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	05/23/2026

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility did not ensure treatment and services was provided, consistent with professional standards of practice, to promote healing and prevent new ulcers from developing for 1 of 3 residents reviewed for quality of care. (Resident #1)The facility failed to implement treatment orders for Resident #1's right heel as ordered by Wound Care Specialist from 5/11/2026-5/18/2026.This failure could place residents at risk for developing avoidable pressure injuries and the worsening of existing pressure injuries.Findings included:Record review of Resident #1's face sheet, dated 5/23/2026, indicated Resident #1 was a [AGE] year-old female, admitted [DATE], diagnoses included intracapsular fracture of right femur (occurs within the joint capsule of the hip, most often involving the femoral head or neck), Hyperlipidemia (a condition characterized by elevated levels of cholesterol in the blood), Alzheimer's (most common cause of dementia, a condition involving significant memory loss and other cognitive abilities that interfere with daily life), and anxiety (an emotional characteristic by an unpleasant state of inner turmoil and includes feelings of dread over anticipated events). Record review of an admission MDS assessment, dated 5/11/2026, indicated Resident #1 was usually understood and usually understood by others. The MDS indicated a BIMS score of 99 which indicated Resident #1 was unable to complete the interview. The MDS indicated Resident #1 was dependent on staff for toileting, showering, dressing lower body and personal hygiene. The MDS indicated Resident #1 was at risk of developing pressure ulcers/injuries and had 1 deep tissue injury that was not present upon admission.Record review of the care plan, last revised on 5/11/2026, indicated Resident #1 had potential/actual impairment to skin integrity related to suspected deep tissue injury, initiated on 5/11/2026 and created on 5/20/2026. Interventions initiated on 5/20/2026 included offloading boots while in bed, administration of treatment as ordered, encourage good nutrition and hydration to promote healthier skin, use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. During record review of Resident #1's Clinical admission note, dated 5/7/2026, indicated Resident #1 had a surgical wound and redness to her buttocks. The Clinical admission note did not indicate Resident #1 had a pressure area to her right heel. During record review of Resident #1's Baseline Care plan, dated 5/7/2026, Resident #1 had potential for pressure ulcer development with interventions to administer treatments as ordered and monitor for effectiveness, monitor nutritional status, serve diet as ordered, monitor intake and record, notify nurse immediately of any new areas of skin breakdown such as redness, blisters, bruises, discoloration noted during bathing or daily care, and weekly head to toe skin at risk assessment.During record review of Resident #1's progress note, dated 5/11/2026 at 5:45 PM as a late entry, the Treatment Nurse indicated Resident #1 had a new skin issue located on the right lateral heel and was unstageable. The Treatment Nurse indicated the right lateral heel pressure ulcer was present upon admission and measured 1.2 cm x 1.5 cm x 1.8 cm. The Treatment Nurse's progress note indicated the family was present during the assessment.Record review of Resident #1's Initial Wound Care Evaluation and Management Summary, dated 5/11/2026, indicated the chief complaint was, Patient present with a wound on her right heel. The evaluation indicated Resident #1 had an unstageable DTI to the right heel. The right heel wound measured 1.20 cm x 1.50 cm with skin (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intact with purple/maroon discoloration. The dressing treatment plan on the wound care evaluation summary included for betadine to be applied once daily and as needed. General recommendations included: Reposition per facility protocol, off-load wounds, float heels in bed, and cleanse with wound cleanser at the time of dressing changes. Record review of Resident #1's consolidated orders, dated 5/23/2026, did not indicate any wound care orders on 5/11/2026. Resident #1 did not receive treatment for the pressure area to her right heel from 5/11/2026-5/19/2026. Record review of Resident #1's Wound Evaluation and Management Summary, dated 5/18/2026, indicated Resident #1's unstageable DTI of right heel measured 2.3 cm x 2 cm with skin intact with purple/maroon discoloration. The dressing treatment plan on the wound care evaluation summary included for betadine to be applied once daily and as needed. General recommendations included: Reposition per facility protocol, off-load wounds, float heels in bed and cleanse with wound cleanser at time of dressing changes.Record review of Resident #1's Wound Evaluation and Management Summary, dated 5/20/2026, indicated RP was at bedside. The RP was noted to be upset about the DTI noted on assessment. The Skin assessment on left heel, sacrum and buttock was performed and no active wounds were observed. The wound to unstageable right lateral heel measured 0.5 cm x 1.6 cm with intact purple/maroon discoloration. The dressing treatment plan on the wound care evaluation summary included betadine apply once daily and as needed. General recommendations included: Reposition per facility protocol, off-load wounds, float heels in bed and cleanse with wound cleanser at time of dressing changes. Right heel wound measured 0.5 cm x 0.7 cm with intact purple/maroon discoloration. The wound care orders indicated skin prep once daily and as needed.Record review of Resident #1's consolidated physician orders, dated 5/23/2026, indicated an order initiated on 5/20/2026 to cleanse right lateral heel with wound cleanser or normal saline, pat dry and apply betadine every day shift for wound care. The order also indicated wound care order for right heel with orders to cleanse with wound cleanser or normal saline, pat dry and apply skin prep starting on 5/21/2026. There were no orders for wound care starting on 5/11/2026. During record review of Resident #1's TAR, Resident #1 had the following orders:Right Heel: cleanse with wound cleanser or normal saline, pat dry, and apply betadine every shift for wound care starting on 5/19/2026 and was discontinued on 5/21/2026. Documentation indicated wound care was performed on 5/19/2026 and 5/20/2026.Right Heel: cleanse with wound cleanser, pat dry and skin prep each shift starting on 5/20/2026 and discontinued on 5/21/2026.Right lateral heel: cleanse with wound cleanser or normal saline, pat dry and apply betadine every day shift for wound care starting on 5/21/2026. Wound Care was documented completed on 5/22/2026.Right Heel: cleanse with normal saline, pat dry, and apply skin prep every day shift for wound care starting on 5/21/2026. Wound care was documented completed on 5/22/2026.Record review of Resident #1's Skin Assessment, completed on 5/11/2026, indicated an unstageable pressure ulcer/injury to right heel and a surgical wound to front right trochanter was present at admission. Record review of Resident #1's Skin Assessment, completed on 5/14/2026, indicated there were no new skin issues found on the evaluation and foot evaluation was completed. Record review of Resident #1's Skin Assessment, completed on 5/21/2026, indicated there were no new skin issues found and foot evaluation was completed. During a phone interview on 5/23/2026 at 8:44 AM, RP said Resident #1 was discharged from the facility at 8:00 AM. RP said the treatment nurse observed a new pressure ulcer on 5/11/2026 and did not notify RP. RP said the treatment nurse had come in and provided treatment. RP stated there was a meeting on 5/11/2026 and no one had informed her of any skin issues. During a phone interview on 5/23/2026 at 10:58 AM, RP reported Resident #1 was covered in wounds and she was unaware of them. During an interview on 5/23/2026 at 3:12 PM, CNA A said she provided showers for Resident #1 on Monday, Wednesday, and Fridays. CNA A said Resident #1 had steri-strips (sterile, reinforced adhesive skin closures used to pull edges of shallow cuts, surgical incisions, or lacerations together) in place after her staples were removed. CNA A said Resident #1 did not have any open areas to her to her right hip surgical incision. CNA A said Resident #1 had, what she thought, was a pressure area to her right heel, and (continued on next page)

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