STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676092	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Jacksonville	810 Bellaire St. Jacksonville, TX 75766

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental and psychosocial needs for 1 of 8 residents (Resident #1) reviewed for care plans. The facility failed to develop a comprehensive care plan that included Resident #1's enhanced barrier precautions related to her feeding tube.This failure could place residents at risk of not having individual needs met and cause residents not to receive needed services.Findings included:Record review of Resident # 1's facility face sheet revealed Resident #1 was a [AGE] year-old female and admitted on [DATE] with diagnosis of encounter for gastrostomy (a tube placed in the stomach to assist with feeding). Record review of Resident 1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 12 indicating intact cognition, relied on staff for all ADL's, was incontinent of bowel and bladder, and required a feeding tube. Record review of Resident #1's comprehensive care plan dated 10/08/2025 revealed Resident #1 required a feeding tube but did not address EBP.Record review of Resident #1's consolidated orders revealed Resident #1 did not have an order for EBP.During an interview on 11/10/2025 at 2:47 pm, the MDS said she was responsible for completing MDS assessments and the comprehensive care plan. She said, with Resident #1, she admitted to the facility with a feeding tube and her comprehensive care plan should have reflected that EBP was required. She said that a comprehensive care plan should have all the resident care areas, interventions and goals. If a care plan was not completed thoroughly and accurately, the residents could have an adverse reaction or change in condition. During an interview on 11/10/2025 at 3:00 pm, the DON said the MDS nurse was responsible for completing the comprehensive care plan accurately and completely. She said that a resident requiring EBP should be care planned as such. She said there was a regional nurse that oversaw the care plans, and they had a plan to start a care plan review to audit all care plans in the facility. She said an incomplete care plan could affect resident care. During an interview on 11/10/2025 at 4:12 pm, the Regional Reimbursement Nurse said that she was responsible for oversight of the care plans, and she had recognized an issue with the care plans last week. She said she had discussed her findings with the team today about a plan to correct them but had not gotten that plan in place. She said inaccurate care plans could result in a lapse of care. During an interview on 11/10/2025 at 4:17 pm, the Administrator said the DON was responsible for the oversight of the care plans, but ultimately fell on her. She said the regional reimbursement nurse came weekly as well and had identified an issue with the care plans last week, but they had not yet put a plan in place to correct the issue. She said they were looking to start an audit today. She said she expected all comprehensive care plans to be completed accurately and thoroughly to prevent delays in resident care. Record review of an undated facility policy titled Comprehensive Care Planning indicated, .The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.

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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 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 1 of 4 residents (Resident #1) reviewed for infection control. The facility failed to ensure CNA A and LVN B followed enhanced barrier precautions and wore a gown and gloves when providing incontinent care to Resident #1 on 11/10/2025. This failure could place residents at risk for cross contamination and infection. Findings included: Record review of Resident # 1's facility face sheet revealed Resident #1 was a [AGE] year-old female and admitted on [DATE] with diagnosis of encounter for gastrostomy (a tube placed in the stomach to assist with feeding). Record review of Resident 1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 12 indicating intact cognition, relied on staff for all ADL's, was incontinent of bowel and bladder, and required a feeding tube. Record review of Resident #1's comprehensive care plan dated 10/08/2025 revealed Resident #1 required a feeding tube, but did not address EBP.Record review of Resident #1's consolidated orders revealed Resident #1 did not have an order for EBP.During an observation on 11/10/2025 at 10:03 am, LVN B and CNA A entered Resident #1's room to reposition her and provide incontinent care. During care, it was observed that the resident had a feeding tube. Neither LVN B nor CNA A had applied PPE before providing care to Resident #1 who had a feeding tube in place. There was no sign on Resident #1's door indicating EBP was required. During an interview on 10/11/2025 at 10:19 am, CNA A said that if a resident needed EBP, there would be a sign on the door and PPE outside the door. She said she provided care to Resident #1, and she did have a feeding tube and should be on EBP. She said she failed to put on PPE when she and the nurse gave care and by doing so infections could spread. During an interview on 10/11/2025 at 10:25 am, LVN B said that any resident that had a wound, feeding tube, or device like an intravenous catheter should be on EBP. She said she was not sure why Resident #1 did not have a sign and PPE outside her room, and she had forgotten when she and CNA A provided care. She said when residents were on EBP a gown and gloves must be worn with direct contact patient care. She said the ADON and the DON were responsible for putting out the signs and PPE, but she should have known. She said by not following EBP infections could spread.During an interview on 11/10/2025 at 10:31 am, the DON said she was the infection prevention nurse and she and the ADON were responsible for ensuring the residents that required EBP that those measures were in place. She said she overseen the staff to ensure they were following the program and Resident #1 had moved rooms and they failed to ensure the EBP sign, and PPE followed her. She said she expected that all staff followed the EBP program for all residents to prevent the spread of infections.During an interview on 11/10/2025 at 4:17 pm, the Administrator said the DON was responsible for the infection control and EBP program in the facility. She said there were clinical meetings every morning and EBP was discussed. She said the staff were notified verbally and there was a sign posted on the door as well to indicate EBP. She said she expected all staff to always follow the EBP program and if they were unsure, they needed to ask. She said if staff were not following EBP infections could happen. Record review of the facility's policy titled Enhanced Barrier Precautions dated 4/01/2024 indicated, .Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.