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	05/11/2026

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 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 interviews and record reviews the facility failed to ensure all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegations were made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility for 1 of 4 (Resident #3) residents reviewed for abuse.LVN B failed to report an allegation of verbal abuse from CNA A involving Resident #3 to the Administrator immediately but no later than 2 hours on 5/1/2026.This failure could place residents at risk of abuse.Findings included:Record review of an admission Record for Resident #3 dated 5/11/2026 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of neurocognitive disorder with Lewy bodies (a progressive brain disorder leading to a decline in cognition, movement and behavioral changes) major depressive disorder (a persistent sadness or loss of interest in doing things) and Parkinsonism (a term used to describe slowed movements, stiffness, tremors and balance issues).Record review of a care plan for Resident #3 dated 5/4/2026 indicated he had a history of trauma that may have a negative impact related to alleged verbal abuse received by staff. Interventions included to monitor for escalating anxiety, depression or suicidal thoughts and report immediately to the nurse.Record review of a Quarterly MDS Assessment for Resident #3 dated 2/26/2026 indicated he was unable to complete the interview with a score of 99. He was dependent on staff for all ADLs.Record review of a care plan for Resident #3 dated 2/25/2026 indicated he had impaired cognitive function/dementia or impaired thought processes. Interventions included to communicate with the residents, family/caregivers regarding resident's capabilities and needs.Record review of a PIR dated 5/3/2026 indicated a report was sent to the state agency with an allegation of Abuse from an incident that occurred on 5/1/2026 involving Resident #3. LVN B stated she heard CNA A say to Resident #3 you better be glad that didn't hit me or I would've slit your throat. The incident occurred on 5/1/2026 but staff did not report to the Administrator until 5/3/2026.During an observation and interview on 5/3/2026 at 10:09 am, Resident #3 was sitting in a specialized chair asleep with CNA A present. CNA A said Resident #3 did not really speak and he did not wake up when Surveyor called his name.During an interview on 5/3/2026 at 10:11 am, CNA A was sitting in the tv room by Resident #3 in a chair. She said she had been employed at the facility for 18 years. She said when Resident #3 was alert he never said much. She said he ate a mechanical soft diet and had to be fed all of his meals. She said sometimes when staff fed him, he would spit out his food. She said last Friday (5/1/2026) she informed RN C that he spit out his tea during the evening meal and RN C told her to give him something else to drink. She said the Administrator called her that Sunday (5/3/2026) along with the DON who was on the phone that an incident occurred when someone said that she would cut Resident #3's throat. She said she did not say that. She said the tv was loud and RN C was right behind her by a medication cart. She said Resident #3 never spit at her and spit in a different direction.During an interview on 5/3/2026 at 10:37 am, RN C said she had been employed at the facility since 2023. She said she worked on 5/1/2026 along with CNA A. She said she overheard CNA (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	A say that Resident #3 did not want any food, and she asked CNA A if Resident #3 would take a shake. She said CNA A replied back that he had spit it out. She said CNA A was sitting by Resident #3 the entire time and he spit his food out in front of him and not at CNA A. She said she did not hear the entire interaction but was told Resident #3 spit out his food. She said she was contacted by the DON to provide a statement after the incident.During an interview on 5/11/2026 at 11:29 am, LVN B said she worked part time at the facility since February 2026 but had been employed since September 2025. She said on 5/1/2026 she arrived at work at the facility at about 5:45 pm for her shift and had just counted the medication cart with RN C. She said it was loud on that evening and all of a sudden, she heard some yelling in the dining area. She said CNA A was giving Resident #3 some orange juice and he had spit it out. She said she did not see Resident #3 spit it out but did see the orange juice on the floor. She said she heard CNA A say, you better be glad that did not hit me, or I would have slit your throat. She said she did not do anything at that point. She said CNA A was upset about the schedule and she asked another staff member if what she had heard was something she needed to report. She said it was reported to the DON a few days later. She said she thought CNA A made the statement because she was stressed about the schedule. She said CNA A was a great staff member and felt like it was said out of anger and her mood but did not think she would ever harm anyone. She said if she witnessed any abuse/neglect she would report it immediately to the Administrator/DON and verbalized the abuse coordinator was the Administrator. She said she was now aware that any incident of abuse must be reported immediately to the DON/Administrator and by not reporting in a timely manner residents could be at risk for further abuse that was unseen. She said in her mind CNA A was a good nurse aide and thought what CNA A said she did not mean it, and then when one of the night nurses said she needed to report it they did.During an interview on 5/11/2026 at 12:48 pm, the DON said she had been employed at the facility for 2 1/2 months. She said she spoke to LVN B on 5/3/2026 following the incident on 5/1/2026 who stated she overheard CNA A while she was passing medications say something like Resident #3 spit on the floor and CNA A said if it hit her, she would have slit Resident #3's throat. She said LVN B stated the incident happened on 5/1/2026 and immediately educated LVN B on the importance of reporting timely for any allegations of abuse. She said there could be risk of abuse going undetected and other residents could be affected if not reported timely. She said the abuse should be reported immediately to the Administrator and then down the chain. She said CNA A was suspended pending the investigation.During an interview on 5/11/2026 at 1:02 pm, the Administrator said she had been at the facility for 3 years. She said she was the abuse coordinator for the facility and was responsible for reporting incidents to the state agency. She said she received a text message from the DON on 5/3/2026 that LVN B informed her that she heard CNA A verbally abuse Resident #3 after he spit out his juice. She said the incident occurred on 5/1/2026 but she was not notified until 5/3/2026. She said the staff were aware they should have reported it to her immediately and have since been retrained. She said during her investigation the only staff that heard CNA A verbally abuse Resident #3 was LVN B. She said RN C was directly behind CNA A and Resident #3 at the time of the incident and denied CNA A saying that. She said if no one reported abuse timely then the abuse could continue.Record review of a facility policy titled Abuse/Neglect undated indicated, .The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. 3. Verbal abuse: examples include but are not limited to threats of harm; E. Reporting: 1. Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse must report this to the DON/Administrator. State law mandates that citizens report all suspected cases of abuse. 2. When a suspected abuse or potential victim comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee. If the discovery occurs outside of normal business hours, the Abuse Preventionist and/or designee will be called. A. If the allegations involve abuse or result in bodily injury, the report is to be made withing 2 hours of the allegation.