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	01/07/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to immediately consult with the resident's physician when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention for 1 of 4 residents (Resident #1) reviewed for notification of changes. The facility failed to notify Resident #1's physician immediately on 12/11/25 at 3:00 a.m. when he fell in the dining room resulting in facial/scalp contusions and a hematoma to his forehead. Resident #1 was on dual antiplatelet therapy of Clopidogrel and Aspirin which increased the risk of intracranial bleeding and the physician was not notified of the fall with head injury until 4:21 a.m., a delay of 81 minutes. This failure could place all residents at risk of delayed medical care, pain, and hospitalization. Findings included: Review of an admission Record dated 1/7/26 for Resident #1 indicated he was a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses of end stage renal disease (kidney failure), dependence on renal dialysis, and atherosclerotic heart disease (plaque in the coronary arteries). Record review of an admission MDS dated [DATE] indicated Resident #1 had intact cognition with a BIMS score of 15. He required supervision with most ADLs, and he was taking an antiplatelet medication. Record review of a comprehensive care plan dated 11/4/25 indicated Resident #1 was on dual antiplatelet therapy of Aspirin and Clopidogrel therapy related to prior myocardial infarction (heart attack). Interventions were in place including labs as ordered, skin inspections as needed, and report changes or increases in bruising. During an observation and interview on 1/7/26 at 9:38 a.m., Resident #1 was observed in his room lying in bed, he had fading bruising around his right eye. Resident #1 said he was trying to get up from his wheelchair to get coffee, and he tripped over the footrest. Resident #1 said he fell and hit the right side of his face and head on the floor and yelled for help. Resident #1 said the nurse arrived and checked him out. Resident #1 said he told the nurse his head was hurting. Resident #1 said the nurse told him that it would get better when the swelling went down. Resident #1 said he went to dialysis later that morning and the doctor there sent him to the ER. Resident #1 said it was all backwards; I should have gone to the ER first. Resident #1 said he was never offered to go to the ER, and he never asked to go. Review of an unwitnessed fall report dated 12/11/25 at 3:00 a.m. by LVN A indicated he was at the nurse's station when he heard a resident yell for help from the kitchen area. LVN A went to the location and observed Resident #1 lying on his right side. LVN A assisted Resident #1 back into his wheelchair and noted a bump on his head. LVN A administered Tylenol for pain and applied an ice pack to resident's head. The same fall report indicated immediate action taken was an assessment with normal vital signs, resident was alert and oriented and reported a pain level of 6/10 (moderate pain); the MD was notified at 4:21 a.m. During an interview on 1/7/26 at 10:00 a.m., RN B said he worked on Resident #1's unit the morning of his fall, on 12/11/25. RN B said he was given report by LVN A that the resident fell at 3:00 a.m. that morning and that all his (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	neurological checks were normal. RN B said he did not see Resident #1 that morning himself due to resident having such an early 7:00 a.m. dialysis appointment, he was already gone from the unit. RN B said the resident went from dialysis to the ER before returning to the facility. RN B said if a resident fell and had a head injury, especially if that resident took an antiplatelet medication, he would call the MD immediately or as soon as possible due to risk of brain bleeding. RN B said any changes to neurological status should prompt contacting the MD again. Review of a Dialysis Communication Form dated 12/11/25 at 05:35 a.m. signed by LVN A indicated there were no new problems or concerns with Resident #1. Review of a physician note from a dialysis center dated 12/11/25 indicated Patient was seen and evaluated this morning on rounds.had a fairly large and prominent bruising and small hematoma on his forehead.He has no headache, no visual changes, or neurological changes.He will be sent to the ER post HD (hemodialysis) by nursing home staff. During an interview on 1/7/26 at 1:00 p.m., the MD said he could not recall when he was notified by facility staff of Resident #1's fall on 12/11/25, but the facility notified him within minutes. The MD said he was unaware there was an 81-minute delay in notification. The MD said he was notified that the resident fell, and all neurological checks were being conducted and were normal. MD said standard teaching for a patient taking clopidogrel is usually to go to the ER if you have a head injury. MD said there was no added risk to resident safety in this case due to neurological checks being completed with normal results. The MD said symptoms of bruising and swelling were reported to him. The MD declined to comment on whether the 81-minute delay was considered prompt notification. During an interview on 1/7/26 at 11:50 a.m., ADON said she was responsible for supervision of nursing staff at the facility. ADON said she expected nursing staff to alert the physician immediately in the result of a resident fall with head injury especially if the resident is taking antiplatelet medication. ADON said that the increased risk of brain bleeding could be fatal. During an interview on 1/7/26 at 12:00 p.m., the DON said she was responsible for supervision of all nursing staff in the facility. The DON said a resident taking antiplatelet medication could increase the risk of injury but as long as neurological checks were normal there was no reason to contact the physician sooner. The DON said nurses notify doctors by either text or phone call depending on the situation and the physician preference. The DON said in this instance she felt the 81-minute delay and texting the physician was acceptable. During an interview on 1/7/26 at 12:23 p.m., the ADM said he was not sure on the timeline of when the physician was notified of the fall. The ADM said his expectation of staff was that the MD be notified immediately or as soon as possible following a fall with head injury. The ADM said he was not sure what the risks would be in delaying notification, it would depend on the situation as long as the resident was stable there may not be additional risk. During an interview on 1/7/25 at 1:00 p.m., LVN A said he was the nurse assigned to Resident #1's care on 12/10/25 on the night shift. LVN A said on 12/11/25 at approximately 3:00 a.m. he heard a resident yell for help from the kitchen area. LVN A said he went to the kitchen area and found the resident lying on his right side on the ground. LVN A said he assessed resident and assisted him back to his wheelchair. LVN A said he gave the resident Tylenol for pain and an icepack for the hematoma on his forehead and initiated neurological checks which were normal. LVN A said Resident #1 never complained to him of blurred vision or any other symptoms but that he was confused. LVN A said he texted MD to notify him of the fall but was unsure of the time of the notification. LVN A said he notified the Resident's family at 3:00 a.m. but did not notify the MD until later due to Resident #1 being confused and unstable. Review of a facility Neurological Assessment sheet dated 12/11/25 at 3:00 a.m. indicated Resident #1 was assessed at 3:20 a.m. and was assessed as not fully oriented. All other assessments documented between 3:00 a.m. and 5:35 a.m. were documented as (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no confusion/disorientation with vital signs within normal limits. During a phone interview on 1/7/25 at 3:24 p.m., RN C said she was the charge nurse for the dialysis center on 12/11/25 the day Resident #1 came in after falling at the nursing home. RN C said the resident arrived at the appointment early and the nurse working noted significant bruising to his face and a hematoma on his forehead prompting her to immediately call the physician. RN C said the physician okayed the resident to have hemodialysis treatment since he didn't use heparin (an anticoagulant) and his neurological status was normal. RN C said the dialysis center physician came in and saw the resident face to face on rounds and advised the NF that Resident #1 should be evaluated in the ER after finishing hemodialysis. RN C said the facility was contacted and refused to have resident sent to the ER so the physician instructed dialysis center staff to call EMS for the resident. Review of hospital discharge records dated 12/11/25 indicated Resident #1 had a diagnosis of face or scalp contusion and hematoma. Resident #1 received a brain CT in the ER which showed no evidence of acute intracranial process, and he was discharged back to the NF on 12/11/25 with no major negative outcome. Review of a facility policy titled Change in a Resident's Condition or Status revised May 2017 indicated .Our facility shall promptly notify the resident's Attending Physician, Nurse Practitioner, or physician on call when there has been a(an): a. accident or incident involving the resident.