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	04/29/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs for 1 of 5 residents (Resident # 63), and 5 of 5 medication carts (LVN Cart N#100/200, LVN Cart N#200/300, LVN Cart S#400, RN Cart S#500, and LVN Cart S#600), reviewed for pharmacy services. *LVN D failed to use the proper technique for administration of eye drops for Resident #63 on 4/28/2026. *LVN E signed the controlled substance count sheets for the end of their shift at the beginning of their shift on LVN Cart N#100/200 on 04/29/2026. *LVN D signed the controlled substance count sheets for the end of their shift at the beginning of their shift on LVN Cart N#200/300 on 04/29/2026. *LVN A did not sign the controlled substance count sheets at the beginning of their shift on LVN Cart S#400 on 04/29/2026. *RN C signed the controlled substance count sheets for the end of their shift at the beginning of their shift on RN Cart S#500 on 04/29/2026. *LVN B did not sign the controlled substance count sheets at the beginning of their shift on LVN Cart S#600 on 04/29/2026. These failures had the potential to place residents at risk for not receiving the intended therapeutic effect of prescribed medications, ineffective treatment, administration of medications that are no longer safe or effective, and inaccurate medication control practices, which could lead to potential resident harm. Findings included: Resident (#63), named in the allegation, was a 74- year-old female who admitted to the facility on [DATE]. She had diagnoses which included Chronic obstructive pulmonary disease, depressive disorder, dysphagia (difficulty swallowing), hypothyroidism, hypertension, chronic viral hepatitis C, contracture left hand, cognitive communication deficit, failure to thrive, and myalgia (muscle pain or aches). According to a Minimum Data Set (MDS) dated [DATE] she had a BIMS score of 15 indicated cognitive function intact.A review of physician orders dated 04/29/2026 indicated Artificial Tears Ophthalmic Solution 1.4 % (polyvinyl phone alcohol) instill 1 drop in both eyes three times a day for dry eyes start date 04/08/2024. 1.Observation on 4/28/2026 at 10:10 a.m., revealed during a medication pass observation, the surveyor observed LVN D administer eye drops to Resident #63. LVN D assembled the required equipment and followed general aseptic technique (creating a designated area free from microorganisms). However, LVN D failed to use the proper technique for administration of eye drops. Specifically, LVN D did not don (to put on) gloves, did not gently pull the resident's lower eyelid down to create a conjunctival pocket (a small pocket), and did not instruct the resident to look upward during installation of the eye drops. During an interview on 4/28/2026 at 10:30 a.m., LVN D said she had been trained in the proper administration and care of eye drops, and further said improper administration may reduce medication effectiveness. LVN D stated the correct technique included maintaining aseptic technique, don (to put on) gloves, instructing the residents to look upward toward the top of their head, and gently lowering the lower eyelid to create a conjunctival sac to ensure the eye drop is properly instilled. During an interview on 4/28/2026 at 11:40 a.m., the Director of Nursing (DON) stated that nursing staff were trained in the proper administration of eye drops, including the facility guidelines and procedural steps. After reviewing the facility policy and professional standards of practice, the DON acknowledged that steps of the procedure were not (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	followed during the observed medication administrations. The DON said she was responsible for training and monitoring staff to ensure medication is administered correctly and that all protocols are followed, she further said that all nursing staff would be re-in-serviced on the proper technique for the administration of eye drops. A record review of the facility policy on Instillation of Eye Drops (PCU037-Eye Application of eyedrops/ointments) dated 3/2025 indicated. # 2 Steps in the Procedure: Wash hands, don (to put on) gloves, Use aseptic technique.Application of Eye Drops/Ointments:Gently pull the lower eyelid down. Retract lower lid (Make a pocket). Instruct the resident to look up.Drop the medication into the mid lower eyelid fornix (Conjunctival fornix is the loose, folded, pocket-like tissue joining the inner eyelid to the eyeball surface).Do not allow the eye drop to fall onto the eyeball. 2. During an observation on 4/29/2026 at 9:35 AM. RN C signed the controlled substance count sheets for both the oncoming and off-going shift count at the beginning of the shift on RN Cart S#500 on 04/29/2026 a 6am to 6pm shift. During an observation on 4/29/2026 at 9:38 AM.LVN D signed the controlled substance count sheets for both the oncoming and off going shift count at the beginning of the shift on LVN Cart N#200/300 on 04/29/2026 a 6am to 6pm shift. During an observation on 4/29/2026 at 9:40 AM.LVN E signed the controlled substance count sheets for the oncoming and off going shift count at the beginning of the shift on LVN Cart N#100/200 on 04/29/2026 a 6am to 6pm shift. During an observation on 4/29/2026 at 9:43 AM.LVN A did not signed the controlled substance count sheet at the beginning of her shift on LVN Cart S#400 on 04/29/2026 a 6am to 6pm shift. During an observation on 4/29/2026 at 9:44 AM. LVN B did not sign the controlled substance count sheets at the beginning of their shifts. On LVN Cart S#600 on 04/29/2026 a 6am to 6pm shift. During an interview on 04/29/2026 at 09:45 AM., with RN C, she stated she was aware that the off going controlled substance count documentation should not be signed until the end of her shift. She said this practice may result in inaccurate medication counts, and failure to identify discrepancies. During an interview on 04/29/2026 at 09:47 AM., with LVN D, she said nurses should not sign the narcotic count sheet for the off-going shift until the end of the correct narcotic count. She said signing the controlled substance count documentation ahead of time creates a risk that the actual narcotic count was not verified at the time of shift change. During an interview on 04/29/2026 at 09:50 AM., with LVN E, said she was aware that nurses should not sign the narcotic count sheet for the off-going shift until the end of narcotic count, or they were leaving their shift. She further said this practice could delay detection of missing controlled substances. During an interview on 04/29/2026 at 09:55 AM., with LVN A, she stated she was aware that nurses should sign the narcotic count sheet in agreement with the off-going shift after completion of the narcotic count. She said forgetting to sign the controlled substances count at shift change could create the potential for inaccurate narcotic accountability. During an interview on 04/29/2026 at 09:59 AM., with LVN B, she stated she was aware that the narcotic count sheet should be signed after each medication counted agreed with the quantity stated on the controlled count record. She said the controlled substance count was completed with the off going nurse but forgot to sign the substance-controlled sheet. She said this practice could create the potential for inaccurate narcotic accountability. Durning an Interview on 04/29/2026 at 12:00 PM., with the DON, she stated nurses should only sign and acknowledge the controlled drug count after verifying the medications on hand and confirmed the quantity of each medication matched the quantity documented on the controlled drug count record. She further stated she was not aware staffs nurses were not signing the count sheets at the correct times, and it was the DON responsibility to monitor the nurses. The DON said controlled medication accountability records and audits record are kept on the medication cart. When completed, audit and accountability records are submitted to the DON and kept on file. A record review of the facility's sign on/off sheet on 04/29/2026 at 12:30 PM., indicated signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication counted were in agreement with the quantity stated on the Controlled Drug-Count Record. A record review of the facility's policy and procedure document titled Controlled Medications-Administration, dated 3/2025 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II -V of the comprehensive Drug Abuse and Control Act of 1976) revised November 2022.#8. Nursing staff coming on duty and nurses going off duty make the count together and document and report any discrepancies to the director of nursing services.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care for 1 of 4 residents (Resident #92) reviewed for care plans. The facility failed to ensure Resident #92 had a baseline care plan that included interventions to address his admission diagnoses and physician orders within 48 hours of admission. This failure could place newly admitted residents at risk of receiving inadequate care and services.Findings included: A record review of a face sheet dated 04/28/2026 indicated Resident #92 was an [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses which included pneumonia (infection of the lungs), chronic congestive heart failure (known as CHF, a chronic, progressive condition where the heart cannot pump blood efficiently causing fatigue, swelling, and shortness of breath), chronic kidney disease (kidney damage leading to causing the kidneys to work less efficiently), chronic obstructive pulmonary disease (known as COPD, a progressive, incurable lung disease that causes obstructed air flow , making it difficult to breathe), malignant neoplasm of the prostate (cancer of the prostate), osteoarthritis (a degenerative joint disease leading to pain, stiffness, and reduced mobility), and weakness. A review of the physician's orders dated 02/06/2026 indicated Resident #92 had allergies to aluminum hydroxide, calcium carbonate, cefdinir, magnesium carbonate, magnesium hydroxide, and Protonix. A record review of an admission MDS dated [DATE] indicated Resident #92 had a BIMS score of 00 which indicated he had difficulties with short-term memory, orientation, and attention and required extensive assistance with most of his activities of daily living. A review of the medical records indicated Resident #92 did not have a baseline care plan. A review of the progress notes dated 02/14/2026 indicated Resident #92 discharged from the facility on 02/14/2026. During an interview with the DON on 04/28/2024 at 01:45 PM, she said a 48-hour care plan should have been completed when the charge nurse admitted Resident #92. She said the completion of the Nursing admission Assessment was designed to identify any assessment findings of concern and trigger them for the baseline care plan. The DON said Resident #92's Baseline care Plan was not completed because the Nursing admission Assessment was incomplete. The DON said she was new to the facility and was not sure who was responsible for ensuring the Baseline Care Plans were completed. She said the purpose of the Baseline Care Plan was to provide directions for caring for a resident and without it, a resident could be at risk for not receiving the care and services he or she requires. A record review of the facility's undated Baseline Care Plan policy indicated the following: Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission.The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. 1. The baseline care plan will:a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:i. Initial goals based on admission orders. ii. Physician orders. iii. Dietary orders.iv. Therapy services. v. PASARR recommendation, if applicable .