STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676048	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Center -	1201 Fm 2685 Gladewater, TX 75647

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but no later than 24 hours after the allegation was made, for 1 of 3 residents (Resident's #1) reviewed for abuse and neglect. The facility failed to report an allegation of neglect on 01/19/2026 to HHSC within 24 hours. This failure could place the residents at increased risk for abuse and neglect.The findings included: Record review of the face sheet, dated 01/29/2026, reflected Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of hemiplegia (paralysis) and hemiparesis (weakness) following a stroke affecting the right dominant side. Record review of the admission MDS assessment, dated 11/17/2025, reflected Resident #1 had clear speech, was understood by others, and was able to understand others. Resident #1 had a BIMS score of 15, which indicated no cognitive impairment. Resident #1 had no signs or symptoms of delirium (sudden, acute and fluctuating disturbance in attention, awareness, and cognition) and there were no behaviors. The MDS reflected Resident #1 was totally dependent on staff assistance for toileting hygiene. Resident #1 was frequently incontinent of bowel. Record review of the comprehensive care plan, dated 11/17/2025, reflected Resident #1 had an ADL self-care performance deficit related to a recent stroke with hemiplegia. The interventions indicated Resident #1 required assistance with toilet use. During an observation and interview on 01/28/2026 beginning at 4:26 p.m., Resident #1 was sitting up in her wheelchair. Resident #1 explained last Monday (01/19/2026) CNA B had an attitude with her. Resident #1 stated she pressed her call light because she needed to be changed. She said she had been given a laxative earlier in the day and was having diarrhea. Resident #1 stated CNA B answered her call light at approximately 6 p.m. and explained that she needed to gather her supplies but would return to get her cleaned up. Resident #1 stated CNA B did not return to her room, so she pressed the call light again. She said when CNA B answered her call light the second time, CNA B stated she only had to change Resident #1 every two hours. Resident #1 stated CNA B refused to change her brief, give her name, and stuck her tongue out at her and rolled her eyes when she walked out of the room. Resident #1 said CNA B kept looking over her shoulder during the conversation, like she did not want someone to walk into the room. Resident #1 stated I had to sit in fecal matter for over an hour and I am human and want to be treated like one. Resident #1 stated she was afraid to press her call light because she did not trust anyone to help her. Resident #1 said she called her family member, and she came up to the facility. She said she had no further contact or interactions with CNA B. The family member was at bedside during the interview. The family member stated she had been at the facility on 01/19/2026. The family member stated Resident #1 pressed her call light around 5:45 p.m. because she needed to be changed. The family member stated CNA B answered the call light around 6 p.m. and explained she had just arrived on shift and needed to gather (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her supplies. The family member stated she left the facility around 6:20 p.m. and CNA B had not returned to provide assistance. The family member stated she sat in the parking lot for approximately 20 minutes and left around 6:40 p.m. The family member stated she assumed care had been provided because Resident #1 did not call her. The family member stated Resident #1 called her around 7:30 p.m. and was audibly upset and in distress. Resident #1 reported that she had still not been changed, and CNA B came into her room, refused to change her, give her name, and stuck her tongue out at her. The family member stated she immediately came up to the facility, confronted CNA B and reported the allegations to the Administrator. During an interview on 01/28/2026 beginning at 8:26 p.m., CNA B stated she was fairly new to the facility and had started around 01/02/2026. She stated she was still working at the facility but was moved off Resident #1's hallway. She said she had only worked 2 days on Resident #1's hallway. She stated Resident #1 did not normally get on her call light, but she was aware Resident #1 was incontinent of her bowels. CNA B stated on 01/19/2026 around 6:10 p.m., Resident #1's family member reported that Resident #1 had diarrhea and needed to be changed. She said she told Resident #1's family member she had just arrived at work and was going to gather her supplies. CNA B stated she changed Resident #1 around 6:20 p.m. and she had just started having a bowel movement but there was no diarrhea. CNA B said she finished changing Resident #1 and told her she would return later to allow her time to finish having a bowel movement. CNA B stated she returned 35 - 40 minutes later and changed Resident #1 a second time. She said Resident #1 had no diarrhea. CNA B stated she was providing care for another resident when Resident #1's family member started asking her questions in a rude tone. CNA B stated the family member accused her of letting Resident #1 sit in her bowel movement for hours, refusing to introduce herself or give Resident #1 her name, and sticking her tongue out at her and rolling her shoulders. CNA B stated she did not stick her tongue out or roll her eyes. She said she re-introduced herself each time she went into the room. She said the Administrator arrived at the facility, explained the allegations were considered neglect and suspended her pending an investigation. CNA B stated she left the facility. During an interview on 01/29/2026 beginning at 12:05 p.m., the Administrator stated on 01/19/2026 he received a call from Resident #1's family member around 8:30 p.m. He said the family was upset that Resident #1 had several large bowel movements and hadn't been changed for two hours. The Administrator said when he arrived at the facility, Resident #1 reported CNA B had come into her room, stated she would be back and turned off the call light, stuck her tongue out at her and rolled her eyes. The Administrator stated he found CNA B and informed her she was suspended pending the investigation and sent her home. The Administrator stated Resident #1 had no evidence of distress and he felt the allegation was more related to customer service versus neglect, which was why he decided not to report the incident to HHSC. The Administrator was unsure of the actual time it took for Resident #1 to receive assistance. The Administrator stated he completed safe surveys and found no further complaints about CNA B. He said there were no resident complaints about call lights not being answered. He said the nurses performed a skin assessment on Resident #1 with no abnormal findings. The Administrator stated neglect was when the facility did not give care, that resulted in further injuries. The Administrator stated there had to be harm or injuries to have been considered neglect. He stated the abuse policy should have been followed, and he felt like he followed the reporting guidelines. The Administrator stated he referenced the state provider letter on abuse reporting and his policy when determining whether an allegation needed to be reported. He said he could also contact several resources within the company. Record review of the 7 safe surveys, dated 01/20/2026, reflected Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, and Resident #8 felt safe in the facility and had no issues or (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concerns with the staff members at the facility. Record review of the Abuse: Prevention of and Prohibition Against policy, last revised in April 2025, reflected Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort, or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress. All allegations of abuse, neglect. should be reported immediately to the Administrator. Allegations of abuse, neglect. will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations.