STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675998	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Town Creek	2212 W Reagan St Palestine, TX 75801

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 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0695 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records review the facility failed to ensure respiratory care was provided, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 5 residents (Resident #1) reviewed for Respiratory Care. The facility failed to ensure appropriate respiratory care was provided to Resident #1 on 10/1/25 when the facility transported her to a doctor's appointment with an empty oxygen tank. This failure could place residents who require supplemental oxygen at risk of hospitalization and diminished quality of life.Findings included:1. Review of an admission Record for Resident #1 dated 10/8/2025 indicated she was an [AGE] year-old female readmitted to the facility on [DATE] with diagnoses of acute respiratory failure, pleural effusion (fluid between the lung and chest wall), and congestive heart failure (heart can't pump blood well enough to meet the body's needs).Review of a quarterly MDS for Resident #1 dated 8/7/2025 indicated she had moderately impaired thinking with a BIMS of 10. She required continuous oxygen therapy.Review of the care plan for Resident #1 dated 8/27/25 indicated she required oxygen therapy related to chronic respiratory failure with hypercapnia (high carbon dioxide levels), CHF, and history of pneumonia. Appropriate interventions were in place including oxygen via nasal cannula at 2 liters per minute, continuous. During an interview on 10/6/25 at 9:42 a.m., the RP said Resident #1 had a doctor's appointment on 10/1/25 and the RP met her at the appointment. The RP said she looked at Resident #1's oxygen tank and noticed it was empty. The RP said she told CNA A who went back to the facility and brought a new, full, oxygen tank. The RP said Resident #1 was having symptoms of shortness of breath including gasping for air. The RP said the doctor's office staff called an ambulance and the resident was transported to the hospital where she was admitted to the emergency room and was discharged on 10/2/25. The RP said Resident #1 had a diagnosis of CHF and was dependent on supplemental oxygen to control symptoms of shortness of breath.During an observation and interview on 10/07/25 at 10:30 a.m., Resident #1 was observed in her room, seated in a wheelchair. She appeared clean and well-groomed with no offensive odor detected and she had no visible marks, bruises, or skin tears. She was receiving supplemental oxygen at 3 liters per minute. Resident #1 said the facility transported her to a doctor's appointment with an empty oxygen tank. She said she was transported to an oncology appointment and began to feel short of breath when someone noticed her oxygen tank was on empty. Resident #1 said the doctor's office called EMS and she was taken to the hospital where she stayed overnight. Resident #1 said she required supplemental oxygen full-time to control her symptoms of shortness of breath. Resident #1 said it made her feel funny and short of breath when she did not have supplemental oxygen. During an interview on 10/07/25 at 3:00 p.m., CNA A said on 10/1/25 he transported Resident #1 to a doctor's appointment. He said Resident #1's RP met them at the doctor's appointment and noted Resident #1's oxygen tank to be empty. CNA A said LVN B checked Resident #1's oxygen tank prior to leaving the facility and said it was full. CNA A said he went back to the facility and got a new oxygen tank and returned to the doctor's office. CNA A said the doctor's office called an ambulance due to Resident #1 being short of breath and she was transported to the emergency room. CNA A said it was the nurse's responsibility to inspect oxygen tanks and replace the tanks if they are low or empty. During an interview on 10/8/25 at 8:45 a.m., the ADM said on 10/1/25 it was reported to him that Resident #1 was transported to a doctor's appointment with an empty oxygen tank. ADM said it was the nurse's responsibility to ensure oxygen tanks were full prior to a resident leaving the facility. ADM said the DON was actively working on improving the system of checking oxygen tanks to include the transportation driver in the process.During an interview on 10/8/25 at 9:00 a.m., the DON said it was the charge nurse's responsibility to ensure residents leaving the unit had a full oxygen tank. The DON said LVN B reported she checked Resident #1's oxygen tank prior to her leaving the facility and noted it to be full. The DON said she was working on improving the system of checking oxygen tanks to include the transportation driver checking before leaving the facility and again upon arriving at the destination. The DON said she also printed and hung new, brightly colored, signs denoting empty oxygen tank storage from full oxygen tank storage. The DON said nursing staff had reported intermittently seeing a red light on the oxygen refilling station and oxygen tanks were not being filled. The DON said she tested the oxygen tank filling station on 10/1/25 and it functioned properly, but she had it replaced on 10/1/25 with a new unit to be safe.During a telephone interview on 10/8/25 at 10:45 a.m., LVN B said the day of Resident #1's appointment she swapped out her oxygen tank with a full tank at approximately