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	02/24/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored securely for one of six halls (Hall 400) reviewed for storage of medications. The facility failed to ensure all drugs and biologicals were securely stored when LVN A took possession of hydrocodone-acetaminophen tablets and kept them for approximately 2 hours while charting. This failure placed residents at risk for drug diversion and consuming non-prescribed medication.Findings included: 1. Record review of Resident #1's face-sheet revealed an [AGE] year-old male, initially admitted to facility on 10/17/23, and readmitted on [DATE]. Resident's diagnosis included: Type 2 Diabetes, senile degeneration of brain (age-related cognitive decline), and unspecified dementia (altered cognition). Record review of a facility Controlled Substance Report indicated Resident #1 was ordered hydrocodone-acetaminophen 5-325 mg 1 tablet by mouth every 8 hours as needed for pain with a last fill date 1/15/2026 for a 30-day supply (90 tablets). The next fill date was indicated to be 2/10/2026. Record review of a statement dated 2/10/26 written by LVN A indicated .At approximately 3:00pm I was handed 45 pills of hydrocodone for a resident. I set card down beside me and continued to chart for 2 more hours when I got distracted and answered to a resident's needs without securing narcotics and when I returned medication card was missing. I searched all med carts, med rooms, supply closets and treatment cart. I was unable to locate medication. Immediately notified ADON and administrator. Record review of Resident #1's progress note dated 2/19/26 at 4:56 p.m. indicated Resident #1 had orders for Hydrocodone-Acetaminophen oral tablets every 8 hours as needed for moderate-severe pain. Record review of the narcotic administration log indicated Resident #1 received hydrocodone-acetaminophen on 2/10/26 at 7:30 a.m. and had 30 tablets remaining. During an interview and observation on 2/24/26 at 10:00 a.m., Resident #1 was sitting in a wheelchair in a common area watching television. Resident #1 appeared calm and in no acute distress. There was no facial grimacing, or observable signs of physical distress were noted. Resident #1 said he took medication for pain, as needed. Resident #1 said his medication was always available when he asked for it, and it was effective at controlling his pain level. During an interview on 2/24/26 at 11:35 a.m., LVN B said she worked on 2/10/26, the day the hydrocodone-acetaminophen tablets went missing. LVN B said she saw LVN A take delivery of the medications, but she did not see if she locked the medication up or not. LVN B said she didn't see the medication lying out in the open. LVN B said she did not note any residents standing near the nurse's station or reaching over nurse's station counter during the timeframe. LVN B said she assisted in searching for the medication but was unable to locate it. During an interview on 2/24/26 at 2:05 p.m., LVN C said she worked 2/10/26; the day the hydrocodone-acetaminophen tablets went missing. LVN C said she saw LVN A take delivery of the medication but did not know she didn't lock it up in the med cart. LVN C said she didn't see the medication lying out (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the open at any point. LVN C said she was out of the facility on break when the medication went missing. During an interview on 2/24/26 at 2:15 p.m., LVN A said on 2/10/26 at approximately 3:00 p.m., she received hydrocodone tablets for Resident #1 from the pharmacy. LVN A said after another nurse signed with her to receive the medication, instead of locking the medication in the medication cart, she placed it on the desk in front of her computer and began charting for approximately 2 hours. LVN A said she should have immediately locked the medication away. LVN A said she got up to assist another resident and forgot about the medication. LVN A said when she returned to the nurse's station, the medication was gone. LVN A said she searched for the missing medication and alerted the DON and ADM immediately. LVN A said staff were unable to locate the medication. LVN A said Resident #1 had ample supply of the medication on hand and did not miss any doses. LVN A said she completed a pain assessment on Resident #1 post-incident and noted no pain. LVN A said the facility interviewed all staff working on the unit at the time, assessed all residents taking similar medications, audited the narcotic administration log, and thoroughly searched all areas in and around the nurse's station. During an interview on 2/24/26 at 2:30 p.m., the DON said she had only worked at the facility for 6 days and was aware of the allegation but had no direct knowledge. The DON said she was responsible for supervision of the nursing staff, and her expectation was for controlled medications to be immediately locked up for safe keeping when received. The DON said risks to residents for unsecured medication could be a resident consumed a medication they were not prescribed. During an interview on 2/24/26 at 2:45 p.m., the ADM said she was notified of the missing medication immediately after it went missing. The ADM said she went to the unit and assisted in searching for the medication but was unable to locate it. The ADM said all staff working the unit were interviewed and all nurses working the South halls were drug-tested with no positive results. The ADM said all controlled medication logs were audited and all residents who took similar medications received assessments. The ADM said Resident #1 had a sufficient supply of medication on the med cart and no missed doses occurred. Record review of facility policy Controlled Medication - Ordering & Receipt dated 2025 indicated .Medications listed in Schedule II, are stored under double lock in a locked cabinet or safe designed for that purpose, separate from all other medications.