STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676113	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Center -	2003 W Hutchins Place San Antonio, TX 78224

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents the right to reside and receive services in the facility with reasonable accommodation of resident needs for 1 of 7 Residents (Resident #3) whose records were reviewed. The facility failed to ensure Resident #3's call light was within reach so he could ask for help as needed. This deficient practice could result in residents not being able to ask for assistance as needed. The findings were:Record Review of Resident #3's face sheet, dated 5/15/26, revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including unspecified Dementia, generalized weakness and below the knee amputation/right lower extremity. Record Review of Resident #3's admission MDS assessment, dated 4/27/26, revealed Resident #3's BIMS score was 9 of 15 reflecting moderate cognitive impairment and he required partial/moderate assistance to total assistance with ADLs. Review of Resident #3's Care Plan, dated 4/26/26, revealed Resident #3 had ADL Self Care Performance Deficit related to generalized weakness, gait/balance problems and below the knee amputation/right lower extremity and Resident #3 was at risk for falls related to gait/balance problems. One of the interventions included for staff to anticipate needs and to make sure the call light was within reach and encourage to use it to call for assistance as needed. Observation and interview on 5/12/26 at 3:07 PM with Resident #3 and the DON revealed Resident #3 was lying in bed with quarter side rails up on both sides of the bed. Resident #3 stated he was doing well. He presented as being alert with confusion. Further observation revealed the call light was placed on top of chair next to Resident #3's bed behind his line of sight. The bedside table was pushed over the chair and then there was a wheelchair in front of the bedside table. Resident #3 stated he would use the call button to call staff for help but stated he did not know where it was. Interview with the DON revealed the call light was on top of the chair and she stated staff probably did not put it back on the bed, but staff should make sure the call light was within Resident #3's reach so he could ask for help as needed. Interview on 5/13/26 at 11:31 AM with the DOR revealed she had worked in her position since 2021/2022. The DOR stated the rehabilitation staff should ensure the call light was within reach after providing services in the resident's room. Otherwise, the residents would not be able to ask for assistance as needed. The DOR stated Resident #3 was new to the facility, had ADL deficits and was considered to be a fall risk; therefore, it was important that he had access to the call light so he could ask for help and to help prevent falls. Review of facility policy, Policy/Procedure - Nursing Clinical, subject: call light/bell read It is the policy of this facility to provide the resident a means of communication with nursing staff. 5. Leave the resident comfortable. Place the call device within resident's reach before leaving the room.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to treat the decisions of a resident representative as the decisions of the resident to the extent delegated by the resident for 1 of 1 Resident (Resident #1) whose records were reviewed. The facility failed to provide Resident #1's representative with Resident #1's medical records per oral and written request. This deficient practice could result in the residents or family members not having access to medical records. The findings were:Record Review of Resident #1's face sheet, dated 5/14/26, revealed she was admitted to the facility on [DATE] with diagnoses including orthostatic hypotension (when blood pressure drops significantly upon standing from a sitting or lying position), personal history of malignant neoplasm of breast (code applies to patients who have been previously diagnosed with breast cancer, but are currently in remission or cancer free and it is not considered a current illness or injury) and acquired absence of right breast and nipple. Further review revealed a family member was identified as emergency contact #1. Resident #1 was discharged from the facility on 5/4/26. Record Review of Resident #1's entry MDS assessment, dated 5/1/26, revealed her BIMS score was 5 of 15 reflective of severe cognitive impairment and participation in assessment and goal setting included the resident and a family member. Record Review of Resident #1's Authorization for Disclosure of Medical Information, dated 4/30/26, revealed Resident #1's family member was designated as the representative and Resident #1 preferred a family member to sign the document. Record Review of Resident #1's Resident admission Agreement, dated 4/30/26, revealed Resident #1 elected a family member as her family representative. Record Review of an email, dated 5/5/26, and addressed to the DON revealed Resident #1's family member requested the following documents:A copy of any incident report (s) related to this eventAll nursing and clinical notes from the date of the incidentThe names and titles of all staff involved, including the third party lab company, and technicianYour facility's written policies regarding limb alert restrictions and blood drawsAny internal documentation or timeline of when this incident was first recognized and addressedCT scan results of right arm, requested by family on 05/03/26. Record Review of an email, dated 5/11/26, written by the ADM and addressed to Resident #1's family member read With respect to records, the facility can provide copies of the resident's medical records in accordance with applicable state and federal privacy laws. To do so, we must receive a completed medical records authorization from the legally authorized representative. Once that authorization is received, we will process the requested medical records promptly. Much of the clinical information you are requesting, including test results, will be reflected within those records. Interview on 5/13/26 at 10:05 AM with the DON revealed Resident #1 was in the facility for about a week. She stated Resident #1's family member was very upset with her and the facility in general because Resident #1 had a mastectomy some years back and the lab tech drew blood from Resident #1's restricted arm. The DON stated they had a sign over Resident #1's bed and Resident #1 was wearing a bracelet which indicated the restrictions, but the lab tech stated he missed it. The DON stated she attempted to schedule a meeting with Resident #1's family and other family members to discuss their concerns, but she and the family member did not reach an agreement on a date and time. The DON stated Resident #1's family member requested a copy of Resident #1's entire medical records but would not provide a POA which she stated was requested from onset, Resident #1's admission. The DON stated Corporate advised that Resident #1's family member would have to provide a POA in order for the facility to release any medical records. The DON stated she understood the resident and resident representative had a right to request and obtain medical records but stated she had to follow protocol. Interview on 5/13/26 at 3:44 PM with Resident #1's family member revealed he wrote a letter to the facility case manager and to the DON requesting Resident #1's medical records and he also had a telephone conversation with the DON and requested Resident #1's (continued on next page)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical records at that time. Resident #1's family member stated the DON told him they would release Resident #1's medical records once he provided an authorization for release for medical records and a POA to the facility. The family member stated the ADM responded on 5/11/26 to the email requests he submitted and stated the facility would release Resident #1's medical records upon receiving an authorization from Resident #1's legal representative. Resident #1's family member further stated he also left a message for the medical records staff, LVN B, requesting Resident #1's medical records. He stated they never talked. Resident #1's family member stated he believed the facility was not going to release medical records unless he provided a POA. The family member stated he had been Resident #1's primary caregiver for years and he signed all of the admitting documentation upon Resident #1's admission to the facility. He stated he believed that sufficed. Telephone interview on 5/14/26 at 9:35 AM with LVN B, medical records staff, revealed she had been in her position for about 8 to 9 years. She stated when releasing medical records, she would usually talk with the resident if the resident was their own RP and would request permission to release their records. LVN B stated if the resident had an assigned RP or emergency contact, she would be able to release the resident's medical records with an authorization for release of medical records. She stated the legal team would then verify the resident's POA status. LVN B stated usually the turnaround period for getting medical records ready was 48 hours. LVN B stated the receptionist let her know Resident #1's family member left a message requesting medical records and she attempted to call Resident #1's family member on the same date the family member called. She stated the first time she called; she left a message and the second time the family member's phone rang but she was not provided with an option to leave a message. LVN B stated she understood it was the resident's right or family representative's right to receive the resident's medical records upon request; however, she stated she had to follow facility protocol. Interview on 5/14/26 at 8:30 PM with the ADM revealed he talked with the facilities' legal team, and they advised him that he would only be able to release Resident #1's medical records to Resident #1's family member upon the family member providing a POA. The ADM stated in the 20 plus years he had been an administrator, he had always requested a POA. He stated he understood Resident #1 had a right to a copy of her medical records and if the family member wanted a copy of Resident #1's medical records he had to provide an authorization for release of medical records. Once that was completed the request was sent to their legal team and Resident #1's family member would be asked to provide a POA. The ADM further stated he understood Resident #1's family member was active in Resident #1's care, but he also had to follow facility protocol. Review of facility policy, Resident Rights, dated 10/25, read It is the policy of this facility that Our residents have certain rights and protections under federal and state law that help ensure they receive the care and services necessary. One essential job function is to protect and promote our residents' rights. 8. A resident may authorize the release of personal and clinical records as provided by law. Review of facility policy, Medical Records, undated, read It is the policy of this facility to ensure every resident has an accurate record. 9. If records are requested by family, a medical records release form must be completed.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	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 ensure residents were able to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility for 1 of 4 days (May 12, 2026) observed for survey results. The Administration failed to include the most recent survey results in the survey binder located in the lobby. This deficient practice could result in residents being denied reading the most current survey results. The findings were: Observation on 5/12/26 at 2:30 PM revealed the last survey results in the survey binder located in the lobby were dated 11/14/25. Interview on 5/12/26 at 2:40 PM with the ADM revealed the last survey results in the survey binder located in the lobby were dated 11/14/25. The ADM stated he thought he had included the most recent survey results from December 2025. He stated the residents and family members had the right to read the results and ask questions. The ADM stated it was their right and failure to post violated their right to access the survey results. Review of a facility policy, Resident Rights, dated 10/25, did not include verbiage related to the right for residents to access the most recent survey results.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview and record review the facility failed to respect the residents right to personal privacy and confidentiality of his or her personal and medical records including 1 of 1 Staff (OTA C) during observations of staff providing care and services. OTA C failed to lock the screen or close her laptop when she walked away from it. This deficient practice could result the resident's medical information being read by anyone walking down the hallway. The findings were:Observation and interview on 5/12/26 at 5:38 PM revealed an open laptop in the rehabilitation gym. The laptop was sitting on a table in front of a window exposed to the hallway. Anyone walking down the hall would have view of it. There were no staff in sight. Surveyor walked into the gym and called out multiple times and OTA C came out of a back office. She stated it was her laptop and was apologetic that she left it open. OTA C stated she stepped away for a minute but should not have left the screen open because it revealed protected resident information and it was a HIPAA violation if anyone else read the information on the screen. Interview on 5/13/26 at 10:05 AM with the DON revealed if OTA C was working on a resident's file, she should have secured it by locking or closing the laptop to ensure the resident's privacy. The DON stated if anyone else read the resident information it would be a violation of HIPAA and the resident's information could be compromised. Review of a facility policy, Resident Rights, dated 10/25, read It is the policy of this facility that Our residents have certain rights and protections under federal and state law that help ensure they receive the care and services necessary. One essential job function is to protect and promote our residents' rights. 8. Receive Privacy and Confidentiality in Clinical Records and personal information shall be always maintained. Records of medical treatment, care, communications, meetings, visitors, or resident groups should be maintained private by staff.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible in 1 of 4 halls (Hall 400) observed for a safe environment. Nursing staff failed to ensure the entrance of the oxygen storage room was not obstructed and that the full containers were separated from the empty containers. This deficient practice could result in oxygen cylinders being tipped over and result in a combustion or fire. The findings were: Observation and interview on 5/12/26 at 5:22 PM revealed the oxygen storage room was located on the 400 hall. The DON opened the door to the oxygen room, and the door immediately hit an item behind the door as soon as the DON opened the door. Observation revealed a full oxygen cylinder on a stand behind the door. There were also multiple empty oxygen stands on the left side of the room further obstructing the passage into the room. Observation revealed the DON was unable to walk freely into the storage room without moving oxygen stands out of the room and the full oxygen cylinder on the stand, behind the door, out of the way. Even when clearing these items, there was minimal space to walk into the room. Further observation revealed a full cylinder stored on the side where the empty oxygen cylinders were stored. There was an empty sign on the wall over the empty cylinders. Interview with the DON revealed the full oxygen cylinder on the stand placed behind the door should not be there because staff could knock it over onto the other full oxygen cylinders. She stated it could cause an explosion and or a fire causing a safety risk for the residents on the 400 hall. The DON further stated it was difficult to walk into the storage room because it was cluttered with the empty oxygen stands upon opening the doors. She stated nursing staff could find it difficult to grab an oxygen cylinder and could delay providing a resident with oxygen as needed. She stated a staff member could grab the full oxygen cylinder when removing the empty cylinders and mistakenly drop the cylinder. The DON stated it was facility policy to store the empty cylinders together on one side and to store the full oxygen cylinders on the opposite side. Review of facility policy Policy/Procedures - Nursing Clinical, subject: Oxygen Handling and Storage, dated 5/2007, read Policy: It is the policy of this facility to provide proper use and handling of oxygen tanks in the facility. Procedures: Storage: Storage of oxygen tanks must be accompanied in a safe manner. All tanks must be secured to a wall within a chain or heavy cable. Full tanks will be separated from empty tanks and identified as such.

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F 0693 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers from 1 of 1 nutrition room observed for stored enteral feedings. The facility failed to ensure one box of Glucerna 1.2 containing 6 quart containers of enteral feedings did not exceed the expiration date and were removed from the nutrition room. This deficient practice could lead to residents receiving expired feedings and result in health complications. The findings were:Observation and interview on [DATE] at 3:40 PM in the nutrition room revealed 6 quarts of Glucerna 1.2 dated [DATE]; they were expired. The DON stated the Glucerna feedings were expired. The DON stated the staff in charge of central supply or any nursing staff member should have removed to formula because it could lead to residents receiving expired feedings and the residents could get sick. The DON stated she did not believe they had any residents who received Glucerna feedings but stated there was always the possibility nursing staff could grab the wrong feeding and give it to the wrong resident. Interview on [DATE] at 3:50 PM with the DON revealed they did not have any residents who received Glucerna 1.2 cal feedings. Interview on [DATE] at 3:30 PM with the DON revealed the facility did not have a policy on expired enteral feedings.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure each resident received food prepared in a form designed to meet their individual needs for 1 of 1 Resident (Resident #2) observed for a puree diet. Nursing staff failed to ensure Resident #2 received a puree diet as prescribed by his physician. On 5/12/26 he received sugar cookies with his lunch meal. This deficient practice could cause the residents to aspirate or choke and could lead to the resident's death. The findings were:Record Review of Resident #2's face sheet, dated 5/15/26, revealed he was admitted to the facility on [DATE] with a diagnosis of dysphagia (trouble swallowing) following cerebral infarction (stroke). Record Review of Resident #2's admission MDS assessment, dated 4/27/26, revealed his BIMS score of 12 of 15 reflective of moderate cognitive impairment. Further review revealed Resident #2 had a swallowing disorder including holding food in mouth/cheeks or residual food in mouth after meals, coughing or choking during meals or when swallowing medications and complaints of difficulty or pain when swallowing. Nutritional approaches included mechanically altered diet and therapeutic diet. Record Review of Resident #2's Care Plan, dated 4/27/26, revealed he had a nutritional problem or potential nutritional problem related to dysphagia. One of the approaches included to provide, serve diet as ordered. Record Review of Resident #2's consolidated physician orders for May 2026 revealed an order, LCS/Renal, diet puree texture, thin liquids. Record Review of the dinner menu dated 5/12/26 included barbeque pork riblette, Italian pasta salad, baked beans, Texas toast and sugar cookies. Observation on 5/12/26 at 5:53 PM revealed Resident #2 was served the dinner meal in puree texture but was also served 2 sugar cookies. Further observation revealed Resident #2 opened the package of sugar cookies, took a couple of bites and he started coughing. LVN A provided water for Resident #2 to drink and he quit coughing. Interview on 5/12/26 at 6:00 PM with LVN A revealed she checked the meal trays for the residents who were eating in their room including Resident #2's meal tray. LVN A stated she checked the trays to ensure they received the diet per physician orders. She stated she did not notice that Resident #2's meal tray included 2 sugar cookies. She stated Resident #2 was on a puree diet because he had problems swallowing and stated he could choke from eating the sugar cookies. LVN A stated she saw Resident #2 coughing when he was eating the sugar cookies, and she provided water and he quit coughing. Interview on 5/13/26 at 12:30 PM with the DON revealed Resident #2 was on a puree diet and should not have received 2 sugar cookies with his dinner tray on 5/12/26. She stated Resident #2 had dysphagia and could choke because of eating the cookies or any food that was not in puree texture. Interview on 5/15/26 at 1:00 PM with the DON revealed she would provide a policy related to resident's receiving therapeutic meals per physician orders. It was not provided by the time of exit on 5/15/26 about 3:30 PM.