

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Legacy Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 4033 W 51st Ave Amarillo, TX 79109	
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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interviews and record reviews the facility failed to ensure residents had the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility through a means other than the postal service for 13 of 13 anonymous residents reviewed for Resident Rights. The facility failed to ensure mail and packages from the U.S Postal Service were delivered to residents on Saturdays. The facility failed to ensure mail and packages delivered by means other than the postal service were delivered to residents on Saturdays and Sundays. These failures could cause residents to experience loneliness, depression, missing property and a decreased quality of life. Findings included: In a Resident Council meeting on 07/30/2025 at 2:00PM, 13 anonymous residents stated they had not received mail on Saturdays. One anonymous resident stated Act E delivered the mail to them Monday through Friday. Another anonymous resident stated packages delivered at a time other than 8AM-5PM, Monday through Friday, sat in the foyer of the facility until Act E returned to work on Monday. One anonymous resident stated she did not like her mail left on her bed or nightstand when she was not in her room. She stated anyone from the hallway could come and take a piece of mail and she would never have known; especially if she received a card for her birthday or other occasion that had money inside. An interview with Act E on 07/30/2025 at 2:32PM reflected she delivered the mail to the residents Monday through Friday, while she was working. She stated she was unsure who delivered the mail on Saturdays. She stated she delivered any packages that arrived over the weekend to the residents on Mondays when she returned to work. She stated it was not a good idea to leave the packages sitting in the foyer all weekend. She stated the negative outcome of leaving resident's mail on their bed or nightstand would be someone could take a bank statement or birthday card and the resident would not know it had been taken. She stated the negative outcome of leaving packages in the foyer over the weekend, would be visitors, staff members and other residents could easily take them. An interview with the Administrator on 07/30/2025 at 4:00PM reflected Recp F worked on the weekend and should deliver mail and packages to the residents. He stated he did not understand why Recp F was not delivering the mail; it was in her job description. He stated he was unsure if she knew it was in her job description due to him only being in his position for one month. He stated he would provide a copy of the job description showing Recp F should have been delivering mail. A telephone interview with Recp F on 07/31/2025 at 11:14AM reflected she was not aware it was part of her job description to deliver the mail and/or packages to the residents on the weekends. She stated she signed the job description before she started her duties as the weekend receptionist. She stated she was told by the Administrator to put any mail that arrived on Saturdays on the top of the shredded document storage container so it could be passed out by Act E on Monday. She stated it was not the current Administrator who told her to put the mail there, but the prior Administrator. She stated any packages that came over the weekend were placed in the foyer for Act E to pick up and distribute on Mondays. She stated Act E sometimes came to the facility on Sundays to play religious music for the residents, so she assumed Act E knew the mail and packages were there and she would hand them out if it was important. She was unable to state a negative outcome for residents not receiving mail and packages over the weekend. An interview with Act E on 07/31/2025 at 11:47AM revealed she came to the facility on Sundays occasionally to play religious music for the residents as (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676010
		If continuation sheet Page 1 of 4

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Legacy Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 4033 W 51st Ave Amarillo, TX 79109	
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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a volunteer, not as a paid worker. An interview with the Administrator on 07/31/2025 at 2:02PM revealed he was conducting in-services with all weekend staff on Saturday and Sunday to cover job descriptions, resident rights and resident privacy. Review of the receptionist's job description dated 11/2021 revealed the following: Essential Duties and Responsibilities: Every effort has been made to identify the essential functions of this position. However, it in no way states or implies that these are the only duties you will be required to perform. The omission of specific statements of duties does not exclude them from the position if the work is similar, related, or is an essential function of the position. All duties and responsibilities shall be performed as set forth in our established policies and procedures. Receive, sort and distribute mail as directed. Make sure all mail is distributed before you go home. Monday through Friday, the Activity Supervisor will hand out mail. If the Activity Supervisor is out, you will be the backup person to hand out mail. On Saturdays, the mail will be handed out by the weekend receptionist.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Legacy Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 4033 W 51st Ave Amarillo, TX 79109	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 3 (LVN A, CNA B, and CNA C) of 6 staff observed for resident care LVN A did not wear a gown when administering medications through Resident #11. CNA A and CNA B did not wear a gown when providing catheter care for Resident #86. This deficient practice could place residents at risk of cross-contamination and infections. Findings include: Resident #11:Record review of Resident #11's clinical record revealed a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include metabolic encephalopathy (a chemical imbalance in the blood that causes problems in the brain), herpes viral encephalitis (a rare but serious inflammation of the brain caused by the herpes simplex virus (HSV)), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), malnutrition (lack of proper nutrition), and dysphagia (difficulty or discomfort in swallowing).Record review of Resident #11's clinical record revealed her last MDS was a Medicare 5-Day completed 06/10/25 listing her with a BIMS of 14 indicating she was cognitively intact, she had a functionality of being dependent on staff for most of her activities of daily living, and she required a feeding tube. Record review of Resident #11's care plan with admission date of 06/04/25 revealed the following: Focus: Resident requires tube feedings r/t swallowing problems and weight loss. Intervention: Use Enhanced Barrier Precautions. Record Review of Resident #11's Active Orders As Of: 07/30/25 revealed the following order: ENHANCED BARRIER PRECAUTIONS: PPE required for high resident contact care activities. Indication: Central line, PEG tube every shift related to HERPESVIRAL ENCEPHALITIS (B00.4) Phone Active 06/04/2025 During an observation on 07/30/2025 at 11:00 AM LVN A administered 4 medications to Resident #11 through her feeding tube. LVN A used handwashing, ABHR, and gloves for the procedure, but LVN A never put a barrier gown on. There was a note posted above Resident #11's bed for Enhanced Barrier Precautions (EBP) to include instructions to wear a gown for Device care or use: central line, urinary catheter, feeding tube, tracheostomy. During an interview on 07/30/2025 at 10:51 AM LVN A reported that Resident #11 was on Enhanced Barrier Precautions (EBP) related to her feeding tube and should have worn a barrier gown during Resident #11's care. LVN A stated, I looked up halfway through the procedure and realized I should have put a barrier gown on, but it was too late. LVN A reported not wearing the proper PPE when Enhanced Barrier Precautions (EBP) were in effect could result in a staff member introducing other to outside bacteria. LVN A reported that the DON provided training on infection control processes. Resident #86:Record review of Resident #86's clinical record revealed a [AGE] year-old female resident admitted to the facility originally on 02/29/24 and readmitted on [DATE] with diagnoses to include urinary tract infection (an infection in any part of the urinary system, the kidneys, bladder, or urethra), flaccid neuropathic bladder (a type of neurogenic bladder dysfunction characterized by the bladders inability to contract effectively, leading to urinary retention and overflow incontinence), neuromuscular dysfunction of the bladder (the nerves and muscles of the bladder do not work well resulting in the bladder not filling or emptying well), and muscle weakness. Record review of Resident #86's clinical record revealed her last MDS was a quarterly completed 06/14/25 listing her with a BIMS that could not be evaluated because she was rarely/never understood, she had a functionality of being dependent on staff for her toileting hygiene, and she required an indwelling catheter for her bladder. Record review of Resident #86's care plan with admission date of 07/28/25 revealed the following: Focus: Resident has an indwelling urinary catheter for neurogenic bladder. Date initiated 03/08/24.Intervention: Use Enhance Barrier Precautions. Date initiated 04/26/24 Record Review of Resident #86's Active Orders As Of: 07/30/25 revealed the following order: ENHANCED BARRIER PRECAUTIONS: PPE required for high resident (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Legacy Rehabilitation and Living		STREET ADDRESS, CITY, STATE, ZIP CODE 4033 W 51st Ave Amarillo, TX 79109	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contact care activities. Indication: Foley Cath every shift. Phone Active 07/29/2025. Record Review of Resident #86's Active Orders As Of: 07/01/25 revealed the following order: ENHANCED BARRIER PRECAUTIONS: PPE required for high resident contact care activities. Indication: Foley catheter and wounds. Verbal Active 07/15/2024. During an observation on 07/30/2025 at 2:36 PM CNA B and CNA C provided catheter care for Resident #86. Both CNAs were observed using proper hand hygiene and glove changes but both CNAs did not wear a gown for Enhanced Barrier Precautions (EBP). A sign posted above Resident #86's bed included instructions to wear a gown for Device care or use: central line, urinary catheter, feeding tube, tracheostomy. During an interview with CNA B and CNA C on 07/30/2025 at 2:51 PM revealed CNA B reported not wearing a barrier gown and complying with EBP was the only thing she forgot. That Resident #86 was on EBP and that they both should have place a barrier gown since Resident #86 had a catheter. CNA B reported not complying with EBP could result in the spread of infection. CNA C stated she agreed with everything CNA B stated, and she did not have any other information other she just forgot to put on a barrier gown. Both CNA B and C reported that the DON provided most trainings on infection control processes. During an interview on 07/31/2025 at 7:39 AM the DON reported that training on infection control to include EBP was provided by the DON and ADON and she has only been the DON for the facility for two weeks. The DON reported this was her second week and she had not had time to correct any of the issues such as training on infection control processes. The DON reported staff not following recommended EBP would increase the risk of infection because they could have something on their cloths which will violate infection control. During an interview on 07/31/2025 at 10:21 AM ADON D reported CNA C was a new hire, and CNA C was trained verbally by herself (ADON D) on EBP when CNA C was hired but no written training was provided. ADON D reported she expects all staff to wear a gown and gloves when EBP was required and if a staff member does not comply with these requirements, then they can place the residents at risk for infection by bringing something in on their cloths or they could carry something out to another resident. Upon review of the last 12 months of training ADON D reported CNA C was hired on 1/14/25 and she (CNA C) was missed on the 3/21/25 training that was provided on Enhanced Barrier Precautions (EBP). Record review of the facility provided Enhance Barrier Precautions (EBP) educational posting placed in each resident's room that required Enhance Barrier Precautions (EBP) revealed the following information provided for visitors and staff: Enhanced Barrier Precautions.Providers and staff must also:Wear gloves and gowns for the following High Contact Resident Care Activities--Device care or use: Central line, urinary catheter, feeding tube, tracheostomy. Record review of the facility provide training to include the current Enhance Barrier Precautions (EBP) policy (undated) completed on 03/21/25 by ADON D revealed the following information: Enhanced Barrier Precautions (Gloves, Gowns, Face Shields/Goggles, Masks).Can be applied (when Contact Precautions do not otherwise apply) to resident with any of the following:Wounds or indwelling medical devices, regardless of MDRO colonization status.Noted that the in-service was signed by LVN A and CNA B.		