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	08/06/2025

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food safety requirements and kitchen sanitation.The facility failed to ensure the [NAME] wore a beard covering on 8/5/2025 when he prepared food.These failures could place residents at risk of foodborne illness and food contamination.Findings included:During an observation on 8/5/2025 at 10:30 AM, revealed the [NAME] was in the kitchen pureeing food for the lunch meal. He had a full beard that was not covered.During an interview on 8/5/2025 at 10:45 AM, the [NAME] said he had been employed at the facility for 10 years and no one ever told him he needed to wear a cover for his beard. He said he should have a beard net on because of his facial hair and if staff did not wear a covering, then hair could drop into the food.During an observation and interview on 8/5/2025 at 11:30 AM, the DM was in the kitchen with the Cook. She said the [NAME] should have on a beard cover and told him to put one on. She said the kitchen had hairnets and beard covers when staff entered the kitchen. She said staff that had facial hair should wear a beard cover, so hair does not get into the food.During an interview on 8/6/2025 at 10:36 AM, the Interim Administrator said she had been at the facility since April 2025. She said staff in the kitchen that prepared food should wear a hair net or beard cover. She said if they did not wear the appropriate coverings for hair then they could contaminate the food. She said she expected for staff to wear the appropriate hair coverings when in the kitchen. Record review of a facility policy titled Food Safety Requirements dated 4/14/2024 indicated, . It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state, and local authorities. 7. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects. d. Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food .

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure all drugs were stored properly, for 1 of 3 medication carts reviewed for medication storage. The facility failed to ensure Resident #101's insulin Lispro multi-dose vial with an expired date of 7/10/2025 was disposed of. This failure could place residents at risk of not receiving the therapeutic benefit of medications prescribed. Findings included: 1.Record review of Resident #101's face sheet, dated 8/5/25, indicated a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus (a condition where the body does not use insulin effectively, leading to high blood sugar levels), dementia (A group of symptoms that affects memory, thinking and interferes with daily life), and bipolar disorder (causes extreme changes in mood and behavior). Record review of Resident #101's significant change MDS assessment, dated 7/28/25, indicated she was able to make herself understood and understood others. Resident #101 had a BIMS score of 07, which indicated her cognition was moderately impaired. Resident #101 required dependent assistance with ADL's. Resident #101 was always incontinent of bowel and bladder. Record review of Resident #101's physician orders, dated 8/05/25, indicated an order of Insulin Lispro solution 100 units per milliliter. Inject subcutaneously before meals and at bedtime according to sliding scale. Sliding scale as follows: Blood sugar of 150-200= 2 units; 201-250= 4 units; 251-300= 6 units; 301-350= 10 units; 350-400= 12 units. Record review of Resident #101's care plan dated 7/08/25 indicated resident had a diagnosis of Diabetes Mellitus. Interventions were for staff to observe resident for signs of hyperglycemia (blood glucose above 140 milligrams/dl; increase thirst, increase urination; increase appetite followed by lack of appetite; nausea, vomiting) and observe for signs of hypoglycemia (blood glucose less than 60milligrams/dl; sweating; cold; clammy skin; numbness of fingers, toes, mouth; rapid heartbeat; nervousness; tremors, faintness, dizziness). During an observation on 8/5/25 at 8:30 A.M., with LVN A, an inspection of a nurse medication cart revealed a bottle of insulin Lispro, with Resident #101's information on the label, and was located in the top drawer. The multi-dose vial had an open date of 6/10/25 printed on the vial and an expired date 07/10/25 on the box, which indicated the vial had been used. Observation of the vial indicated it was opened and approximately half of the contents missing. During an interview on 8/5/25 at 10:00 A.M., LVN A said the insulin should have been removed and replaced with a new bottle 30 days after being opened. She said after a multi-dose vial of insulin was opened the date it was opened should be written on the bottle. She stated multi-dose insulin vials were good for 30 days. She said the vial should be observed for the date opened by the nurse prior to administering any multi-dose medication. She stated the charge nurses were responsible for monitoring expiration dates on medications and replacing them when needed. She said medications that are expired could be less effective. During an interview on 8/6/2025 at 8:00 AM, LVN B stated the charge nurse was responsible for monitoring the medication cart for expired medications. She stated medication expiration dates should be checked prior to administering any medications. She stated if a multi-dose vial of insulin was used, an open date was written on the vial when it was opened. She stated that most multi-dose vial insulins were good to use for 30 days after opening but manufacturers vary. She said if a vial was out of date, it was taken from the cart and placed in the discontinued medication area and a new vial was opened and dated for the resident. She stated using medications that were expired could be less effective. During an interview on 8/6/2025 at 8:15 AM, LVN C stated the charge nurse was responsible for monitoring the medication cart for expired medications. She stated medication expiration dates should be checked prior to administering any medications. She stated if a multi-dose vial of insulin was used, an open date was written on the vial when it was opened. She stated that most multi-dose vial insulins are good to use for 30 days after opening. She said if a vial is out of date, it was removed from the cart and a new vial (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was opened and dated for the resident. She stated using medications that are expired could be less effective and insulins could affect the residents blood sugar levels. During an interview on 8/6/2025 at 8:30 AM, the Administrator stated the charge nurses were responsible for monitoring the expiration dates of medications. She stated the nurses should remove any expired medications from the medication cart. She stated the nurse should be checking expiration dates of medications daily. She stated she expected staff to monitor all expiration dates and to remove medications that are expired. She stated a possible effect of administering expired medications is decreased effectiveness of the medication. During an interview on 8/6/2025 at 8:45 AM, the DON stated the charge nurse was responsible for monitoring expiration dates on all medications. She stated the nurses should check the carts daily for any expired medications and prior to administering medications. She stated expiration dates for insulin vary with manufacturer and that the nurses have the information available to them at each nurses station. She stated moving forward the charge nurses would be checking medications daily and the nurse management would be conducting observations checks weekly. She stated that a possible outcome of administering expired medications would be decreased effectiveness of medication. Record review of the facility's policy, Medication Storage revised 01/2025 indicated:14. Outdated, contaminated, discontinued, or deteriorated medications.are immediately removed from stock, disposed of according to procedures for medication disposal. Manufacturer of insulin Lispro, Lilly Pharmaceuticals, recommend Insulin Lispro that has been opened can be kept at room temperature (59-86 degrees Fahrenheit) for up to 28 days.

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items, per facility policy for 1 of 4 resident's (Resident #80) personal refrigerators reviewed for food safety.The facility failed to ensure the refrigerator for Resident #80 did not contain three containers of yogurt that were past their use by dates from 8/4/2025-8/6/2025.This failure could place residents at risk for food borne illnesses. Findings include:Record review of active physician orders for Resident #80 dated 8/6/2025 indicated she had diagnoses of Parkinson's (a progressive disorder that affects movement), dementia, major depressive disorder (persistent feelings of sadness and loss of interest that may affect daily lift), and osteoporosis (brittle bones). Record review of an admission Record dated 8/5/2025 for Resident #80 indicated she admitted to the facility on [DATE] and she was [AGE] years old.Record review of a Significant Change MDS assessment dated [DATE] for Resident #80 indicated she had moderate impairment in thinking with a BIMS score of 12. She required setup/cleanup assistance with eating.Record review of a care plan dated 7/26/2023 for Resident #80 indicated she had an ADL self-care performance deficit related to Parkinson's. Interventions for eating: required set up help. There was not a care plan that indicated she refused for staff to clean out her refrigerator.During an observation and interview on 8/04/2025 at 11:04 AM, revealed Resident #80 was in her room in bed awake. She said she had been at the facility for a little while. She had a personal refrigerator in the room that contained: one container of Greek yogurt that expired on March 16, 2025; one container of strawberry yogurt that expired on March 16, 2025; and one container of blueberry yogurt dated May 12, 2025. She said she never looked at the expiration dates of foods in her refrigerator and the staff checked it daily. She said she ate items from her refrigerator. During an observation and interview on 8/06/2025 at 8:27 AM, revealed Resident #80 was in her room in bed awake. Her personal refrigerator still had the containers of expired yogurt. She said someone checked her refrigerator daily but did not know who they were.During an interview on 8/06/2025 at 8:35 AM, the HSK Supervisor said the housekeepers checked the personal refrigerators daily for the temperatures and kept a log for them. She said the Activity Directors checked them for expired food items and was not sure how often.During an interview on 08/06/2025 at 8:36 AM, the Activity Director said the facility had two activity directors who were responsible for checking the personal refrigerators for expired foods. She said Activity Director F was responsible for checking Resident #80's refrigerator but she was out of the facility on vacation. She said they checked the refrigerators weekly. She said if a resident had foods that were expired, then they should be removed and if residents ate food past their expiration dates, they could get sick. She said she was not aware Resident #80 had expired foods in her refrigerator but would take care of it. During an interview 8/6/2025 at 10:36 AM, the Interim Administrator said she had been at the facility since April 2025. She said activities was responsible for checking the personal refrigerators weekly for outdated foods. She said if residents ate foods that were outdated or expired, they could get sick. She said her expectations were for the staff to make sure foods were safe and if there were any issues to involve the families.Record review of a facility policy titled Foods Brought by Family/Visitors revised July 2017 indicated, .Food [NAME] to the facility by visitors and family is permitted. 8. The nursing staff will discard perishable foods on or before the use by date .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #5) and 1 of 6 staff (CNA D) reviewed for infection control. The facility failed to ensure CNA D did not store dirty linens on the floor on 8/5/2025. These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices.Findings include: Record review of an admission Record dated 8/6/2025 indicated Resident #5 readmitted to the facility on [DATE] and was [AGE] years old.Record review of active physician orders dated 8/6/2025 for Resident #5 indicated she had diagnoses of hemiplegia affecting right side (paralyzed on right side), Parkinsonism, and depression.Record review of an Annual MDS assessment dated [DATE] for Resident #5 indicated she did not have any impairment in thinking with a BIMS of 15. She was dependent on staff for all ADL's.Record review of a care plan dated 5/24/2024 for Resident #5 indicated she had an ADL self-care performance deficit related to limited mobility. Interventions included: toileting: total staff assistance with incontinent care for bowel and bladder incontinence.During and observation and interview on 8/5/2025 at 8:41 AM, revealed Resident #5 was in her room, in bed, dressed and said the nurse aide had just left out of the room, and she had been changed. Dirty linens were observed on the floor by the trash can not in a plastic bag.During an observation on 8/5/2025 at 8:43 AM, revealed CNA D entered Resident #5's room with CNA E. CNA E placed gloves on her hands and put the dirty linens that were on the floor in a plastic bag. CNA E took the bag out of the room.During an interview on 8/5/2025 at 2:40 PM, CNA E said she had been employed at the facility for 15 years. She said earlier that day when she helped CNA D in Resident #5's room, she noticed the linens on the floor and picked them up. She said linens should not be placed on the floor and should be placed in a plastic bag. She said there was a risk for infections or cross contamination if dirty linens were placed on the floor.During an interview on 8/6/2025 at 8:31 AM, CNA D said she had been employed at the facility since April 2025. She said on yesterday 8/5/2025, the linens that were in the room of Resident #5 she placed on the floor after she changed her bed. She said she did not know why she put them on the floor and knew that they should have been placed in a bag and not on the floor. She said she was trained to put dirty linens in a bag. She said she made a mistake. She said there could be a risk for contamination if dirty linens were thrown on the floor.During an interview on 8/6/2025 at 10:12 AM, the DON said she had been at the facility for 6 weeks. She said she along with the ADONs at the facility were responsible for training staff on infection control practices. She said dirty linens should be placed in a barrel and not left on the hall and never on the floor. She said there could a risk for contamination.During an interview on 8/6/2025 at 10:24 AM, the ADON said she had been at the facility for 2 years. She said she was the IP for the facility and trained staff on infection control. She said dirty linens should be placed in a plastic bag and then in a soiled linen barrel. She said dirty linens should never be placed on the floor unless they were in a bag. She said there was a risk for bacteria or contamination if dirty linens were placed on the floor. During an interview on 8/6/2025 at 10:36 AM, the Interim Administrator said she had been at the facility since April 2025. She said dirty linens should be placed in the soiled linen barrel and not on the floor. She said the linens should be placed in a plastic bag and then taken out. She said there was a risk for infection control and spreading of things and could be an accident hazard. She expected the staff to properly bag linens and them to be taken to the appropriate container.Record review of a facility policy titled Infection Prevention and Control Program dated 2/5/2025 indicated, .This facility has established and maintains an infection prevention and control designed to provide a safe, sanitary, and comfortable environment and to help prevent and development and transmission of communicable diseases and infections as per accepted national standards and guidelines. 11. Linens: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom .