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	04/15/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Give residents a notice of rights, rules, services and charges. Based on observations, interviews, and record review the facility to ensure residents were informed orally of their rights for 8 of 8 confidential residents reviewed for resident rights. The facility failed to ensure residents were provided ongoing communication of their rights during their stay at the facility. This failure could place residents at risk for a decreased quality of life and awareness and execution of their rights. The findings included: A record review of resident council minutes indicated resident rights were not reviewed or discussed for the resident council meetings dated 11/06/2025, 12/04/2025, 01/08/2026, 03/05/2026, or 04/02/2026. Resident council minutes indicated only yes for the meeting on the date of 02/02/2026 and did not indicate what rights were reviewed. During an observation on 04/13/2026 at 3:15 PM of the facility bulletin board, resident rights postings were observed on the wall in English and Spanish. During a confidential interview at an undisclosed date and time, 8 confidential residents indicated staff had not discussed or reviewed their rights with them. 8 confidential residents were unable to verbalize any of their rights as residents. During an interview on 04/14/2026 at 1:22 PM the AD indicated she was not aware she should have been reviewing and explaining residents' rights with them. The AD indicated she believed it was important for residents to know their rights. The AD indicated she had assumed residents already knew their rights. The AD indicated she would be responsible for ensuring residents knew their rights. The AD indicated if residents did not know their rights they were more susceptible to abuse. During an interview on 04/14/2026 at 1:50 PM the ADM indicated all staff were responsible for ensuring residents knew their rights. The ADM indicated he believed there would be no reason a resident would not know their rights. The ADM indicated residents were provided a written statement of their rights in the admission packet. The ADM indicated residents were spoken to about their rights as issues arose. The ADM indicated the risk to residents for not knowing their rights would be a reduction in capability for the facility to determine if there is abuse, neglect, or exploitation. A record review of the facility policy revised 11/08/2024 titled Resident Rights and Responsibilities, Notice of indicated the following: Policy:It is the policy of this facility to inform the resident both orally and in writing of his/her rights as a resident, as well as, the rules and regulations governing the resident's conduct and responsibilities during his/her stay in the facility.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and record review, the facility failed to ensure residents were provided reasonable access to receive their mail in a timely manner for 8 of 8 confidential residents reviewed for mail. The facility failed to implement a system to distribute incoming mail daily and ensure residents promptly received their mail. This failure could place residents at risk of a delay in residents' personal correspondence, financial information, or other time-sensitive materials. The findings include: During a confidential group interview at an undisclosed date and time, 8 confidential residents indicated they did not receive mail on Saturdays. 8 confidential residents indicated if they were expecting mail on a Saturday they would expect to receive their mail that day. During an interview on 04/14/2026 at 1:28 PM the AD indicated she was responsible for ensuring residents receive their mail on weekdays. The AD indicated she went to the post office and obtained the mail and delivered it to residents throughout the week. The AD indicated she was unsure if the post office was open on Saturdays to obtain the mail. The AD indicated anybody had the ability to obtain the mail on the weekend. During an interview on 04/14/2026 at 1:58 PM the ADM indicated he was unsure if the post office was open on the weekends for staff to obtain mail. The ADM indicated the AD and the transportation manager alternated weekends to obtain mail. The ADM indicated he felt the risk to residents due to not receiving mail on the weekend would be low and it could cause them to be a little bit depressed if they did not get it for one day. During an interview on 04/14/2026 at 2:21 PM, a Postal Service Employee at the post office indicated post office boxes were available to obtain mail from at any time of day seven days a week and mail was distributed into the post office boxes on Saturdays for anyone with a key to obtain. During an interview on 04/14/2026 at 3:13 PM, the Transportation Manager indicated she was on call every other weekend and went to the post office to obtain mail and distribute it to residents then. The Transportation Manager indicated when she does not obtain and distribute mail the AD was responsible. The Transportation Manager indicated if a resident was expecting mail and did not receive it she would expect them to be upset. A record review of the facility policy most recently updated 06/2017 titled Resident Personal Mail revealed the policy did not address receiving and distributing mail on Saturdays.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observations, interviews and record review the facility failed to make information available to residents and their representatives on filing grievances for 7 of 8 confidential residents reviewed for grievances. The facility failed to ensure residents and their representatives had access to grievance forms and accommodations to file an anonymous grievance. This failure could place residents at risk of unresolved grievances and decreased quality of life. The findings include: An observation on 04/13/2026 at 3:15 PM revealed the facility had no grievance forms available for residents or their representatives freely available. The grievance policy was observed posted on the facility bulletin board and in English only. During a confidential group interview at an undisclosed date and time, 7 confidential residents indicated they were unaware of how to file a grievance. 7 confidential residents indicated they had never seen the grievance form. 8 confidential residents were unaware they could file an anonymous grievance. During an interview on 04/14/2026 at 1:15 PM, the AD indicated all staff were responsible for grievances. The AD indicated she had not reviewed with residents how to file a grievance, but she kept the grievance form in her personal resident council binder. The AD indicated she felt most residents felt free to inform the ADM of their concerns. The AD indicated formal grievances are important because they allowed for a designated person to ensure the issue was resolved. During an interview on 04/14/2026 at 1:31 PM, the SW indicated all staff were responsible for grievances. The SW indicated she had only been employed at the facility for 5 days and would soon like to go to resident council to ensure residents were aware of their right to file a grievance. The SW indicated if a resident wanted to file a grievance anonymously she would not put their name on the grievance, they could place the grievance under her door, or they could call the facility and not leave their name. The SW indicated the risk to residents for not knowing how to file a grievance would include being unhappy about something and the issue not being addressed. During an interview on 04/14/2026 at 1:40 PM, the ADM indicated he was responsible for grievances and residents were to bring their grievances to him. The ADM indicated he had not discussed with the residents how to file a grievance. The ADM indicated he assumed residents knew to go to him if they had a concern and they had been informed of the process prior to his employment at the facility. The ADM indicated he probably should have explained the grievance process to residents. The ADM indicated residents did not have the information for how to file an anonymous grievance. The ADM indicated when the facility received a new admission, he would not go over the formal grievance process but would tell them to come to him or a nurse. The ADM indicated the risk to residents for not knowing how to file a grievance or having the ability to anonymously file a grievance would be allowing issues to go on longer than necessary. During an interview on 04/14/2026 at 2:01 PM, LVN B stated he was unable to find a grievance form. LVN B indicated if a resident wanted to file a grievance he would bring them to the ADM. LVN B indicated if a resident wanted to file a grievance anonymously he would provide them a blank sheet of paper. A record review of facility policy most recently revised 04/2025 titled Grievances indicated the following: PolicyIs is the policy of this facility to establish a grievance process that allows the resident(s) a way to execute their right to voice concerns or grievances to the facility or other agency/entity without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment, which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their facility stay. The facility will make information on how to file a grievance available to the residents and make prompt efforts to resolve grievances that the resident might have.Procedure:.2. Information is made available to the resident and/or representative and posted in designated locations throughout the facility. Information includes: Resident/resident representative have the right to file a grievance orally, in writing and/or anonymously.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on interviews and record review the facility failed to provide, based on the preferences of each resident, activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 8 of 8 confidential residents reviewed for activities. The facility failed to provide activities to meet the residents' interests on the weekends. This failure could place residents at risk for a decline in quality of life and psychosocial well-being. The findings included: A record review on 04/13/2026 at 2:03 PM of the last 6 months, November 2025 through April 2026, activities calendars indicated there were no activities available for residents on Sundays for the months of November 2025, December 2025, January 2026, February 2026, March 2026, or April 2026. Every other weekend there was church available for residents and no activity scheduled for the alternate weekend for the months of November 2025, December 2025, January 2026, February 2026, March 2026, or April 2026. During a confidential interview at an undisclosed date and time, 8 confidential residents indicated they did not have activities on the weekend other than church every other Saturday. 8 confidential residents indicated they would like more activities on the weekend. During an interview on 04/14/2026 at 1:18 PM the AD indicated she was at the facility every other Saturday to assist with providing residents with the scheduled church activity. The AD indicated she got an assistant recently that would be able to assist with the alternating Saturday. The AD indicated residents did not have any scheduled activities for Sundays. The AD indicated she believed it to be okay for residents to not have a scheduled activity on Sundays. During an interview on 04/14/2026 at 1:45 PM the ADM indicated he believed there were weekends he believed had enough activities for the residents. The ADM indicated the resident council informed him of their wish to be provided more activities on the weekends during the September 2025 resident council meeting and he was working on providing these. The ADM indicated the risk to residents for not having preferred activities on the weekends would include a need for socialization. A record review of the resident council minutes for the month of September 2025 revealed the minutes did not include the ADM name signed under Staff Members in Attendance. The resident council minutes did not include any indication weekend activities were discussed. A record review of facility policy revised 07/2007 titled Activities indicated the following: PolicyIt is the policy of this facility to ensure residents have the right to choose the types of activities and social events in which they wish to participate. Procedures:.2. When developing the resident's activity and social care plan, the resident should be given an opportunity to choose when, where, and how he or she will participate in activities and social events. Activities, social events, and schedules are developed in conjunction with the resident's interests, assessment, and plan of care.7. Daily activities, including those on weekends and holidays, are provided, as well as scheduled religious and social activities.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review the facility failed to ensure a system was established for records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determined that all drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 2 of 4 licensed nurse medication carts (100 and 300 hall carts) observed for pharmacy services. 1. The facility failed to ensure RN A did not sign the controlled substance count sheets for the end of their shift at the beginning of their shift on Cart #300 hall, on 04/14/2026. 2. The facility failed to ensure LVN B signed as receiving the controlled substance count sheets for his shift on Nurses Cart #100 on 04/14/2026. These failures could place residents at risk for medication diversion, administration of incorrect medication and compromised resident safety could place residents at risk of not receiving medications as ordered by the physician.Findings include: During an observation on 4/14/2026 at 1:49 PM, revealed 4/4 medication cart that RN A was signing on and off at the same time of signing on at shift count, The controlled drugs on hand. During an observation on 4/14/2026 at 1:57 PM, revealed 4/4 med cart that LVN B had not signed for receiving at the beginning of his shift on the count sheet, The controlled drugs on hand. During an interview on 4/14/2026 at 1:49 PM with RN A, said she always signed both coming/going slots on the Nurse on and Nurse off at the same time so he would not forget at the end of his shift, she said she thought this was ok to do so she would not forget to sign at the end of her shift, she knew she would be responsible if something happened during her shift, for possible drug diversion. During an interview on 4/14/2026 at 2:00 PM, LVN B said he almost always signed the controlled count sheet when receiving control off the count, he just forgot to do so today, He stated he knew he should sign because he was responsible for the cart and the narcotics it contained and he would be responsible if something happened during his shift. During an interview on 4/14/2026 at 2:30 PM, the Corporate Nurse and the DON said each nurse was to sign the Drug Administration Record Controlled Drug Count Record at the time coming on to their shift and at the time they were going off their shift. The DON said she had in serviced all nurses on the procedure and she was ultimately responsible for monitoring and making sure it was done correctly this could cause a resident not to receive their medication as ordered. During a record review and observation on 4/14/2026 at 2:00 PM, the sign on/off sheet read, signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication count is in agreement with the quantity stated on the controlled. Record review of the facility's, undated, policy and procedure titled Narcotic Count reflected It is the policy of this facility to justify amount of narcotics remaining when control of supply is released to nurses coming on duty. Undated document.1. One RN or one LVN/LPN going off duty and one RN or one LVN/LPN coming on duty must count and justify narcotics supply for each individual resident at the change of each shift2. After the supply is counted and justified, each Nurse must record the date and his/her signature verifying that the count is correct.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and restore continence to the extent possible for 2 of 3 residents (Resident #2 and Resident #3) reviewed for urinary catheters. The facility failed to ensure Resident #2's foley catheter was secured and/or anchored to prevent complications. The facility failed to ensure Resident #3's suprapubic catheter was secured and/or anchored to prevent complications. These failures could place residents with urinary catheters at risk for damage to the bladder or urethra, dislodging of the catheter, and urinary infections. Findings included: 1.Record review of a face sheet dated 04/15/2026 indicated resident #2 was a [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses which included dementia (a loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), chronic kidney disease (a long-term condition where the kidneys are damaged and cannot effectively filter the blood), intra-abdominal and pelvic mass (an abnormal growth, swelling, or enlargement in the lower abdomen and/or pelvic region), and obstructive uropathy (blockage in the urinary tract that prevents urine from flowing freely). Record review of a quarterly MDS dated [DATE] noted Resident #2 had a BIMS score of 3 which indicated her cognition was severely impaired. She was noted to be dependent on staff for all activities of daily living except eating. Record review of a care plan initiated on 11/06/2025 indicated Resident #2 had an indwelling catheter with a goal for her to be free of catheter related trauma and urinary infection. Interventions included instructions to secure the catheter to facilitate flow of urine, prevent kinking of tubing, and accidental removal. Record review of physician's orders dated 04/14/2026 indicated Resident #2 had an order dated 07/22/2025 with instructions to monitor the urinary catheter for pulling causing tension every shift. The physician's orders also included an order dated 08/22/2025 to change leg strap (used for securing/anchoring catheter tubing) every week and as needed. Record review of a care plan initiated on 11/06/2025 indicated Resident #2 had an indwelling catheter with a goal for her to be free of catheter related trauma and urinary infection. Interventions included instructions to secure the catheter to facilitate flow of urine, prevent kinking of tubing, and accidental removal. During observation and interview on 04/14/2026 at 10:30 AM, Resident #2 was seen lying on her back in bed with the head of the bed slightly elevated. She was noted to have a foley catheter with the catheter tubing connected to tubing that drained urine into a urine collection bag suspended from the bedframe. There was no slack in the catheter tubing as it extended over Resident #2's right leg, over the edge of the bed, and formed a loop before ending at the urine collection bag. There was no leg strap or other device in place to secure or anchor the catheter tubing to prevent it from being pulled or kinked. An attempt to engage Resident #2 in a conversation about the catheter was unsuccessful. 2.Record review of a face sheet dated 04/14/2026 indicated Resident #3 was a [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses which included obstructed and reflux uropathy, urethral abscess (a rare, severe infection involving a localized collection of pus in the tissues surrounding the urethra), and surgical aftercare following surgery on the genitourinary system. During an interview on 04/15/2026 at 10:12 AM, Resident #3 said he could feel the catheter tubing lying on his leg. He said he tried to be careful not to pull it. He said he did not recall having anything on his leg to keep the tubing from being pulled. Record review of an admission MDS dated [DATE] noted Resident #3 had a BIMS score of 15 indicating his cognition was intact. He was able to voice needs and required assistance with mobility and bathing. Record review of a care plan initiated on 02/19/2026 indicated Resident #3 had a suprapubic catheter with a goal for him to be free of catheter related trauma. The care plan included instructions to secure catheter to facilitate flow of urine, prevent kinking, and accidental removal. Record review of physician's orders dated 04/16/2026 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident #3 had an order dated 02/13/2026 for suprapubic catheter care every shift with instructions to monitor the suprapubic catheter for pulling causing tension. During observation of wound care on 04/15/2026 at 08:50 AM, Resident #3 was noted to have a suprapubic catheter (a tube inserted into the bladder through a small abdominal incision to drain urine). The catheter tubing was connected to tubing that drained urine into a urine collection bag suspended from the bed frame. There was no slack in the catheter tubing as it extended downward from Resident #3's lower abdomen, over his left leg, over the edge of the bed, and formed a loop before ending at the urine collection bag. There was no device in place to secure or anchor the catheter tubing to prevent it from being pulled or kinked. RN-E performed wound care to the suprapubic catheter insertion site and then asked Resident #3 to turn to his right side. RN-E removed the urine collection bag from the bed frame, passed it over the resident's lower body, and handed it to ADON-C who was on the opposite side of the bed. ADON-C suspended the urine collection bag to the bed frame. RN-E completed wound care and assisted Resident #3 to return to his original position on his back. ADON-C removed the urine collection bag from the bed frame, passed it over Resident #3's lower body and handed it to RN-E who lowered the bag and secured it to the bed frame on that side of the bed. At no time during the transfer of the urine collection bag from the left side of the bed to the right side and back to the left side was there any action taken to prevent the catheter tubing from being pulled. Resident #3 did not voice any discomfort during the process. During an interview with RN-E on 04/15/2026 at 11:00 AM, she said it was her responsibility to ensure urinary catheters were monitored for proper care. She said she assessed urinary catheters for pulling or tension, but could not describe how she would know if a catheter was being pulled or if a catheter was in a position that may place tension on the bladder or urethra. During an interview with the DON on 04/15/2026 at 11:15 AM, she said she expected the nurses to monitor residents with urinary catheters for pulling which could result in tension or pressure on the bladder, tears in the urethra, or obstruction of urine flow. She said the nurses would monitor catheters for pulling by looking for slack in the tubing. Record review of the facility's policy dated May 2007 and last revised November 2017 and titled Catheter Care, Indwelling Urinary reflected the following: Policy: It is the policy of this facility that each resident with an indwelling catheter will receive the necessary care and services related to minimizing the risks and promoting the highest practicable well being. This includes but is not limited to.care planning the specific catheter size with resident specific interventions. Record review of Lippincott's Nursing Procedures, 6th Edition reflected that urinary catheters must be secured to prevent movement and traction on the bladder neck, reducing infection risk and mucosal trauma.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for one of four medication carts (Hall 100 medication cart) reviewed for labeling and storage. The facility failed to ensure LVN B locked the hall 100 medication cart when it was unattended. This failure could place residents at risk of drug diversion, administration of incorrect medication and compromised resident safety.Findings include: Observation on 4/14/2026 at 2:10 PM revealed the medication cart was at the nurse's station with the drawers closed but was unlocked and unattended for approximately five minutes, with no residents or visitors observed around the medication cart. During an interview on 4/14/2026 at 2:15 PM, the corporate nurse stated the cart should remain locked when unattended and it was left unsecured. During an interview on 4/14/2026 at 2:20 PM, LVN B said he stepped away to talk to the DON about orders for a resident for the medical director and failed to lock his cart. LVN B stated the medication cart should remain locked at all times when not under direct supervision of authorized personnel. The LVN B stated leaving the cart unlocked and unattended was a violation of facility policy and it should have been locked before I stepped away, even for a short time. Record review of the facility's policy titled, Medication Access and Storage (revised 5/2007) reflected: it is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls, The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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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 observations, interviews, and record reviews, 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 2 of 4 residents (Resident #27 and Resident #65) reviewed for Infection Control. The facility failed to correctly identify residents who required EBP. The facility failed to provide consistent identification of residents who required EBP. The facility failed to ensure Resident #65 who had 2 (two) surgically inserted drainage tubes was on EBP. These failures could place residents at risk for the development and transmission of communicable diseases and infections. Findings included: 1.A record review of a face sheet dated 04/15/2026 indicated Resident #27 was an [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses which included dementia and colostomy status. She had no diagnoses to support the use of EBP. A review of a quarterly MDS dated [DATE] noted Resident #27 had a BIMS score of 2 indicating her cognition was severely compromised. She was dependent on staff for most activities of daily living. She was mobile via wheelchair. The MDS did not indicate any factors that Resident #27 would require EBP. A record review of Resident #27's physician's orders did not indicate she was to have EBP. During observations of residents on Hall 400 on 04/13/2026 at 09:15 AM, Resident 27 was noted to have an EBP sign posted at the entrance to her room. There were 2 (two) residents names listed on the doorway nameplate. There was no indication of which of the 2 residents required EBP or if both required it. During an interview with ADON-C on 04/13/2026 at 11:15 AM, she said the EBP sign had been posted at Resident #27's doorway because Resident #27 had a colostomy. She said there was an in-service on 04/10/2026 and she learned colostomies did not require EBP. She said staff forgot to remove the sign from Resident #27's doorway. 2.A record review of a face sheet dated 04/15/2026 indicated Resident #65 was an [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses which included COPD (chronic obstructive pulmonary disease - a chronic lung disease that causes obstructed airflow), surgical after care for pseudoaneurysm (a collection of blood between the layers of an artery or in surrounding tissue) with placement of JP drains (a soft, bulb-shaped surgical device used to remove accumulated fluids from a wound site through gentle suction), pleural effusion (excess buildup of fluid between the thin membranes lining the lungs and chest cavity). A record review of a 5-day MDS dated [DATE] noted Resident #65 had a BIMS score of 6 indicating his cognition was severely impaired. He was dependent on staff for most activities of daily living. The MDS indicated Resident #65 had surgical wounds. A record review of Resident #65's physician's orders indicated he had an order dated 02/20/2026 for EBP due to surgical drains following surgery on the circulatory system. During observations of residents on Hall 400 on 04/13/2026 at 09:27 AM, Resident #65 was noted to have a pink dot beside his name on the door nameplate. There was no EBP sign posted at the entrance to the room. During an observation and interview on 04/13/2026 at 09:32 AM, LVN-F was seen standing in the doorway of room [ROOM NUMBER] on Hall 400. When asked, LVN-F said she did not know what the pink dots on the resident name plates were for. During an observation and interview on 04/13/2026 at 09:33 AM, the AD was seen on Hall 400. the AD said she did not know what the pink dots on the resident name plates were for. During an observation and interview on 04/13/2026 at 09:35 AM, the Transportation Person was seen on Hall 400. She said she did not know what the pink dots on the resident name plates were for. During an observation and interview on 04/13/2026 at 09:40 AM, the PT was seen on Hall 400. When asked, the PT said she did not know what the pink dots on the resident name plates were for. During an observation and interview on 04/13/2026 at 09:45 AM, the DON was noted on Hall 400. She said the pink dots on the resident name plates were placed beside the name of the resident in that room who required EBP. The DON removed the EBP sign at the entrance to Resident #27's room and said Resident #27 did not require EBP without explaining why the sign was posted. The DON (continued on next page)

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	04/15/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said the pink dot beside Resident #65's name on the nameplate meant he required EBP. She said Resident #65 had a sign posted but it must have fallen off. As we walked down the hallway, the DON noted an EBP sign on top of a box on the wall in the hallway and said it was the sign for Resident #65's door. The DON placed the EBP sign at the entrance of Resident #65's room. When asked why 2 (two) rooms on Hall 400 had an EBP sign and a pink dot beside the residents' names, 1 (one) room had an EBP sign but no pink dot to indicate who required EBP, and 1 (one) room had a pink dot beside a name but no EBP sign, the DON said the facility had just started using the pink dots to indicate which resident required EBP. She said the nursing staff working on 04/13/2026 had not been in-serviced on the use of the pink dots. The DON said an EBP posted on the doorway into a resident's room indicated someone in that room required EBP. She said the pink dot on the nameplate identified which resident in the room required the EBP. During an interview on 04/14/2026 at 09:01 AM, RN-E said she was the IP nurse. She said residents who required EBP would have an EBP sign posted at the doorway to their rooms. She said a pink dot would be posted beside the name of the resident in the room who required EBP. She said an PPE caddy would be hung on the outside of the closet door of the every resident who required PPE. She said half of the nursing staff were in-serviced on EBP on Friday, 04/10/2026 and the other half were to be in-serviced the next week. During an interview on 04/14/2026 at 02:01 PM, the DON said she, the ADONs, and the IP Nurse worked together to monitor EBP use. She said they reviewed the 24-hour report daily and checked postings for EBP to ensure EBP were initiated and discontinued as indicated. Record review of the facility's undated policy titled Enhanced barrier Precautions Policy indicated the following: Training and Implementation: Staff Awareness and Training1.All staff members will receive initial training on EBP upon hire and annually thereafter. 2.Training will include identification of when EBP are needed; which residents should be placed in EBP.3.Nursing staff ensures that the resident and staff are aware of need to use EBP.a.Posting outside of roomMonitoring and AdherenceThe Infection preventionist ensures that regular audits of staff adherence to EBP guidelines are conducted. Any deviations from protocol should prompt additional training and education efforts.

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	676048	A. Building B. Wing	04/15/2026

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to post their most recent survey of the facility in an area of the facility accessible to residents, and family members and legal representatives of residents, in 1 of 1 survey binder. The facility failed to ensure the most recent standard survey dated 02/12/2025 was readily available within the survey binder. This failure could place residents at risk for not having access to current information regarding the facility's compliance with federal and state regulations, limiting their ability to make informed decisions and exercise their rights. The findings include: An observation on 04/13/2026 at 3:25 PM revealed the survey binder located within the facility next to the front entrance. Review of the binder indicated it did not include the results from the most recent standard survey completed 02/12/2025. During an interview on 04/13/2026 at 3:35 PM, the ADM indicated he was responsible for ensuring the survey binder was up to date. The ADM indicated he believed the most recent standard survey to be located within the binder. The ADM reviewed the survey binder and recognized the most recent standard survey was not located inside. The ADM indicated the potential risk to residents would include if a resident requested to review the survey results and he was not present at the facility it would not be readily available. The ADM indicated he understood it was a residents right to review the most standard survey results without having to ask for them. The ADM indicated it was an oversight on his part to not have the most recent standard survey results available for residents to review. During a confidential group interview at an undisclosed date and time, 8 confidential residents indicated they did not have access to the most recent standard survey results and they would like to review them. Record review of a facility policy revised 05/2025 titled Required Postings did not address the requirement to post the most recent standard survey results of the facility in an area of the facility accessible to residents, and family members and legal representatives of residents.

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	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post the nurse staffing data on a daily basis, in a clear and readable format and in a prominent place, and readily accessible to residents and visitors that included the facility name, the number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care for 7 of 7 days (April 7-13, 2026) reviewed for posting of nurse staffing data. The facility failed to post the required nurse staffing information on 04/07/2026, 04/08/2026, 04/09/2026, 04/10/2026, 04/11/2026, 04/12/2026, and 04/13/2026. This failure could place residents at risk for adverse resident outcomes due to understaffing and loss of public trust. Findings included: During an observation on 04/13/2026 at 08:35 AM, the nurse staffing data for 04/06/2026 was noted to be posted on the wall at the beginning of Hall 300. There was no daily nurse staffing data was posted for 04/13/2026. During a second observation on 04/13/2026 at 09:15 AM, the nurse staffing data for 04/06/2026 was still posted on the Hall 300 wall. There was no posting of the daily nurse staffing data was posted for 04/13/2026 anywhere in the facility. During an interview with ADON-C and ADON-D, they said the nursing staffing data was posted so residents and their families would know how the facility was staffed for the current day. They said the failure to post the nursing staffing data prevented that information from being shared with those who were interested. They said they and the DON worked together to monitor the posting of the nursing staffing data. During an interview with the DON on 04/13/2026 at 10:54 AM, she said the Staffing Coordinator was responsible for posting the daily nurse staffing data. She said she and the ADONs shared the responsibility for monitoring the posting of the nurse staffing information. She said the posting of the nursing staffing data had not been posted for the day of 04/13/2026. When shown the 04/06/2026 date of the nursing staffing data posted on Hall 300, the DON said it had not been posted for a week. During an interview with the DON and the Staffing Coordinator on 04/06/2026 at 11:01 AM, the Staffing Coordinator nodded her head yes when asked if she was responsible for posting the nurse staffing data daily. The DON said the Staffing Coordinator had been filling in by working the night shifts lately. She said the posting of the nurse staffing data was overlooked because the Staffing Coordinator had been filling working the night shifts. A review of the facility's policy dated 05/2007 and titled Staffing Numbers, Posting indicated the following: Policy: It is the policy of this facility to post staffing numbers.1. Post the number of staff working who are directly responsible for resident care.2. To comply with the Benefits Improvement and Protection Act of 2000, the facility must include hours worked by Registered Nurses, Licensed Practical/Vocational Nurses, and Nursing Assistants for each shift.3. Post prominently in a public area in readable font on a surface of at least 8.5x11 inches. The policy did not include any instructions on how often the nurse staffing data was to be posted.