

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676113	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation Center -		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 W Hutchins Place San Antonio, TX 78224	
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 (Resident #13 and #126) of 3 residents reviewed for incontinence care. 1. CNA-B did not clean Resident #13's pubic area and did not open the labia and thoroughly clean the vaginal area for Resident #13 during incontinence care. 2. CNA-C did not clean Resident #126's pubic area during incontinence care. This failure could place residents who required incontinence care at risk for cross contamination and the development of urinary tract infections. The findings included: 1. Record review of Resident #13's face sheet, dated 12/04/2025, revealed the resident was [AGE] years old female, originally admitted to the facility on [DATE], and re-admitted to the facility on [DATE] with diagnoses of protein calorie malnutrition (a nutrition status in which reduced availability of nutrients leads to changes in body composition and function), dementia (loss of memory and thinking ability), and osteoporosis (bones become weak and are likely to fracture). Record review of Resident #13's quarterly MDS assessment, dated 11/05/2025, revealed the resident's BIMS was 0 out of 15 which indicated the resident had severe cognitive impairment, and the resident was always incontinent of bladder and bowel. Record review of Resident #13's comprehensive care plan, dated 02/24/2025, revealed [Resident #13] has bowel and bladder incontinence related to dementia and impaired mobility. For intervention - incontinent: check as required for incontinence. Wash, rinse and dry perineum. Change clothing as needed after incontinence episodes. Observation on 12/03/2025 at 9:59 a.m., revealed CNA-B removed the soiled brief from Resident #13, cleaned the resident's left groin area and right groin areas. When CNA-B cleaned the vaginal area of Resident #13, CNA-B did not separate the resident's labia and thoroughly clean the area and then rolled the resident to her left side and cleaned the resident's buttock area without cleaning the resident's pubic area. During an interview on 12/03/2025 at 10:20 a.m., CNA-B stated when she cleaned Resident #13's vaginal area, she did not open or separate the resident's labia area. Further interview with CNA-B said she did not clean Resident #13's pubic area also. CNA-B said she should have cleaned Resident #13's pubic area and separated the resident's labia area to prevent possible infection, but CNA-B was nervous and forgot cleaning those areas. CNA-B said she received skill check for peri care of female resident every year. During an interview on 12/03/2025 at 3:52 p.m., DON stated CNA-B should have cleaned Resident #13's pubic area and should have separated the resident's labia area to clean the base of the labia to prevent possible infection or skin breakdown. 2. Record review of Resident #126's face sheet, dated 12/04/2025, revealed the resident was [AGE] years old male, originally admitted to the facility on [DATE] and readmitted to the facility 11/26/2025 with diagnoses of orthopedic aftercare (following rehabilitation program after musculoskeletal treatment), hemiplegia (paralysis of the muscles of the lower face, arm, and leg on one side of the body), and malignant neoplasms of colon (cancer of large intestine). Record review of Resident #126's admission MDS assessment revealed In Progress because the resident was admitted to the facility on [DATE]. - Record review of Resident #126's baseline care plan, dated 12/02/2025, (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed [Resident #126] has urinary catheter and bowel incontinence related to activity intolerance. For intervention - incontinent: check as required for incontinence. Wash, rinse and dry perineum. Change clothing as needed after incontinence episodes. Observation on 12/03/2025 at 3:12 p.m., revealed CNA-C removed Resident #126's soiled brief, and CNA-C started cleaning the resident's left groin, right groin, penis, and urinary catheter, and then rolled the resident to his left side and cleaned the resident's buttock area without cleaning the resident's pubic area. During an interview on 12/03/2025 at 3:35 p.m., CNA-C stated when she cleaned Resident #126's perineal area and urinary catheter, she did not clean the resident's pubic area, and she said she should have cleaned the resident's pubic area to prevent possible infection. CNA-C said she was checked-off regarding male peri and catheter care every year. During an interview on 12/03/2025 at 3:52 p.m., the DON stated CNA-C should have cleaned Resident #126's pubic area to prevent possible infection. Record review of the facility's policy, titled Perineal Care, revised 05/2007, revealed Female-without catheter.4. Wash pubic area, including upper, inner aspect of both thighs and frontal portion of perineum. 9. Wash perineal area thoroughly, with each stroke beginning at the base of the labia and extending up over the buttock. Male - 1. Wash pubic area, including upper inner aspect of thighs as well as the penis and scrotum.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents' right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate for 1 of 5 residents (Residents #57) reviewed for medications. MA-D gave Resident #57's Fluticasone Propionate Nasal Suspension to the resident, and the resident sprayed the medication to each nostril by himself. However, the facility did not assess and evaluate Resident #57's ability to self-administer medications and did not obtain a physician's order for self-administration of medications. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. The findings included: Record review of Resident #57's face sheet, dated 12/04/2025, revealed the resident was a [AGE] year old male, originally admitted to the facility on [DATE], and re-admitted to the facility on [DATE] with diagnoses of sepsis (the body responds improperly to an infection), chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems), hypertension (high blood pressures), and malignant neoplasm of colon (cancer of the large intestine). Record review of Resident #57's admission MDS assessment, dated 11/28/2025, revealed the resident's BIMS was 15 out of 15 which indicated the resident's cognitive was intact and required setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) to eating and required Partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) to sit to stand and toilet transfer. Record review of Resident #57's comprehensive care plan, dated 11/16/2025, revealed there was no care plan related to self-administration of medications for the resident's Fluticasone Propionate Nasal Suspension. Record review of Resident #57's physician order, dated 11/16/2025, revealed there was no physician order related to self-administration of medications for the resident's Fluticasone Propionate Nasal Suspension. Further record review of the resident's physician order, dated 11/15/2025, revealed the resident had the order of Fluticasone Propionate Nasal Suspension, 1 spray in both nostrils one time a day for allergies. Record review of Resident #57's medication administration record, from 12/01/2025 to 12/31/2025, revealed Fluticasone Propionate Nasal Suspension, 1 spray in both nostrils one time a day for allergies was scheduled at morning time every day. Observation on 12/03/2025 at 8:38 a.m. revealed MA-D entered Resident #57's room and gave the resident's Fluticasone Propionate Nasal Suspension to the resident, and Resident #57 sprayed the medication to each nostril by himself and returned the medication to MA-D. During an interview on 12/03/2025 at 12:49 p.m. with MA-D stated she gave Resident #57's Fluticasone Propionate Nasal Suspension to the resident, and the resident sprayed the medication to each nostril by himself because the resident wanted to administer the medication by himself and had no cognitive impairment. Further interview with MA-D said she notified nurses regarding Resident #57's self-administration of the medication, but MA-D said she did not receive any direction, so she thought it was fine to give this medication to the resident for self-administration by the resident. During an interview on 12/03/2025 at 12:50 p.m. with LVN-E stated she knew Resident #57 sprayed his Fluticasone Propionate Nasal Suspension to each nostril by himself because the resident was able to do it by himself, but there was no physician's order related to self-administration of the medication by the resident and did not know what reason the facility did not obtain the order from the resident's physician. During an interview on 12/04/2025 at 3:52 p.m. with Resident #57 refused interviewing with the surveyor by saying, I am busy now. During an interview on 12/04/2025 at 3:52 p.m. with DON said according to the facility policy regarding self-administration of medication, the facility IDT should have assessed the resident's ability to self-administer medications, and the resident's cognitive, communication, visual, and physical ability to carry out this responsibility should have been evaluated. DON said Resident #57 was able to self-administer his Fluticasone nasal spray by himself (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	without any problem, but the facility should have obtained a physician's order. DON said the facility might miss the procedures related to obtaining self-administration order of the medication by the resident. Record review of the facility policy, titled Self-Administration of Medications, revised 05/2016, revealed To determine the ability of alert residents to participate in self-administration of medications. To maintain the safety and accuracy of medication administration. 1. Upon admission, alert residents will be informed of their right to self-administer medications. 2. If a resident desires to participate in self-administration, the interdisciplinary team will assess the resident's ability to self-administer medications. 3. The resident's cognitive, communication, visual, and physical ability to carry out this responsibility will be evaluated. 4. If the resident is a candidate for self-administration of medications, a physician's order will be obtained.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident has a right to personal privacy and confidentiality of his or her personal and medical records for 1 (Resident #86) of 29 residents reviewed the privacy of medical records. LVN-A left her computer open and unattended with Resident #86's personal and medical information on the nursing cart at the 300-hallway on 12/03/2025. This failure could place residents at risk of resident identifiable and medical information being accessed by unauthorized persons. The findings were: Record review of Resident #86's face sheet, dated 12/04/2025, revealed the resident was a [AGE] year old female, originally admitted on [DATE], and re-admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy), osteoporosis (bones become weak and are likely to fracture), hypothyroidism (abnormally low activity of the thyroid gland), and neuropathy (happens when the nerves that are located outside of the brain and spinal cord are damaged). Record review of Resident #86's quarterly MDS assessment, dated 09/23/2025, revealed the resident's BIMS score was 7 out of 15, which indicated the resident had severe cognitive impairment, and the resident had insulin injections that were received during the last 7 days. Observation on 12/03/2025 at 11:10 a.m. revealed LVN-A opened her computer located on the cart and looked at Resident #86's electronic MAR. LVN-A took out Resident #86's glucometer, lancet, alcohol swap, and gauze from the cart and put them inside a basket. LVN-A knocked on the door of Resident #86's room and entered the room without closing or logging off the computer. Resident #86's electronic MAR on the screen of the computer, including the resident's face photo, date of birth , and medications to be provided, was opened. During an interview on 12/03/2025 at 11:26 a.m. with LVN-A stated the nurse did not close or log off the computer when the nurse entered Resident 86's room to check the resident's blood sugar, so the computer screen on the cart was opened with Resident #86's face photo, date of birth , and medications to be provided. LVN-A said she left her computer open with Resident #86's personal and medical information on the nursing cart at the 300-hallway, and it was Resident #86's privacy violation because anybody could see Resident #86's personal and medical information. During an interview on 12/03/2025 at 3:52 p.m. with DON said LVN-A should have closed or logged off her computer when she left her nursing cart at the 300-hallway to protect Resident #86's personal and medical information, and it was the nurse's mistake and HIPAA violation. Record review of the facility policy, titled HIPAA, undated, revealed It is the policy of this facility to protect the privacy of patient/resident health information - 1. Protected health information that identifies patient/resident or contains information that can be used to identify the patient/resident must be kept safe, confidential, and protected. This include: electronic, written, and paper and/or verbal formats.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 1 resident (Resident #11) of 8 residents reviewed for MDS assessments. The facility failed to ensure Resident #11's admission 5-day MDS and Significant change MDS were coded accurately for Preadmission Screening and Resident Review (PASRR). These deficient practices could affect residents who receive care and could result in missed or inappropriate care. The findings included: Record review of Resident #11's face sheet dated 12/03/2025, revealed Resident #11 was admitted to the facility on [DATE], readmitted on [DATE] with diagnoses that included: schizophrenia unspecified, bipolar disorder unspecified, and unspecified intellectual disabilities. Record review of Resident #11's admission 5-day MDS assessment, dated 02/07/2025 Section A1500 Preadmission Screening and Resident Review (PASRR) coded 0 (No) for was the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? Record review of Resident #11's Significant Change MDS assessment, dated 09/28/2025 Section A1500 Preadmission Screening and Resident Review (PASRR) coded 0 (No) for is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? Record review of Resident #11's care plan, revision date of 11/13/2025, revealed Resident #11 had a focus of PASRR positive and currently only receives Habilitation Coordination. Record review of Resident #11's PASRR Level 1 Screening, dated 02/03/2025, revealed, Section C PASRR Screening coded yes for Mental Illness, Intellectual Disability and Developmental Disability. Record review of Resident #11's PASRR Evaluation, dated 03/06/2025, read, Section B0200 coded yes for To your knowledge, does the individual have a Developmental Disability other than an Intellectual Disability that manifested before the age of 22? During an interview on 12/04/2025 at 2:09 p.m. the MDS Nurse stated Resident #11 was PASRR positive and received habilitative services. The MDS Nurse further stated Resident #11's MDS assessments should have been coded yes for PASRR. The MDS Nurse stated she was responsible for the coding of the section and guessed she had overlooked it. The MDS Nurse stated it was important to accurately code the MDS assessments because they were sent to HHSC, and they were signing off they were being truthful. During an interview on 12/04/2025 at 3:52 p.m. the DON stated the MDS Nurse was responsible for MDS assessments accuracy. The DON stated the MDS assessments being coded accurately was important to make sure the services needed were triggered. The DON further stated by miscoding the MDS assessments could have the potential to cause services not to be provided. Record review of facility's policy titled Resident Assessment and Associated Processes, revised date 12/2023, read, Policy: It is the policy of this facility that resident's will be assessed and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident. Procedure: Comprehensive Assessment: Includes the completion of the MDS (Minimum Data Set) as well as the CAA (Care Area Assessment) process, followed by development and/or review of the comprehensive care plan. Comprehensive MDS assessments include Admission, Annual, Significant Change. An accurate Comprehensive Assessment will be made of the resident's needs, strengths, goals, life history and preferences. Record review of the CMS RAI Version MDS 3.0 Manual dated October 2025 revealed in part, .The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. Section A: Identification Information Intent: The intent of this section is to obtain the reasons for assessment, administrative information, and key demographic information to uniquely identify each resident. Coding instructions for A1550 Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 7.41% based on 2 errors out of 27 opportunities, which involved two residents (Residents #57 and #18) of five residents reviewed for medication errors. 1. MA-D gave Resident #57's Fluticasone Propionate Nasal Suspension to the resident, and the resident administered two sprays to each nostril by himself, but the physician order said, Fluticasone Propionate Nasal Suspension, 1 spray in both nostrils one time a day for allergies. 2. MA-D administered 15 ml of Resident #18's Enulose Solution 10 gm/15 ml to the resident on 12/03/2025. However, the physician order indicated Enulose Solution 10 gm/15 ml, Give 30 ml by mouth two times a day for constipation. These failures could place residents at risk of not receiving the intended therapeutic benefits of their medications or not receiving them as prescribed, according to physician orders. Findings include: 1. Record review of Resident #57's face sheet, dated 12/04/2025, revealed the resident was a [AGE] year old male, originally admitted to the facility on [DATE], and re-admitted to the facility on [DATE] with diagnoses of sepsis (the body responds improperly to an infection), chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems), hypertension (high blood pressures), and malignant neoplasm of colon (cancer of the large intestine). Record review of Resident #57's admission MDS assessment, dated 11/28/2025, revealed the resident's BIMS was 15 out of 15 which indicated the resident's cognitive was intact and required setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) to eating and required Partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) to sit to stand and toilet transfer. Record review of Resident #57's physician order, dated 11/15/2025, revealed the resident had the order of Fluticasone Propionate Nasal Suspension, 1 spray in both nostrils one time a day for allergies. Record review of Resident #57's medication administration record, from 12/01/2025 to 12/31/2025, revealed Fluticasone Propionate Nasal Suspension, 1 spray in both nostrils one time a day for allergies was scheduled at morning time every day. Observation on 12/03/2025 at 8:38 a.m. revealed MA-D entered Resident #57's room and gave the resident's Fluticasone Propionate Nasal Suspension to the resident, and Resident #57 administered two sprays to each nostril by himself and returned the medication to MA-D. During an interview on 12/03/2025 at 12:49 p.m. with MA-D stated she gave Resident #57's Fluticasone Propionate Nasal Suspension to the resident, and the resident administered two sprays to each nostril by himself, but the physician order said, one spray to each nostril. The MA-D said she did not say one-spray to each nostril to Resident #57 when giving it to the resident on 12/03/2025 because the resident already knew it, but the resident sometimes made two sprays to each nostril. MA-D said she would report it to the nurse. During an interview on 12/03/2025 at 12:50 p.m. with LVN-E stated she would report to the physician regarding Resident #57 administered two sprays of Fluticasone Propionate Nasal Suspension to each nostril because the physician order said, one spray to each nostril. During an interview on 12/04/2025 at 3:52 p.m. with Resident #57 refused interviewing with the surveyor by saying, I am busy now. During an interview on 12/04/2025 at 3:52 p.m. with DON said it was medication error that Resident #57 administered two sprays of his Fluticasone to each nostril, and MA-D did not say one spray to each nostril to the resident before giving it to the resident, but the physician indicated one spray to each nostril. MA-D should have reeducated the resident whenever giving the medication to the resident. 2. Record review of Resident #18's face sheet, dated 12/04/2025, revealed the resident was a [AGE] year-old male and originally admitted to the facility on [DATE] with diagnoses of cerebral infarction (disrupted blood flow to the brain due to problem with the blood vessels that supply it), chronic respiratory failure (when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the body), severe protein-calorie malnutrition (a nutrition status in which reduced availability of nutrients leads to changes in body composition and function), and type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels). Record review of Resident #18's admission MDS assessment, dated 11/06/2025, revealed the resident's BIMS was 13 out of 15 which indicated the resident's cognitive was intact and required Supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) to eating and required Partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) to sit to stand. Record review of Resident #18's physician order, dated 10/24/2025, revealed the resident had the order of Enulose solution 10 gm/ml (Lactulose Encephalopathy) Give 30 ml by mouth two times a day for constipation. Record review of Resident #18's medication administration record, from 12/01/2025 to 12/31/2025, revealed Enulose solution 10 gm/15 ml (Lactulose Encephalopathy) Give 30 ml by mouth two times a day for constipation was scheduled at morning time and hours of sleep every day. Observation on 12/03/2025 at 8:30 a.m. revealed MA-D entered Resident #18's room and gave 15 ml of Enulose solution 10 gm/15 ml to Resident #18, and the resident took 15 ml of Enulose solution. During an interview on 12/03/2025 at 12:49 p.m. with MA-D stated she administered 15 ml of Enulose solution 10 gm/15 ml to Resident #18, and the resident took 15 ml of Enulose solution, but the physician's order indicated Enulose solution 10 gm/ml (Lactulose Encephalopathy) Give 30 ml by mouth two times a day for constipation. MA-D said she should have administered 30 ml of Enulose solution to Resident #18 as ordered, but she was confused about the dosage, and it was medication error. During an interview on 12/04/2025 at 3:52 p.m. with DON said it was medication error that Resident #18 should have received 30 ml of Enulose solution for constipation, but the resident took 15 ml of Enulose solution, and it might affect not receiving the intended therapeutic benefits of the medication. Record review of the facility policy, titled Medication Administration, revised 05/2007, revealed verify medication cards with medication orders and read the label on the bottle as it is removed from the shelf and check label with medication orders.		

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NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation Center -		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 W Hutchins Place San Antonio, TX 78224	
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 observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 of 27 residents (Residents #130 and #81) reviewed for storage. 1. Resident #130's insulin Degludec Flex Pen for diabetes had no open date, found inside 100-wing nursing cart on 12/02/2025. 2. Resident #81's insulin Glargine Flex Pen for diabetes had no open date, found inside 100-wing nursing cart on 12/02/2025. These failures could place residents at risk of having no therapeutic effects by using old insulins. The findings were: 1. Record review of Resident #130's face sheet, dated 12/04/2025, revealed Resident #130 was a [AGE] year-old male and admitted to the facility 11/19/2025 with diagnoses of sepsis (the body responded improperly to an infection), Chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems), type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), and hypertension (high blood pressures). Record review of Resident #130's admission MDS, dated [DATE], revealed the MDS was In Progress. Record review of Resident #130's physician's order, dated 11/20/2025, revealed the resident had the order of Insulin Degludec Subcutaneous Solution 100 UNIT/ML (Insulin Degludec) Inject 10 unit subcutaneously at bedtime for Diabetes Hold if blood sugar is less than 100. Record review of Resident #130's medication administration record, dated from 12/01/2025 to 12/31/2025, revealed the resident was receiving Insulin Degludec Subcutaneous Solution 100 UNIT/ML (Insulin Degludec) Inject 10 unit subcutaneously at bedtime for Diabetes at 8:00 pm. Observation on 12/02/2025 at 3:08 p.m. revealed Resident #130's insulin Degludec Subcutaneous Solution 100 UNIT/ML Pen for diabetes with no open date was found inside the 100-wing nursing cart. Further observation on the box of the insulin indicated after first use store at room temperature for up to 56 days. Interview on 12/02/2025 at 3:22 p.m. with LVN-F stated Resident #130's insulin Degludec Subcutaneous Solution 100 UNIT/ML Pen for diabetes with no open date was found inside the 100-wing nursing cart, and the insulin pen should have been discarded 56 days after opening it. If the insulin pen did not have any open date, nurses did not know when they have to discard the insulin pen. LVN-F said she did not know if she should discard the insulin pen because the insulin pen did not have open date, and the nurse did not know when the facility nurses opened Resident #130's insulin pen. 2. Record review of Resident #81's face sheet, dated 12/04/2025, revealed Resident #81 was a [AGE] year-old male and admitted to the facility on [DATE] with diagnoses of encephalopathy (serious neurological change), type 2 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels), protein-calorie malnutrition (a nutrition status in which reduced availability of nutrients leads to changes in body composition and function), and hypertension (high blood pressures). Record review of Resident #81's admission MDS, dated [DATE], revealed the resident's BIMS was 4 out of 15 which indicated the resident had severe cognitive impairment and received insulin injection. Record review of Resident #81's physician's order, dated 12/02/2025, revealed the resident had the order of Insulin Glargine-yfgn Subcutaneous Solution 100 UNIT/ML (Insulin Glargine-yfgn) Inject 10 unit subcutaneously at bedtime for diabetes Hold insulin if Blood Sugars less than 70. Record review of Resident #81's medication administration record, dated from 12/01/2025 to 12/31/2025, revealed the resident was receiving Insulin Glargine-yfgn Subcutaneous Solution 100 UNIT/ML (Insulin Glargine-yfgn) Inject 10 unit subcutaneously at bedtime for diabetes at 8:00 pm. Observation on 12/02/2025 at 3:08 p.m. revealed Resident #81's insulin Glargine-yfgn Subcutaneous Solution 100 UNIT/ML (Insulin Glargine-yfgn) Pen for diabetes with no open date was found inside the 100-wing (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing cart. Further observation on the box of the insulin indicated discard after 28 days. Interview on 12/02/2025 at 3:22 p.m. with LVN-F stated Resident #81's insulin Glargine-yfgn Subcutaneous Solution 100 UNIT/ML (Insulin Glargine-yfgn) Pen for diabetes with no open date was found inside the 100-wing nursing cart, and the insulin pen should have been discarded 28 days after opening it. If the insulin pen did not have any open date, nurses did not know when they have to discard the insulin pen. LVN-F said she did not know if she should discard the insulin pen because the insulin pen did not have open date, and the nurse did not know when the facility nurses opened Resident #81's insulin pen. Interview on 12/03/2025 at 3:52 p.m. with DON said the facility nurses should have written open dates on insulins when they opened them to discard them after the insulins were opened. Nurses would not know when they have to discard insulins if insulins did not have open dates, and it might cause improper use, and residents might not have therapeutic effects. DON said that it was nurse's responsibility, and DON sometimes reviewed nursing carts, but they did not know what reason nurses did not write the open dates. Record review of the facility policy, titled Medication Access and Storage, revised 05/2007, revealed that The provider pharmacy dispense medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen observed for puree diet preparation. The facility failed to ensure dietary staff preparing the puree diets used sanitary preparation procedures. These failures could place residents who received meals and/or snacks from the kitchen at risk of food born illness. The findings included: Observation on 12/03/2025 at 10:46 a.m. revealed the [NAME] using a processor to prepare the pureed pork loin. The [NAME] had the processor sitting on one side of the counter near the 2-compartment sink with a pot of pork loin next to it. The [NAME] was observed scooping out the pork loin with a large cooking spoon and placing it in the processor to puree it. After blending the pork loin, the [NAME] reached across the 2-compartment sink grabbing the plastic liquid measuring cup which was sitting on the metal counter with liquid droplets around and near it. The [NAME] then placed the measuring cup into the pot of pork loin and gathered the broth from the pork loin then poured it into the processor and proceeded to blend the pureed pork loin. The [NAME] left the measuring cup in the pot with the pork loin while pureeing the pork loin. The [NAME] again pressed the measuring cup down in the pot to gather broth and poured it into the processor, continuing to puree the pork loin. This time the [NAME] placed the measuring cup on a piece of tin foil that had been placed behind the food processor. The [NAME] once finished pureeing the pork loin scooped it out of the processor into a metal pan and covered it to be placed on the steam table. During an interview on 12/03/2025 at 11:09 a.m. the [NAME] stated when she took the measuring cup from the other counter, she risked cross contamination by using it after it had been setting on the counter due to it touching the surface and it having not been sanitized before. The [NAME] further stated by not using the spoon and dipping the measuring cup in the pork loin for the broth risked cross contamination. The [NAME] stated this could have made people get sick. During an interview on 12/03/2025 at 11:12 a.m. the DS stated the [NAME] should have used the ladle instead of grabbing a cup from the counter and sticking it in the pork loin for the broth. The DS further stated this could cause cross contamination and could get people sick. The DS instructed the cook to throw out the pork loin she had prepared and make more. Review of facility's policy, Infection Control Policy/Procedure, revised 05/2007, read Section: Departmental, Subject: Dietary Services: Policy: It is the policy of this facility to prevent contamination of food products and therefore prevent foodborne illness. Procedures: 6. Proper Food Handling, N. Utensils, cups, glasses, and dishes must be handled in such a way as to avoid touching surfaces with which food or drink will come in contact.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #16) out of 27 residents reviewed for medical records. Facility nurses did not document their initials when they administered Resident #16's oxygen via a nasal cannula as ordered on the resident's medication administration record. This failure placed residents at risk for missed treatment regarding oxygen therapy as ordered which could result in decline in healing and well-being. Findings included: Record review of Resident #16's face sheet, dated 12/04/2025, revealed the resident was a [AGE] year old female and admitted to the facility on [DATE] with diagnosis of type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), protein-calorie malnutrition (a nutrition status in which reduced availability of nutrients leads to changes in body composition and function), heart failure (heart not pumping enough blood to the body), and peripheral vascular disease (slow and progressive disorder of the blood vessels). Record review of Resident #16's quarterly MDS, dated [DATE], revealed the resident's BIMS was 7 out of 15, which indicated the resident had severe cognitive impairment, required Dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) such as sit to stand, chair to bed, and toilet transfer, and receiving oxygen therapy on Section O (Special Treatments and Programs). Record review of Resident #16's comprehensive care plan, dated 12/02/2025, revealed Oxygen therapy related to ineffective gas exchange. For intervention - Oxygen per medical doctor orders. Record review of Resident #16's physician order, dated 11/03/2025, revealed the resident had the orders of O2 (oxygen) AT 2 LPM (liter per minute) CONTINUOUS PER Nasal Cannula as needed for Short of breathing / WHEEZING. Record review of Resident #16's medication administration record from 12/01/2025 to 12/31/2025 revealed the order of O2 (oxygen) AT 2 LPM (liter per minutes) CONTINUOUS PER Nasal Cannula as needed for Short of breathing / WHEEZING was scheduled as needed, and the dates of 12/01/2025, 12/02/2025, and 12/03/2025 were all left blank. Observation on 12/01/2025 at 10:54 a.m. revealed Resident #16 was sitting on the wheelchair in her room, and the resident had oxygen 2 liter per minute via nasal cannula, and the oxygen tubing and nasal cannula had label for change, and the label indicated they were changed on 12/01/2025. Interview on 12/04/2025 at 10:55 a.m. with LVN-A stated the nurses administered oxygen 2 liter per nasal cannula to Resident #16 as ordered on 12/1/2025, 12/02/2025, and 12/03/2025, but they did not document on the resident's medication administration record. The facility nurses should have documented on Resident #16's medication administration record after administering the resident's oxygen per nasal cannula to keep accurate medical records and communicate with other nurses with the documentation. Interview on 12/04/2025 at 3:52 p.m. with DON stated the facility nurses should have documented on Resident #16's medication administration record after administering the resident's oxygen per nasal cannula to keep accurate medical record and communicate with other nurses with the documentation. Record review of the facility policy, titled Oxygen Administration, revised 05/2007, revealed that . 17. Document all appropriate information in medical record for Oxygen therapy.		