HOSPICE PATIENTS, THIS RN NOTIFIED [HR], HUMAN RESOURCES AND [ADM] IMMEDIATELY UPON ARRIVAL OF ABUSE ALLEGATIONS THAT [Resident #2] HAD STATED TO THIS RN. RN EXPLAINED EVENTS OF THE ALLEGATIONS: PT CLAIMS WHEN SHE WAS LIVING AT facility] THAT A BIG TALL AFRICAN AMERICAN MAN THAT WORKED AS EITHER AN AIDE OR A NURSE GRABBED HER LEFT WRIST AND PULLED HER ONTO THE FLOOR AND STATED THIS HAS HAPPENED PREVIOUSLY BUT PT UNAWARE OF DATES OF EITHER OCCURENCES. PT HAS BRUISING PRESENT TO LEFT WRIST. FAMILY AWARE AND PRESENT DURING THE ACCUSATIONS. RN INFORMED PT THAT SHE IS AT A DIFFERENT FACILITY AND THAT SHE IS SAFE.[facility] ADMINISTER AND [facility] HR WERE MADE AWARE THAT FAMILY WAS PRESENT DURING ALLEGATIONS AND THAT THEY ARE AWARE AS WELL. [ADM] STATED THAT SHE WAS NOT PLANNING TO REPORT ALLEGATIONS TO STATE. [Hospice Agency] REPORTED ALLEGATIONS OF ABUSE TO STATE. During an interview on 6/1/2026 at 11:50 am, HN stated she visited Resident #2 on 5/12/2026 at the facility she had been transferred to and the Resident told her, She was pulled by the left wrist out of her wheelchair to the floor by the big black man. HN stated Resident #2 could not provide a date or time frame in which this happened. HN stated she assessed Resident #2 in the wrist area and noticed some discoloration but was not sure if it was bruising or skin discoloration due to aging. HN stated on 5/14/2026 while at the facility, she spoke to the ADM and HR staff in person and informed them of the abuse allegations. HN stated the ADM stated she would not be reporting this to the state. During an interview on 6/1/2026 at 12:20 pm ADM stated HN spoke to her on 5/14/2026 and mentioned Resident #2's allegations that she had been grabbed. She stated she immediately called the FM and he stated he did not feel like they had mistreated her. She stated she did not report it because she didn't feel like she had been abused and she was not aware of any injuries or bruising. She stated she doesn't remember the conversation with the HN word for word. She stated the day before she transferred to the other facility, Resident #2 had been aggressive with staff, hitting the staff, hitting the doors, and trying to get out the door of the facility. She stated it was her (continued on next page)		

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsibility to report any allegation of abuse or neglect and if potential allegations are not reported - if someone is in danger - they could get hurt. During an interview on 6/1/2026 at 12:28 pm, FM stated he was aware of the allegations from Resident #2. He stated he had no concerns with Resident #2's care while at the facility. He stated he had been aware of Resident #2 being very disruptive and exit seeking the day before they transferred her. He stated the ADM called him on 5/14/2026 and asked him about the allegations and he honestly did not see anything there as far as abuse. He stated he did not notice any bruising on her left wrist, but she did have some discoloration on her wrists and arms. He added that Resident #2 is older and had changes to her skin so he could not say it was bruising. He stated he had no suspicions of abuse or neglect and had been up to the facility at all hours of the day or night and does not think anyone would have done anything to harm her. During an interview on 6/1/2026 at 1:41 pm, ADO stated he was not aware of the allegation of abuse from Resident #2 until today and there was no bruising noted when she arrived at the other facility on 5/11/2026. He stated ADM normally calls him on everything and thinks this is an isolated case and not a pattern. She usually reports everything- it's a one-off situation. ADO stated it is the ADM's responsibility to report all allegations of abuse or neglect per the provider letter and that he would be doing an in-service with her that day. He stated unreported abuse or neglect could lead to us not knowing a situation in the facility. Review of skin assessment for Resident #2 dated 5/11/2026, from the facility she transferred to reflected: 3. Check if the resident has any of the following. If so describe in the space provideda. bruisea Nob. Skin Teara. Noc. Abrasiona. Nod. Lacerationa. [NAME]. Surgical Incisiona. No i. Other skin findingsseveral dark skin spots sporadic on arms, back and lower legs. Review of undated Facility Policy Abuse and Neglect reflected: C. Prevention3. All reports of abuse or suspicion of abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and/or AbusePreventionist within 24 hours of complaint. Appropriate notification to state and home office will be theresponsibility of the administrator and per policy. E. Reporting3. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents,misappropriation of resident property or injury of unknown source to the facility administrator. Thefacility administrator or designee will report to HHSC all incidents that meet the criteria of ProviderLetter 2024-14 dated 8/29/24.a. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2hours of the allegationb. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24hours of the allegation.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one of seven residents (Resident #1) reviewed for post fall neuro assessments. The facility failed to complete neuro checks on Resident #1 after a fall on 5/13/2026 at 7:30 am, 8:30 am, 10:30 am, and 12:30 pm. This failure could cause residents injuries, pain, hospitalization and decreased quality of life. Findings include: Review of Resident #2's face sheet dated 6/1/2026 reflected he was an [AGE] year-old male admitted on [DATE] with diagnoses that included: acute respiratory failure with hypoxia (inadequate oxygen distribution to the body tissues), muscle wasting, chronic obstructive pulmonary disease (progressive, irreversible lung disease that restricts airflow), hypertension (high blood pressure), hyperlipidemia (high cholesterol), malignant neoplasm of broncos or lung (lung cancer) and dementia. (decline in mental abilities) Review of Resident #2's admission MDS dated [DATE] reflected a BIMS of 1 suggesting severe cognitive impairment. Review of Resident #2's care plan dated 6/1/2026 reflected the following focus: The resident is risk for falls [related to] confusion, deconditioning, gait/balance problems, incontinence. 5/13/2026 observed on floor beside bed - no injury. Review of progress dated 5/13/2026 at 4:30 am reflected: Summoned to room by staff member. Notified that resident was half way off the bed. On entering the room this nurse noted residents torso on the floor. posterior torso against the floor while [bilateral extremities] still on the bed. Complete [head to toe] assessment done [no apparent] injuries noted. I dont know. states [resident] when asked what happened. Assist [x2] back to bed. MD. RP & DON notified. Encouraged to use c/l for assistance. verbalized understanding. [call light] functional & [within] reach. No Pain. Resident Statement: I dont know. states when asked what happened. Review of Fall event note dated 5/13/2026 at 4:30 am reflected 2. Fall1. Location Event Occurred1) Resident Room2. Unwitnessed or Hit Head? (select all that apply)[box checked] 1. Unwitnessed Fall3. (Select all that apply)[box checked] 9. Discovered on floor Review of neuro assessments for Resident #2 in the EMR on 6/1/2026, reflected assessments were not completed for 5/13/2026 at 7:30 am, 8:30 am, 10:30 am, and 12:30 pm. Further review reflected an off-cycle neuro assessment was completed at 9:30 am. During an interview on 6/1/2026 at 1:54 pm DON stated any unwitnessed fall the staff are supposed to initiate neuro checks. If it was witnessed fall with head injury, neuro checks should also be done. She stated she was not aware that some neuro checks for Resident #2 had been missed. She stated potential injuries or changes in condition could be missed if neuro checks are not done. During an interview on 6/1/2026 at 2:55 pm MD stated he had seen Resident #1 a few times after his admission and he saw him on 5/13/2026 and he was admitted to hospice later than day. MD stated Resident #1 had lung cancer with hypoxia and significant dementia. He stated he had recommended hospice to FM about 2 weeks prior as Resident #2 was in a pretty poor state when he saw him, was not eating or drinking very much and was not going to get better. He stated any unwitnessed fall or a fall with a head injury should have neuro checks done. He stated he was not aware neuro checks were missed for Resident #2, but he was a very sick man and does not believe the resident had any injuries and this did not have any impact on his end-of-life care. During an interview on 6/1/2026 at 5:00 pm, Regional Compliance Nurse stated neuro assessments were to be completed in the EMR. She stated if an assessment stayed open in the EMR it will not trigger the next one and that is what they think happened with Resident #2 and why they had not been visible. She stated the neuro checks were completed on night shift, but several were missed on day shift by Nurse A. She stated her expectation was that neuro assessments would be completed timely or they could potentially miss a decline in cognition status for the resident. She stated it is DON's responsibility to make sure neuro checks are completed in the EMR. During an interview on 6/1/2026 at 5:10 pm, DON stated she was responsible for getting the neuro assessments done and she was (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	able to get information on falls in the morning meeting so she would know who was supposed to be getting neuro checks. She stated Nurse A had missed several neuro checks on Resident #2 that day. During an interview on 6/1/2026 at 5:24 pm, Nurse A stated she had been working 6 am to 6pm on 5/13/2026 and she was aware that she had missed some neuro checks on Resident #2. She stated, that morning was busy - that is not an excuse - but I recall it being very busy. She stated the EMR should trigger neuro checks but even if it did not, she knew what needed to be done when she got a fall passed on in report. Nurse A stated it was the nurse's responsibility to complete the neuro checks, and she had been checking on him frequently because of the decline in his condition and going on hospice, but she had not documented any of this in the EMR so she could not prove it had been done. She stated not doing neuro checks could potentially cause them to miss a patient decline due to an injury from the fall - head injury from a fall - ultimately - depending on severity, they could get very sick even death. Review of an email from Senior VP of Clinical Services dated 6/1/2026 at 2:56 pm reflected the neuro assessment schedule as follows in EMR: Per [EMR] the first neuro is done on the fall event note then triggered: Every 15 minutes x4, then Every 30 minutes x2, then Every 1 hr x2, then Every 2 hr x2, then Every 8hr x 8. Review of undated Facility Policy Neurologic Checks reflected: Neurologic checks are a combination of objective observations and measurements done to evaluate neurologic status. The results of the checks assist to determine nervous system damage and/or deterioration. Goals 1. The caregiver will identify changes indicating progressive improvement or deterioration in neurologic status. 2. The resident will be free from injury.		