STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676137	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Center -	8902 West Rd Houston, TX 77064

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure assessments accurately reflected the resident's status for 1 of 5 resident (Resident #1) reviewed for accuracy of assessments. - The facility failed to ensure Resident #1's Quarterly MDS dated [DATE] and Discharge MDS dated [DATE] accurately reflected the residents behavior of verbally aggressive behaviors to others and resistance to care. This failures could place residents at risk of inaccurate assessments, which could compromise their plan of care . Findings include Record review of Resident #1's Face Sheet dated 11/12/25 revealed, a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included: COPD (group of lung diseases that block airflow cause difficulty breathing), muscle weakness, depression, difficulty walking, right great toe amputation, lower left leg open wound and peritoneal abscess (pus within the abdomen due to an infection). Record review of Resident #1's Quarterly MDS dated [DATE] revealed, severely impaired cognition as indicated by a BIMS score of 00 out of 15, fluctuating behaviors of: inattention, disorganized thinking and altered level of consciousness. Behavioral symptoms of: physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing), Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, , or verbal/vocal symptoms like screaming, disruptive sounds) were marked as Behavior not exhibited. Rejection or care and wandering were marked as: Behavior not exhibited. Record review of Resident #1's Discharge MDS dated [DATE] revealed, an unplanned discharge for a short term general hospital stay with return anticipated. Resident #1 had fluctuating behaviors of: inattention, disorganized thinking and altered level of consciousness. Behavioral symptoms of: physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing), Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, , or verbal/vocal symptoms like screaming, disruptive sounds) were marked as Behavior not exhibited. Rejection or care and wandering were marked as: Behavior not exhibited. Record review of Resident #1's undated Care Plan revealed, Focus created on 09/16/24 and revised on 09/29/25: [Resident #1] exhibits Behaviors r/t Elopement risk/wanderer, disoriented to place, wanders aimlessly, refuses ADL care/showers frequently. Yells out at other residents. Removes her wound bandages, removes her colostomy bag. In an interview on 11/12/25 at 09:51 AM, the Administrator said Resident #1 attempted to elope from the building in April of 2025. She was observed going out the side door at the end of her hall and was immediately brought back into the building by ADON A. He said the resident was confused and propelled herself around the facility. In an observation and interview with ADON A on 11/12/25 at 09:58 AM, ADON B pushed open all exit doors at the end of the 100, 200, 300 and 400 Halls and an alarm was audible. She said Resident #1 liked to challenge the door, was confused, attempted to elope from the building, was generally combative and resistant to care. ADON B said in April of 2025, she observed Resident #1 as she exited the door as the alarm went off and she immediately brought the resident back in. In an interview on 11/12/25 at 10:55 AM, the DON said in April 2025 Resident #1 was visualized going out the door at the end of the hall by ADON A but the staff could not get to her before she went out the door. She send ADON A was alerted to Resident #1 going out the door by an audible alarm, and then immediately returned the resident inside the facility. The DON said Resident #1 was in a wheelchair and she propelled herself around the building, was combative and resistant to care. She said the MDS represented the resident and the care they should receive. The DON said an inaccurate MDS could potentially impact how the resident is cared for. In an interview on 11/12/25 at 11:30 AM, the MDS Nurse said she was new and did not complete Resident #1's assessments. She said the MDS is completed with information from the IDT as well as interviews and observations with family and the resident. She said from what she heard, Resident #1 had behaviors of resisting care but her MDS was codded as no behaviors. The DON said Resident #1 had behaviors since she admitted to the facility in 2024. She said the resident was not friendly, had behaviors most of the time, would grab staff, had verbal behavioral symptoms, roamed in her wheelchair, wandered around and rejected care 4-6 times a week. After the DON reviewed Resident #1's MDS from 10/03/25 and 10/28/25 she said they were inaccurate because they did not acknowledge Resident #1's physical, verbal and other behavioral symptoms. An observation on 11/12/25 at 11:54 AM revealed, Resident #1 sitting in her wheelchair in the doorway of her room receiving Vancomycin 750 mg/ml in 750 ml IV at 250 ml/hr. Her left foot was wrapped in

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. (continued on next page)

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to administer Parenteral fluids consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 1 (Resident #1) residents reviewed for parenteral fluids. - RN A failed to administer Resident #1's IV antibiotic Vancomycin, a medication with known infusion rate reactions, as ordered when she administered the medication at 250 ml/hr. instead of 150 ml/hr. as ordered on by the pharmacy on 11/12/25. This failure could place residents at vancomycin infusion reactions which could result in hypotension (low blood pressure), tachycardia (fast heartrate) and cardiac arrest (when the heart suddenly stops beating). Findings includeRecord review of Resident #1's Face Sheet dated 11/12/25 revealed, a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included: COPD (group of lung diseases that block airflow cause difficulty breathing), muscle weakness, depression, difficulty walking, right great toe amputation, lower left leg open wound and peritoneal abscess (pus within the abdomen due to an infection). Record review of Resident #1's Quarterly MDS dated [DATE] revealed, severely impaired cognition as indicated by a BIMS score of 00 out of 15, fluctuating behaviors of: inattention, disorganized thinking and altered level of consciousness. Behavioral symptoms of: physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing), Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, , or verbal/vocal symptoms like screaming, disruptive sounds) were marked as Behavior not exhibited. Rejection or care and wandering were marked as: Behavior not exhibited.Record review of Resident #1's undated Care Plan revealed, focus: COPD (Chronic Obstructive Pulmonary Disease) r/t SOB, use of medications. Focus: Is on IV Vancomycin HCl Intravenous Solution Reconstituted 750 MG (Vancomycin HCl) r/t leukocytosis (elevated white blood cell count indicating infection). Goal: Will not have any complications related to IV Therapy through the review date. Focus created on 09/16/24 and revised on 09/29/25: [Resident #1][exhibits Behaviors r/t Elopement risk/wanderer, disoriented to place, wanders aimlessly, refuses ADL care/showers frequently. Yells out at other residents. Removes her wound bandages, removes her colostomy bag.Record review of Resident #1's Oder Summary Report dated 11/12/25 revealed, Vancomycin HCl Intravenous Solution Reconstituted 750 MG (Vancomycin HCl) Use 750 mg intravenously every 12 hours for abnormal lab for 10 Days; start date 11/11/25.Record review of Resident #1's November 2025 MAR revealed, the first dose of Vancomycin Resident #1 received was administered by RN A on 11/12/25 at 11:21 AM.Record review of Resident #1's Change in Condition assessment dated [DATE] revealed, staff monitored for adverse reactions due to Vancomycin and Resident #1 did not have any changes/remained stable. Her vitals were within range, she had normal body temperature (97.7), blood pressure (118/62), Respirations (17), pulse (72) and her oxygen rate was at 97 %. The nurse received orders for an immediate test of Resident #1's Vancomycin Levels and a BMP.Record review of Resident #1's Progress Notes dated 11/12/25 at 12:35 PM signed by ADON A revealed, Resident assessed for [adverse reactions] to Vancomycin IV. Medical Director in building and updated on Vancomycin administration issue. MDinformed no adverse reaction noted during assessment. New orders received from medical director after viewing resident for STAT Trough (immediate laboratory values) ordered to ensure resident is in therapeutic range with medication. BMP to be drawn tomorrow and redraw for Vanco trough 11/14. Vancomycin to be held until result is received for STAT trough and observed resident q 1hr x 24 hours. NP called and updated on the above.Record review of Resident #1's Lab results dated 11/13/25 revealed, the vancomycin levels came out as low and there were no significant change to her BMP.An observation on 11/12/25 at 11:52 AM revealed, Resident #1 in her wheelchair in the doorway of her room as she received Vancomycin 750 mg/150 ml at 250 ml/hr. (calculated administration duration of 36 minutes). Her left foot was wrapped in a white dressing and her right arm had IV tubing that protruded from under a white gauze dressing. The IV bag had no labeling outside of the manufacturer labeling, there was no pharmacy label that contained the resident's name, dose and instruction for use, administration flow rate, name of prescriber, or date the medication was ordered. The resident was not interviewable, she was confused, tugged on her IV tubing and was combative with staff who passed by. Resident #1 appeared to be in no immediate distress, her skin was not red, she took normal breaths and had no shortness of breath.In an interview on 11/12/25 at 11:54 AM, RN A said the label for Resident #1's

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure nurses were able to demonstrate competency in skills to provide nursing and related services for 1 of 1 resident (Resident #1) by 1 of 4 nurses (RN A) reviewed for competent staff. - The facility failed to ensure RN A was competent to administer medications via IV prior to administering medications to Resident #1 on 11/12/25 This failure could place residents at complications from IV medications and adverse reactions. Findings included: Record review of Resident #1's Face Sheet dated 11/12/25 revealed, a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included: COPD (group of lung diseases that block airflow cause difficulty breathing), muscle weakness, depression, difficulty walking, right great toe amputation, lower left leg open wound and peritoneal abscess (pus within the abdomen due to an infection). Record review of Resident #1's Quarterly MDS dated [DATE] revealed, severely impaired cognition as indicated by a BIMS score of 00 out of 15, fluctuating behaviors of: inattention, disorganized thinking and altered level of consciousness. Behavioral symptoms of: physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing), Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, , or verbal/vocal symptoms like screaming, disruptive sounds) were marked as Behavior not exhibited. Rejection or care and wandering were marked as: Behavior not exhibited. Record review of Resident #1's undated Care Plan revealed, focus: COPD (Chronic Obstructive Pulmonary Disease) r/t SOB, use of medications. Focus: Is on IV Vancomycin HCl Intravenous Solution Reconstituted 750 MG (Vancomycin HCl) r/t leukocytosis (elevated white blood cell count indicating infection). Goal: Will not have any complications related to IV Therapy through the review date. Focus created on 09/16/24 and revised on 09/29/25: [Resident #1] exhibits Behaviors r/t Elopement risk/wanderer, disoriented to place, wanders aimlessly, refuses ADL care/showers frequently. Yells out at other residents. Removes her wound bandages, removes her colostomy bag. Record review of Resident #1's Oder Summary Report dated 11/12/25 revealed, Vancomycin HCl Intravenous Solution Reconstituted 750 MG (Vancomycin HCl) Use 750 mg intravenously every 12 hours for abnormal lab for 10 Days; start date 11/11/25. Record review of Resident #1's November 2025 MAR revealed, the first dose of Vancomycin Resident #1 received was administered by RN A on 11/12/25 at 11:21 AM. An observation on 11/12/25 at 11:52 AM revealed, Resident #1 in her wheelchair in the doorway of her room as she received Vancomycin 750 mg/150 ml at 250 ml/hr. (calculated administration duration of 36 minutes). Her left foot was wrapped in a white dressing and her right arm had IV tubing that protruded from under a white gauze dressing. The IV bag had no labeling outside of the manufacturer labeling, there was no pharmacy label that contained the resident's name, dose and instruction for use, administration flow rate, name of prescriber, or date the medication was ordered. The resident was not interviewable, she was confused, tugged on her IV tubing and was combative with staff who passed by. Observation revealed a dial a flow pump. Resident #1 appeared to be in no immediate distress, her skin was not red, she took normal breaths and had no shortness of breath. In an interview on 11/12/25 at 11:54 AM, RN A said the label for Resident #1's Vancomycin must have fallen off after she hung the medication and all medications must have a pharmacy label that includes the residents name, medication information and directions for use. She went to get a new label and when she returned she informed the surveyor the pharmacy label ordered the vancomycin be administered at 750 mg at 150 ml/hr. every 12 hours and she started the infusion at approximately 11:30 AM. RN A said if Vancomycin was administered rapidly a resident could suffer from burning from the IV, she was not aware of any Vancomycin specific infusion reactions. In an observation and interview that started at 11/12/25 at 11:59 AM, the DON said Vancomycin must be administered at the ordered rate because rapid infusion of Vancomycin can result in red man syndrome which could result in flushing (redness), hypotension and cardiac arrest. In an interview on 11/12/25 at 12:05 PM, ADON A said to her knowledge RN A intentionally changed the medication flow rate to 250 ml/hr. because it was going to slow. ADON A said RN A said she was told by ADON B not to administer the medication until the pump arrived but RN A did not want a delay in Resident #1 receiving her antibiotic due to the absence of an IV pump. In an interview on 11/12/25 at 12:20 PM, the Medical Director said residents who received Vancomycin intravenously could suffer from Red Man Syndrome which is a Vancomycin infusion reaction that can result in tinnitus (ringing/buzzing or hissing in the ear caused by no external source), changes in

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure that the daily staffing was posted and readily accessible for review for 1 of 1 facility reviewed for required postings. - On 11/12/25 the facility failed to ensure the Direct Care Daily Staffing Numbers were updated. The postings read 11/11/25. This failure could affect residents, facility visitors, vendors, and emergency personnel by placing them at risk of not having access to information regarding daily nursing staffing in a timely manner. Findings Included: An observation on 11/12/25 at 08:51 AM revealed, the facility Direct Care Daily Staffing Numbers displayed on the pony wall on the left side of the front entrance. The posting read Date: 11-Nov-2025' and included the facility name, census, the scheduled hours, and staffing totals for direct care staff. RNs, LVNs and some CNAs worked 12 hour shifts from 6:00 AM to 6:00 PM or 6:00 PM to 6:00 AM. Nursing Managers and the DON worked from 9:00 AM to 5:00 PM, CNAs: 10:00 PM to 6:00 AM, CMAs 6:00 AM - 2:00 PM and 2:00 PM to 10:00 PM. An observation on 11/12/25 at 08:51 AM revealed, the facility Direct Care Daily Staffing Numbers displayed on the wall by the DON's office. The posting read Date: 11-Nov-2025' and included the facility name, census, the scheduled hours, and staffing totals for direct care staff. RNs, LVNs and some CNAs worked 12 hour shifts from 6:00 AM to 6:00 PM or 6:00 PM to 6:00 AM. Nursing Managers and the DON worked from 9:00 AM to 5:00 PM, CNAs: 10:00 PM to 6:00 AM, CMAs 6:00 AM - 2:00 PM and 2:00 PM to 10:00 PM. An observation on 11/12/25 at 09:08 AM revealed, the Staffing Coordinator as she removed the old direct care posting from the wall by the DONs office. In an interview on 11/12/25 at 10:38 AM, the Administrator said the Staffing Coordinator was responsible for the direct care posting. He said the posting should be posted somewhere visible within 2 hours of the first shift. He said the facility had 12 hour shifts for nurse and CNAs from 6- 6 and the posting should be up by 8:00 AM and before each shift. The Administrator said failure to update the posting timely could cause family members confusion of who was giving care that day. In an interview on 11/12/25 at 11:16 AM, the Staffing Coordinator said she made the schedules for the nursing department, found staffing, worked as a CNA/MA as needed and she was responsible for the daily direct care posting. She said the direct care posting had to be posted within 2 hours of the shifts, the facility shifts were 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM and must include the facility name, date, census, staffing types scheduled and the total number of scheduled staff. She said failure to update the posting timely could result in residents and visitors to the building not knowing the facility census or the staffing available for the day. The Staffing Coordinator said her shifts typically ran from 08:15 AM to 05:15 PM and she was expected to update the posting within 2 hours of the beginning of her shift. She said she had not received any training about the regulations regarding the timing of the posting. The Staffing Coordinator said when she arrived on 11/12/25 she was helping residents on the floor which caused her update of the posting to be delayed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free from any significant medication errors for 1 of 4 residents (Residents #1) reviewed for significant medication errors. - RN A failed to administer Resident #1's IV antibiotic Vancomycin, a medication with known infusion rate reactions, as ordered when she intentionally administered the medication at 250 ml/hr. instead of 150 ml/hr. as ordered by the pharmacy. This failure could place residents at vancomycin infusion reactions which could result in hypotension (low blood pressure), tachycardia (fast heartrate) and cardiac arrest (when the heart suddenly stops beating). Findings included Record review of Resident #1's Face Sheet dated 11/12/25 revealed, a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included: COPD (group of lung diseases that block airflow cause difficulty breathing), muscle weakness, depression, difficulty walking, right great toe amputation, lower left leg open wound and peritoneal abscess (pus within the abdomen due to an infection). Record review of Resident #1's Quarterly MDS dated [DATE] revealed, severely impaired cognition as indicated by a BIMS score of 00 out of 15, fluctuating behaviors of: inattention, disorganized thinking and altered level of consciousness. Behavioral symptoms of: physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing), Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, , or verbal/vocal symptoms like screaming, disruptive sounds) were marked as Behavior not exhibited. Rejection or care and wandering were marked as: Behavior not exhibited. Record review of Resident #1's undated Care Plan revealed, focus: COPD (Chronic Obstructive Pulmonary Disease) r/t SOB, use of medications. Focus: Is on IV Vancomycin HCl Intravenous Solution Reconstituted 750 MG (Vancomycin HCl) r/t leukocytosis (elevated white blood cell count indicating infection). Goal: Will not have any complications related to IV Therapy through the review date. Focus created on 09/16/24 and revised on 09/29/25: [Resident #1] exhibits Behaviors r/t Elopement risk/wanderer, disoriented to place, wanders aimlessly, refuses ADL care/showers frequently. Yells out at other residents. Removes her wound bandages, removes her colostomy bag. Record review of Resident #1's Oder Summary Report dated 11/12/25 revealed, Vancomycin HCl Intravenous Solution Reconstituted 750 MG (Vancomycin HCl) Use 750 mg intravenously every 12 hours for abnormal lab for 10 Days; start date 11/11/25. Record review of Resident #1's November 2025 MAR revealed, the first dose of Vancomycin Resident #1 received was administered by RN A on 11/12/25 at 11:21 AM. Record review of Resident #1's Change in Condition assessment dated [DATE] revealed, staff monitored for adverse reactions due to Vancomycin and Resident #1 did not have any changes/remained stable. Her vitals were within range, she had normal body temperature (97.7), blood pressure (118/62), Respiratiosn (17), pulse (72) and her oxygen rate was at 97 %. The nurse received orders for an immediate test of Resident #1's Vancomycin Levels and a BMP. Record review of Resident #1's Progress Notes dated 11/12/25 at 12:35 PM signed by ADON A revealed, Resident assessed for [adverse reactions] to Vancomycin IV. Medical Director in building and updated on Vancomycin administration issue. MDinformed no adverse reaction noted during assessment. New orders received from medical director after viewing resident for STAT Trough (immediate laboratory values) ordered to ensure resident is in therapeutic range with medication. BMP to be drawn tomorrow and redraw for Vanco trough 11/14. Vancomycin to be held until result is received for STAT trough and observed resident q 1hr x 24 hours. NP called and updated on the above. Record review of Resident #1's Lab results dated 11/13/25 revealed, the vancomycin levels came out as low and there were no significant change to her BMP. An observation on 11/12/25 at 11:52 AM revealed, Resident #1 in her wheelchair in the doorway of her room as she received Vancomycin 750 mg/150 ml at 250 ml/hr. (calculated administration duration of 36 minutes). Her left foot was wrapped in a white dressing and her right arm had IV tubing that protruded from under a white gauze dressing. The IV bag had no labeling outside of the manufacturer labeling, there was no pharmacy label that contained the resident's name, dose and instruction for use, administration flow rate, name of prescriber, or date the medication was ordered. The resident was not interviewable, she was confused, tugged on her IV tubing and was combative with staff who passed by. Observation revealed a dial a flow pump. Resident #1 appeared to be in no immediate distress, her skin was not red, she took normal breaths and had no shortness of breath. In an interview on 11/12/25 at 11:54 AM, RN A said the label for Resident #1's Vancomycin must have fallen off after she hung the medication and all medications must have a pharmacy label that includes the residents

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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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676137	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Center -	8902 West Rd Houston, TX 77064

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, included the appropriate accessory and cautionary instructions, the expiration date when applicable and stored all drugs and biologicals in locked compartments and under proper temperature controls, and permitted only authorized personnel to have access to the keys for 1 of 4 residents (Resident #1) reviewed for medication storage. - RN A failed to ensure Resident #1's Vancomycin IV was labeled when she administered the medication on 11/12/25. This failure could place residents at risk of incorrect medication administration and adverse reactions to medications. Findings included: Record review of Resident #1's Face Sheet dated 11/12/25 revealed, a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included: COPD (group of lung diseases that block airflow cause difficulty breathing), muscle weakness, depression, difficulty walking, right great toe amputation, lower left leg open wound and peritoneal abscess (pus within the abdomen due to an infection). Record review of Resident #1's Quarterly MDS dated [DATE] revealed, severely impaired cognition as indicated by a BIMS score of 00 out of 15, fluctuating behaviors of: inattention, disorganized thinking and altered level of consciousness. Behavioral symptoms of: physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing), Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, , or verbal/vocal symptoms like screaming, disruptive sounds) were marked as Behavior not exhibited. Rejection or care and wandering were marked as: Behavior not exhibited. Record review of Resident #1's undated Care Plan revealed, focus: COPD (Chronic Obstructive Pulmonary Disease) r/t SOB, use of medications. Focus: Is on IV Vancomycin HCl Intravenous Solution Reconstituted 750 MG (Vancomycin HCl) r/t leukocytosis (elevated white blood cell count indicating infection). Goal: Will not have any complications related to IV Therapy through the review date. Focus created on 09/16/24 and revised on 09/29/25: [Resident #1]exhibits Behaviors r/t Elopement risk/wanderer, disoriented to place, wanders aimlessly, refuses ADL care/showers frequently. Yells out at other residents. Removes her wound bandages, removes her colostomy bag. Record review of Resident #1's Oder Summary Report dated 11/12/25 revealed, Vancomycin HCl Intravenous Solution Reconstituted 750 MG (Vancomycin HCl) Use 750 mg intravenously every 12 hours for abnormal lab for 10 Days; start date 11/11/25. Record review of Resident #1's November 2025 MAR revealed, the first dose of Vancomycin Resident #1 received was administered by RN A on 11/12/25 at 11:21 AM. An observation on 11/12/25 at 11:52 AM revealed, Resident #1 in her wheelchair in the doorway of her room as she received Vancomycin 750 mg/150 ml at 250 ml/hr. (calculated administration duration of 36 minutes). Her left foot was wrapped in a white dressing and her right arm had IV tubing that protruded from under a white gauze dressing. The IV bag had no labeling outside of the manufacturer labeling, there was no pharmacy label that contained the resident's name, dose and instruction for use, administration flow rate, name of prescriber, or date the medication was ordered. In an interview on 11/12/25 at 11:54 AM, RN A said the label for Resident #1's Vancomycin must have fallen off after she hung the medication and all medications must have a pharmacy label that included the residents name, medication information and directions for use. She said failure to have a label could result in individuals not knowing what the medication was or how it should be administered. In an observation and interview in the medication room on 11/12/25 at 12:43 PM, the DON said all IV medications should have a pharmacy label that included the pharmacy's information, resident's name, medication information and directions for use. A bag of Resident #1's IV Vancomycin was observed in the fridge with each IV bag wrapped in a foil manufacturer bag and an attached pharmacy label with pharmacy information, resident information, provider information, drug information and directions for use. The label read Vancomycin 750 ml: Infuse intravenously 150 ml (750 mg) over 60 minutes every 12 hours for 10 days. The DON said failure to label medication could result in staff being unaware of the instructions for use including the dosing. Record review of the facility policy titled Infusion Therapy Product Labels revised 11/13/2018 revealed, Policy: Infusion therapy products are labeled in accordance with facility requirements and applicable state and federal laws. The label includes sufficient additional information as required to assure safe and efficient administration to residents. Procedures: a. Infusion therapy products are labeled by the provider with: 1) Resident name; 2) Physician name; 3) Pharmacy name, address, and telephone number 4) Contents of