STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675501	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Corsicana Rehabilitation and Healthcare	3300 W 2nd Ave Corsicana, TX 75110

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 3 of 5 residents (Resident #1, Resident #23, Resident #60) reviewed for comprehensive care plans. 1. The facility failed to indicate what Resident #1's communication problem was related to, and why he required tube feeding.2. The facility failed to indicate what Resident #23 was allergic to, what her pain level goals were, what her pain was aggravated by and what alleviated her pain, and her discharge plans.3. The facility failed to indicate what Resident #60's swallowing problem was related to, why he required tube feedings, and how many cc's of gastric contents were needed in order to hold a tube feeding. These failures could place residents at risk for not receiving necessary care and services or having important care needs identified and met.Findings included:Review of Resident #1's comprehensive MDS assessment dated [DATE] reflected a[AGE] year-old male who admitted to the facility on [DATE]. He had the following diagnoses: Gastroesophageal Reflux Disease (chronic condition where stomach acid flows back into the esophagus), septicemia (blood poisoning), seizure disorder (neurological condition characterized by recurrent, unprovoked seizures), muscle wasting and atrophy, and dysphagia (difficulty swallowing). In section K - Swallowing/Nutritional Status Resident #1 was indicated as having a feeding tube On Admission, While not a resident, and While a resident. Resident #1 had clear speech, was able to make himself understood, and was able to understand others. Resident #1 had a BIMS score of 04, indicating severe cognitive impairment.Review of Resident #1's comprehensive care plan dated 01/22/2026 reflected a focus of The resident has a communication problem r/t and The resident requires tube feeding r/t initiated by the CCN.In an observation/interview on 02/18/2026 at 10:26AM with Resident #23 she stated that she had been in and out of the hospital related to her heart recently. She stated that it caused her pain frequently, and so did her arm that she received physical therapy for. She stated that her body was tired a lot due to dialysis and physical therapy. She stated that taking medication, doing physical therapy, and going to sleep were all ways in which her pain was alleviated. Review of Resident #23's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old female who admitted to the facility on [DATE]. She had the following diagnoses: coronary artery disease (when the coronary arteries become narrowed or blocked due to plaque buildup), heart failure (when the heart muscle is unable to pump enough blood to meet the body's needs), renal failure (when the kidneys can no longer effectively filter waste and toxins from the blood), diabetes (chronic condition where the body cannot properly use blood sugar), cirrhosis of liver (chronic condition in which healthy liver tissue is replaced by scar tissue), fibromyalgia (widespread pain and other symptoms such as fatigue, muscle stiffness, and insomnia), and chest pain. The MDS indicated she had not had any falls since admission. In Section J - Health Conditions, under the question Should Pain Assessment Interview be conducted? the answer was Yes. In the Pain Assessment Interview Resident #23 indicated she had not experienced pain in the last 5 days, therefore the assessment was concluded. Resident #23 had a (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 - Some	BIMS score of 15, indicating intact cognition. Review of Resident #23's comprehensive care plan dated 02/17/2026 reflected a focus of Allergic to (specify) a goal of will not receive (specify) over the next 90 days. A goal of The resident's pain level goal is (__). The resident will maintain or have a lower pain level than this number. Interventions of The resident's pain is aggravated by: (specify) and The resident's pain is alleviated/relieved by: (Specify) A focus of Discharge from the facility is not feasible as evidenced by (reason discharge is not feasible).Review of Resident #23's physician orders active as of 02/17/2026 reflected allergies of iodine, lidocaine, sulfa antibiotics, and TAPE. Resident #23 had the following orders related to pain: Acetaminophen 500 MG every 6 hours as needed for pain. Diclofenac gel applied two times a day to knees for pain. Pregabalin 100 MG 1 time a day for pain in right shoulder. Tramadol 50 MG 3 times a day related to pain in right shoulder. In an observation/attempted interview on 02/17/2026 at 10:55AM with Resident #60, he was observed lying in bed with the head of bed elevated, when asked questions by the state surveyor he made noises but did not answer coherently. Review of Resident #60's comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old male who admitted to the facility on [DATE]. He had the following diagnoses: stroke (sudden interruption of blood flow to the brain), anemia (deficiency of healthy red blood cells), high blood pressure, and pneumonia (infection that inflames the air sacs in the lungs). In section K - Swallowing/Nutritional Status, Resident #60 was coded as having a tube feeding upon admission and while a resident. He was indicated as receiving 51% or more of his total calories by tube feeding, and his average fluid intake per day by tube feeding was 501 cc a day or more. Resident #60 had a BIMS score of 02, indicating severe cognitive impairment. Review of Resident #60's comprehensive care plan dated 02/18/2026 reflected a focus of The resident has a swallowing problem r/t, initiated by the MDSC. The resident requires tube feeding r/t. An intervention of Check for tube placement and gastric contents/residual volume per facility protocol and record. Hold feed if greater than (X) cc aspirate initiated by LVN K.Review of Resident #60's physician orders active as of 02/17/2026 reflected an NPO diet, an enteral feed order and to keep HOB elevated 30-45 degrees at all times, aspiration precautions. Resident #60 had an enteral feed order for 1 carton of 250 ml five times a day. In an interview on 02/19/2026 at 1:44 PM with the SCNA, she stated that she had been working at the facility for about 3 months. She stated that she provided care to Resident #23 and was assigned to work with her today. She stated they (CNA's) would chart certain tasks in the computer such as, the amount of food eaten by the resident, if the resident showered. She stated the nurse or med aide charted pain levels. She stated that she was not aware of Resident #23 complaining of pain, and that the nurse or medication aide could administer pain medication if needed. She stated that nurses or family could notify CNA's of what was on the resident's care plan, but she did not have access to the care plan itself. In an interview on 02/19/2026 at 1:48 PM with MA C, she stated that she passed medications to Resident #23. She stated that she was not responsible for charting resident pain levels, unless the nurse told her to. She stated that Resident #23 received routine Hydrocodone, and that Resident #23 complained of pain approximately a couple times a week . She stated she had access to the POC (it would tell her resident ADL needs, showers, anything in the care plan), or the nurse could tell her what was on the resident's care plan. She stated if she had questions about a care plan, she could ask the nurse or the social worker. She stated she thought therapy aggravated Resident #23's pain and that medication or going to lay down in bed would usually alleviate the resident's pain. In an interview on 02/19/2026 at 1:59 PM with LVN K, she stated that she became the ADON about 2 weeks ago, before she worked on the floor as an LVN for about 8 months. She stated that regarding Resident #60's care plan she was not aware of the care plan being incomplete. She stated that he required tube feeding d/t stroke. She stated the cc's should have been 100. She stated that best practice as a nurse was to check for residual (malabsorption, stomach being too full) before administering a feeding. She stated that she would update the care plan. She stated that everyone (department heads) could modify the care plans.In an interview on 02/19/2026 at 2:38 PM with LVN D, she stated that she had been working at the facility for 2 years as an MDSC. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She stated that everyone (department heads) could edit the care plans and not just one person was assigned to oversee them. She stated the DCS could see what was on the care plan from the Kardex. She stated that for Resident #60, the swallowing problem was r/t to his CVA. She stated that Resident #60's comprehensive care plan was due on 2/18/2026, so it was recently completed, and she thought she had been working too fast and missed the specifics on some areas. She stated she was also responsible for not accurately completing Resident #1's care plan and that she was just working too fast. In an interview on 02/19/2026 at 3:15 PM with the DON and ADM, they stated their expectations regarding care plans were that they were done completely and accurately. They stated that all department heads could access and edit the care plans, and at the time there was no one person that went back and checked for accuracy, they could correct things as they were made aware. They stated that the DCS would use the Kardex to understand the care plan, but the nurses would have access to the full care plans. The DON stated that it was standard practice as a nurse, that before going to administer a tube feeding, the nurse should check for residuals and not administer a feeding if there was 100 CC's. In regard to Resident #23's allergies, they stated that resident allergies were posted in red lettering under the resident name in the computer, and for dietary, allergies were printed on the meal tickets. In an interview on 02/19/2026 3:26 PM with the CCN, she stated that she assisted the facility staff with care plans. She stated that she activated the CAA's to go over with the families. She stated that once the CAA's were activated, they discussed it with the family. She stated that MDS would go in an update the care plan within 21 days of admission. She stated the issue with Resident #23's care plan did not cause any harm because allergies were listed in red in the PCC home screen, and dietary would have it printed on tickets. She stated that if anywhere on the UDA had pain indicated, it would transfer to the baseline care plan. She stated MDS was responsible for ensuring accuracy. Review of the facility's policy titled Comprehensive Care Planning undated, reflected: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.The comprehensive care plan will describe the following - The residents' goals for admission and desired outcomes.Each resident will have a person-centered comprehensive care plan developed and implemented to meet his otherpreferences and goals, and address the resident's medical, physical, mental and psychosocial needs. Residents' goals set the expectations for the care and services he or she wishes to receive. Measurable objectives describe the steps toward achieving the resident's goals, and can be measured, quantified, and/or verified.The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventionsare the specific care and services that will be implemented.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure the resident's right to secure and confidential personal and medical records for 1 (unknown resident) of 21 residents.The facility failed to ensure the privacy of the unknown resident by not locking the laptop screen on the medication cart, so the resident's information could not be seen by someone walking by.This failure puts residents at risk for confidential health information exposure, and decreased quality of life. Findings included:In an observation on 02/18/2026 at 9:17AM, a med cart was parked in front of room [ROOM NUMBER] unlocked. MA A was behind a privacy curtain administering medication. The computer screen was visible with unknown residents' medication medical information. The MA could not see medication cart from behind the curtain In an interview on 02/18/2026 at 10:00 AM, MA A stated she could not see the medication cart from where she was in the resident's room behind the privacy curtain. MA A stated every time she stepped away from the medication cart the screen should not be visible. She stated she had been trained on locking the computer screen when not in direct line of eyesight or in use. She stated she had been checked off on medication pass yearly by the pharmacist and as needed by the DON. MA A stated negative effects for leaving screen visible was that medical records could be seen, violating resident rights.In an interview on 02/18/2026 at 2:44 PM, the DON stated she had worked for facility for 8 weeks as interim DON. The expectation was that when the medication aide was passing pills the computer screen should be closed so no one could see resident information. She stated the medication aides were monitored by the pharmacy consultant who made medication pass observations with the medication aides. She said the Administration nurses also do random audits as needed. The DON stated leaving the computer screen visible would lead to violations of resident rights to privacy. In an interview on 02/18/2026 at 2:52 PM, the ADM stated she expected the cart to be locked and computer screen where no patient information was visible when the medication cart was not in use. The ADM said Supervisors monitored by spot checking the medication carts and educating the medication aides as needed on privacy. The risk included resident rights to privacy violation, others could potentially have access to other resident private medical information.Record review of facility policy titled RESIDENT RIGHTS undated reflected Privacy and confidentiality - The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals were in locked compartments and inaccessible to unauthorized staff, visitors, and residents for 1 of 2 medication carts (Med Cart #1) reviewed for medication storage in that:The facility failed to prevent Med Cart #1 from being unattended and unlocked in front of room [ROOM NUMBER] on 02/18/2026.This failure could allow residents, visitors, staff, and unauthorized individuals unsupervised access to prescription and over-counter medications.Findings included:In an observation on 02/18/2026 at 9:17 AM a med cart was parked in front of room [ROOM NUMBER] unlocked. MA A was behind a private curtain with a resident. The screen was visible with unknown resident information. A box of eye lubricating drops was on top of the medication cart. There were other unknown residents in wheelchairs with their family members in the hallway.In an interview on 02/18/2026 at 10:00 AM, MA A stated she could not see the medication cart from where she was. MA A stated that every time she stepped away from the medication cart all medications and the cart should be locked up and secured. She stated she had been trained on medication storage and locking the cart when not in direct line of eyesight or in use. She stated she had been checked off on medication pass yearly by the pharmacist and as needed by the DON. MA A stated negative effects for leaving medications out and an unlocked medication cart was that medications could be accessed by another person family or residents that walked by.In an interview on 02/19/2026 at 2:44 PM, the DON stated she had worked for facility for 8 weeks as interim DON. The expectation was that when the medication aide was passing pills all medications were put away and the medication cart locked. She stated the medication aides were monitored by the pharmacy consultant who made medication pass observations with the medication aides. She said the Administration nurses also do random audits as needed. She stated administration staff also monitor by making rounds frequently throughout the halls and monitored daily. She stated leaving the cart unlocked could result in medication being in the wrong hands.In an interview on 02/19/2026 at 2:52 PM, the ADM stated she expected the medication cart to be locked and all medications locked away. The ADM said Supervisors monitor by spot checking the medication carts and educating the medication aides as needed on locking the cart. The ADM said risks included other residents or visitors could potentially have access to other medication that was not assigned to them. Record review of facility policy titled Medication Storage in the Facility dated 2025 reflected, Medications and biologicals are stored safely, securely, and properly following manufacturers recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure each resident was provided with food that accommodates resident allergies, intolerances, and preferences for 2 (Resident #34 and Resident #36) of 3 residents reviewed for food and nutritional services.1. The facility failed to provide Resident #34 with an alternative or substitute meal of similar nutritive value to the main meal served during lunch service on 2/17/2026. 2. The facility failed to provide Resident #36 with an alternative meal that took into consideration the resident's preferences and condition during lunch service on 2/17/2026 These failures placed the residents at risk of weight loss, malnutrition, pain and discomfort, and a diminished quality of life. Findings included:Review of Resident #34's face sheet on 2/19/2026 reflected a [AGE] year-old female admitted to the facility on [DATE], with diagnoses including malignant neoplasm of head of pancreas (pancreatic cancer), hypertension (high blood pressure), Type 2 Diabetes Mellitus (metabolic disorder related to the body's resistance to insulin or the pancreas' failure to produce enough insulin), Hypercholesterolemia (high cholesterol), and Major Depressive Disorder Recurrent (repeated episodes of major depression). Review of Resident #34's comprehensive MDS admission assessment dated [DATE], revealed the resident had a BIMS score of 13, which indicated mild cognitive impairment. Furthermore, the assessment revealed Resident #34 utilized a nutritional approach in the form of a therapeutic diet (e.g. low salt, diabetic, low cholesterol) while a resident at the facility and within the prior 7 days of the assessment. Resident #34's oral/dental status was assessed to have obvious or likely cavity or broken natural teeth, inflamed or bleeding gums or loose natural teeth, and mouth or facial pain, discomfort or difficulty with chewing. Review of Resident #34's progress notes revealed the following:2/17/2026 22:33 Resident on oral antibiotic therapy amoxicillin 875 mg po for treatment for dental infection no adverse reaction noted2/17/2026 16:47 Resident continues on oral antibiotic therapy amoxicillin 875 mg po for treatment for dental infection no adverse reaction noted at this time2/16/26 22:57 Resident on oral antibiotic therapy amoxicillin 875 mg po for treatment for dental infection no adverse reaction noted2/13/26 10:28 Returned from appointment [at local dental clinic] .[prescribed] Amoxicillin 875mg 1-tab po twice day x 7 days for dental infection; RP inquired about issues resident is experiencing [with] her pancreas 2/13/26 20:54 Initial dosage administered at 8:30p.m on 2-13-26. Amoxicillin Oral Tablet 875mg bid x 7 days related to dental infection.2/11/26 17:44 .poor appetite. Refused lunch and supper. Offered a health shake. Pending consummation. Staff to monitor. Review of Resident #36's face sheet on 2/19/2026 revealed a [AGE] year-old female resident admitted to the facility 1/14/2022 with diagnoses that included unspecified dementia (a decline in cognitive function and memory), protein calorie malnutrition (a condition caused by insufficient intake of protein and calories), and hyperlipidemia (lipids or fats in the blood). Review of Resident #36's annual comprehensive MDS assessment dated [DATE] revealed the resident had a BIMS score of 15, indicating intact cognitive functioning. The assessment revealed no nutritional approaches had been utilized by the resident. The resident's oral/dental status indicated the resident had no natural teeth or tooth fragments. Review of Resident #36's progress notes revealed the following:02/17/2026 14:03 Promethazine HCl Tablet 25 MG Give 1 tablet by mouth every 6 hours as needed for Nausea and Vomiting02/17/2026 13:37 Promethazine HCl Tablet 25 MGGive 1 tablet by mouth every 6 hours as needed for Nausea and Vomiting c/o nausea2/16/2026 13:35 Promethazine HCl Tablet 25 MGGive 1 tablet by mouth every 6 hours as needed for Nausea and Vomiting2/16/2026 1259 resident at nurses' station dry heaving NO vomit at this time. Resident states she is nauseas Observation and interview of Resident #36 on 2/17/2026 at 12:27 PM revealed the resident sitting alone near a dining table in her wheelchair. The resident was not eating from any served plate and appeared discontent. The resident shared that she had not been feeling well for the last few days. She stated that she had been (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	throwing up and had an upset stomach. The resident stated that she requested a bowl of soup instead of the alternate meal provided, which was a meat and cheese sandwich and potato chips, but staff refused. Record review of Resident #36's printed meal ticket on 2/17/2026 at 12:27 PM reflected no indication that the resident was served an alternate or substitute meal. The ticket reflected the resident's dislikes: fish/tuna, tomato products, tomatoes (fresh or cooked) and juice. The special notes section of the ticket stated the resident was allergic to tomatoes and apple juice, and DON'T EAT BEEF OR PORK ALL THE TIME, JUST SOMETIMES. Observation on 02/17/2026 at 12:30 PM of the facility's only dining room, revealed no alternate menu posting. Observation and interview on 2/17/26 at 12:27 PM of Resident #34, revealed the resident sitting alone at a dining table in her wheelchair attempting to eat a plain meat and cheese sandwich cut in half and with a side of crumbled potato chips. When asked if the resident was satisfied with her meal she stated not really. She said that she had been unable to bite or chew due to dental problems and mouth, gum and tooth pain. The resident stated that she had been to a dentist recently and was being treated for an infection. The resident indicated that she was missing most of her teeth which also contributed to her inability to chew food. The resident stated that she requested the alternate menu today and was served the observed sandwich and chips. She thought the sandwich might have been soft enough for her to chew, but it was not. Record review of Resident #34's printed meal ticket on 2/17/2026 at 12:32 PM reflected the resident's dislikes to be rice, raw celery, raw apples, raw apricots, lettuce, salads, and raisins. The special notes section of the ticket stated, NO SPICY FOOD NO CHOCOLATE. Under the special notes section handwritten in pen it stated, Sandwich Chips. In an interview on 02/17/2026 at 12:30 PM DC A stated that the microwave in the kitchen was broken and they could not heat up the individual soups from the always available menu. When asked if they could use the stove to heat up the soup, she questioned the surveyor about using the stove for 1 little soup. The cook stated they did have always-available menu, but it was not posted. Some of the items she listed were a chef's salad, tomato soup, and sandwiches. In an interview on 2/17/2026 at 12:35 PM the DM stated that kitchen staff were in the process of heating up soup for Resident #34 and Resident #36. The DM stated that DC A should not have refused or denied Resident #36's request for soup. The DM stated that residents usually let them know in advance if they want an alternative menu item. She said often when alternative menu items were requested by residents it was usually for a sandwich and chips, so that was what was served to the residents. In an interview on 2/19/2026 at 3:00 PM the ADM stated that it was her expectation that facility policies be followed regarding honoring resident requests for alternative menu items and staff should never refuse a resident's request for an alternative menu item out of convenience for staff. The ADM stated that was not the typical practice of the staff at the facility. Record Review of the facility's Dietary Services Policy & Procedure Manual FP 00-10.0 regarding menu approval and honoring resident special requests, and food brought to the facility from unapproved sources, reflected the following: 4. Every attempt will be made to honor resident food preferences the facility has a five week cycle menu that can be modified by the dietary manager to meet the preferences of the majority of the residents in addition an appealing option of similar nutritive value is provided for each meal for those residents who do not like the main menu items being served there are other items that can also be prepared on demand when a resident does not like the main menu or alternate option these include sandwiches soup salads fruit and other foods that can be prepared quickly if the resident has notified the kitchen of an available food request that can be prepared prior to the meal this item will be provided when the meal tray is prepared and usual sequence if the resident receives his or her meal and then requests an alternate option or substitute that will require additional preparation prior service then it will be provided once the other residents have been served their meal.

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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, interviews, and record reviews, the facility failed to update and follow posted menus in accordance with professional standards for all residents for 1of 2 meals observed. The facility failed to follow their posted lunch menu for Tuesday, 2/17/2026.The facility failed to update their posted lunch menu for Tuesday, 2/17/2026 when a substituted menu was provided. These failures could place residents at risk for dissatisfaction with their meals and decreased nutritional intake. Findings included: Observation of the kitchen on 2/17/2026 at 11:43 AM revealed kitchen staff preparing white rice, a variety of combined meats with vegetables, including chopped chicken and sausage, and individual servings of ribs with no apparent sauce. In an interview on 2/17/2026 at 11:43 AM, DC A stated the meal being prepared was jambalaya in honor and in celebration of Mardi Gras. In an interview on 2/17/2026 at 11:43 AM, the DM stated that the facility was celebrating Mardi Gras with themed activities and foods, which included serving jambalaya and other traditional type foods. Observation on 2/17/2026 at 12:10 PM of residents' plated and served meals in the facility's only dining room revealed residents were served a combination of white rice, vegetables and meat along with a cupcake for dessert, tea, and a roll. No concerns with the appearance of the meal or its nutritional value were noted. In an interview on 2/17/2026 at 12:20 PM, Resident #41 stated that he enjoyed the meal he was served. The resident stated that the meal tasted good and the portion sizes and variety met his needs and preferences. The resident indicated the meal served was not what was listed on his meal ticket or what was expected as he was not served baked macaroni and cheese or apple cobbler, but the resident expressed satisfaction with the meal and had no complaints. The resident stated that he was typically served what was listed on the menu or on his meal ticket. The resident denied suffering from unwanted weight loss, appetite loss, or problems related to the food served at the facility. Observation of residents in the facility's only dining room on 2/17/2026 at 12:21 PM revealed the residents consumed most, if not all, of the meal that was served without complaint or dissatisfaction expressed. Record review of residents' individually printed meal tickets on 2/17/2026 from 12:23 PM to approximately 12:30 PM revealed the meal tickets did not correctly reflect the meal the residents were served. The residents' meal tickets indicated the following items were served: Entree 3 oz GR Chicken QTR w/ BBQ Sauce Starch 1/2 C Baked Macaroni & Cheese Vegetable 1/2 C Homestyle Grean Beans Bread 1 Ea Margarine Dessert 1/2 C Apple Cobbler Beverage 8 fl oz Iced Tea Observation of the facility's only dining room on 02/17/2026 at 12:30 PM, revealed the posted menu for 02/17/2026 did not match what residents were being served. Record review of the posted printed Weekly Menu For Creative Solutions FW 25-26 - Week 1 Regular Diet on 2/17/2026 at 12:35 PM reflected the lunch menu for Tuesday, 17-FEB to be BBQ Chicken Quarter, Baked Macaroni and Cheese, Homestyle [NAME] Beans, Honey Kissed Roll, Apple Cobbler, Iced Tea. No modifications or changes were observed to have been made to the posted printed menu. In an interview on 2/17/2026 at12:35 PM, the DM stated that residents' meal tickets did not reflect the meal being served because the meal was a substitution initiated and implemented by their corporate office in recognition of Mardi Gras. The DM stated that she noted the substitution in her own records but did not electronically make the menu changes because she didn't know how. The DM stated that she did not make the changes to the posted printed menu because it was overlooked. In an interview on 2/19/2026 at 1:49 PM, the DM stated that she had been employed with the facility since 12/10/2025, but she had several years of prior experience working in and running kitchens in different types of establishments. The DM stated that she was comfortable in her role and could manage the facility's dietary service requirements and needs. The DM stated upon being hired she received proper orientation and training that assisted her when she assumed her supervisory role. She stated that in-service training was provided regularly and included a variety of topics including resident care and needs. The DM stated that the facility utilized an electronic menu and ticketing system. The DM (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675501	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Corsicana Rehabilitation and Healthcare	3300 W 2nd Ave Corsicana, TX 75110

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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Many	stated she was not aware she could electronically override the scheduled menu and add a substituted menu in the system. The DM stated that the lunch meal served on 2/17/2026 was pre-planned and pre-approved by their corporate office. She stated that she consulted her corporate office supervisor after this issue was brought to her attention on 2/17/2026, and she was now fully aware of their system's functions, and the menu change process. The DM stated that the substitute meal and menu served on 2/17/2026 was generated by their electronic menu service, which took the residents' dietary needs into consideration when the menu was developed. The DM acknowledged that residents could have suffered negative outcomes because of the menu not being followed, such as displeasure or intolerance of ingredients, but she denied that had occurred. The DM stated that she felt supported by management and staff and the facility was a positive environment for the residents and staff. In an interview on 2/19/2026 at 2:01 PM, the DA stated she had been employed with the facility since October 2025. She stated that she received orientation and training related to her position and duties and resident care and needs. She stated that staff were regularly in-serviced on a variety of topics, not just those related to dietary services. The DA stated that she didn't manage, create or modify menus, but she was required to follow the menus unless instructed otherwise. The DA stated that the DM was responsible for managing their menus and did so well. The DA stated that the DM had made a positive difference in the kitchen since she took the position. She said the DM was supportive of the dietary staff, positive, and willing to help. The DA said the DM was knowledgeable about the management and oversite of the kitchen and has taught the dietary staff a lot. The DA said the DM was considerate of the residents' needs and preferences and made sure the residents' were happy and satisfied. In an interview on 2/19/2026 at 2:01 PM, DC B stated that she had been employed with the facility since March 2025. She stated that she received orientation and training related to her position and duties. She said she had also been trained in resident care and needs. DC B stated that she wasn't responsible for creating, managing or updating the facility's menus, but she was responsible for preparing scheduled meals according to instructions and recipes. DC B stated that the DM was knowledgeable in kitchen management and practices and had made a positive difference in the kitchen with willingness to help and teach. In an interview on 2/19/2026 at 3:00 PM, the ADM stated that the facility utilized an electronica menu management system for the development and management of their menus. The ADM stated that their corporate office was responsible for the approval of menus, including substituted menus, in accordance with and in consideration of resident's needs, preferences, and restrictions. She stated that their corporate office was also responsible for uploading their menus into their digital system. The ADM stated that the DS was responsible for updating their electronic and printed menus when menu modifications occurred, which was her expectation too. The ADM stated that the DS was new to her position, in that she began her employment in December 2025, but she had been trained on how to override and modify menus in their electronic meal ticketing system. The ADM stated that the special menu served on 2/17/2026 had been developed and served specifically to promote a positive experience and outcomes for the residents. The ADM stated that the substituted menu was well thought out, met the nutritional needs of each resident, and included items in accordance with residents' known preferences. The ADM stated that the dietary staff go above and beyond to accommodate the residents' dietary likes and dislikes, and residents have not expressed displeasure with their menus or dietary services. The ADM stated they have had no recent complaints or grievances filed about the food or menus. The ADM denied any resident suffering any negative outcome due to the modification of the menu. In an interview on 2/19/2026 at 3:20 PM, the DON stated that she had been the interim DON at the facility for 8 weeks. She stated that she has extensive experience and training in the provision of care in long-term care facilities and was aware of the possible negative impact inconsistent or unexpected menus or meals could have on residents. The DON stated that residents who were not served food or meals according to their preferences and specific needs run the risk of negative outcomes including poor appetite, malnutrition, and weight loss. The DON stated that the residents at the facility have not (continued on next page)

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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Many	experienced negative outcomes because of their menus or meals. She stated that nurses conduct Ambassador Rounds daily and are required to conduct observations and monitoring during each meal service. She stated that the residents were treated well and their preferences were a priority. The DON stated that the staff at the facility were competent, caring, and invested in the overall well-being of the residents. The DON stated that the DS was knowledgeable, competent and invested in the resident's care and needs. Record Review of the facility's Dietary Services Policy & Procedure Manual FP 00-10.0 regarding menu approval and honoring resident special requests, and food brought to the facility from unapproved sources, reflected the following: 4. Every attempt will be made to honor resident food preferences. The facility has a five-week cycle menu that can be modified by the dietary manager to meet the preferences of the majority of the residents.8. The menu will reflect the religious, cultural, and ethnic needs of the resident population as well as input received from residents and resident groups, based on the facility's reasonable efforts.