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	06/06/2025

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 8 residents (Resident #18) reviewed for comprehensive assessments. The facility failed to ensure that Resident #18's care plan documented interventions for the resident's diagnoses of acute respiratory failure with hypoxia, chronic obstructive respiratory disease, and sleep apnea to include continuous oxygen therapy and the use of BiPAP (bilevel positive airway pressure, a form of noninvasive ventilation) at bedtime. This deficient practice could place residents at risk of not receiving proper care and services. Findings included: Record review of Resident #18's undated admission face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. She was initially admitted on [DATE]. Resident #18's diagnoses included: acute respiratory failure with hypoxia (inadequate gas exchange by the respiratory system), pneumonia, and morbid obesity. Record review of Resident #18's history and physical dated 3/10/25 revealed diagnoses to include obstructive sleep apnea (OSA). Record review of Resident #18's hospital Discharge summary dated [DATE] revealed a past medical history of chronic obstructive pulmonary disease (COPD): a lung condition caused by damage to the airway. Record review of Resident #18's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18's Brief Interview for Mental Status (BIMS) (a score used to assess cognitive function) was 13 out of 15 which indicated intact cognition. Further review revealed she received respiratory treatments: oxygen and non-invasive mechanical ventilator. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #18's active physician's orders as of 06/05/25 revealed the following orders: an order for vent settings for the non-invasive ventilator (NIV) with oxygen at 2 liters/min every evening at bedtime for COPD and keep on. Remove at 8:00 AM start date was 04/03/25. An order for Oxygen at 2L/min continuous per nasal cannula, every shift r/t acute respiratory failure with hypoxia, start date 6/04/25. An order for Albuterol inhalation solution, 3ml inhale orally every 6 hours for SOB, start date 04/01/25. An order for Flovent inhalation, 1 puff inhale orally as needed for SOB, rinse mouth and spit out after use, start date 05/04/25. Record review of Resident #18's MAR for May 2025 revealed the resident had been receiving oxygen at 2L/m continuous per nasal cannula every shift, order date was 03/31/25. The resident had been receiving the NIV physician's order every night, order date was 03/31/25. Record review of Resident #18's undated care plan revealed: Focus - At risk for falls r/t Respiratory Failure, anemia, depression, CAD, HTN, CHF, pain, date initiated and created was 03/10/25. Interventions - call light in reach; ensure appropriate footwear; maintain a clear pathway. Focus - has acute/chronic pain r/t Respiratory failure, A-Fib, CHF, CAD, GERD, Cellulitis (a bacterial skin infection), date initiated and created was 03/10/25. Interventions included - administer analgesic medications as per orders. Monitor/record/report to nurse any s/sx of non-verbal pain: changes in breathing. Further review revealed the resident's diagnoses of COPD and sleep apnea were not addressed. Interventions for use of oxygen therapy and the need for the BiPAP were not addressed. Observation and interview on 06/03/25 at 11:00 AM, revealed Resident #18 had humidified oxygen on at 2L/min via nasal cannula. Resident #18 stated she used the BiPAP machine for 7 hours each night, like she would do when she was at home and that she used it because her coughing had been an issue. In an interview on 06/06/25 at 10:27 AM, LVN-G stated she was responsible for care plans for all LTC and skilled care residents since the second MDS nurse recently left the facility 2 months ago. LVN-G stated the purpose of the care plan was to have knowledge on how to care for each individual resident. LVN-G stated the IDT put all their input about the resident's care together and then she would apply the information into the care plan properly. LVN-G stated she oversaw the development of the care plan and would be the only one who would make updates. LVN-G stated Resident #18's respiratory diagnoses, obstructive sleep apnea (OSA), use of oxygen and use of the NIV ventilator should be in the care plan because it was part of continuity of care for the resident. LVN-G stated she did not know about it until she saw the orders for respiratory therapy on 6/4/25, and that it did fall through the cracks. LVN-G stated Resident #18's care plan should have been updated upon admission and she did not know she needed to audit her former partner's work. LVN-G stated she planned to audit every resident so nothing like this happened to other residents. LVN-G stated if it was not in the care plan that meant the team was not reviewing it during IDT meetings but the information was in the TARS so there would not be any harm to the resident as her respiratory status was being monitored. When asked who used or looked at the care plan, LVN-G stated she would hope the whole nursing department and the family would. LVN-G stated for new residents she put everything about the resident and their needs into the care plan and would not wait to put it into the MDS so nurses could know how to care for the residents properly and safely. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/06/25 at 11:05 AM, the DON stated the care plan allows the IDT to know how to meet the needs of the resident. The DON stated the first care plan is initiated by the DON or ADON and the MDS nurse will update from there. The DON stated the respiratory needs of Resident #18 should be in the care plan because it is part of her care and informs the IDT and staff of what they need to do for the resident. The DON stated if not in the care plan, it should not affect the resident because there were other ways to identify the care that Resident #18 needed. Record review of the facility's policy and procedure for Comprehensive Person-Centered Care Planning, revised on August 2017, read in part: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment 2. The baseline care plan will include minimum healthcare information necessary to properly care for a resident .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan or the residents' goals and preference for 2 of 2 residents (Resident #18 and #2) reviewed for respiratory care. -The facility failed to maintain oxygen therapy equipment in a clean and sanitary manner. Resident #18's and Resident #2's mask used with the BiPAP (bilevel positive airway pressure, a form of noninvasive ventilation) was open to air and not stored in a plastic bag. This failure could place residents at risk of infection or a decline in health. Findings included: 1. Record review of Resident #18's undated admission face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. She was initially admitted on [DATE]. Resident #18's diagnoses included: acute respiratory failure with hypoxia (inadequate gas exchange by the respiratory system), pneumonia, heart failure, cellulitis of the right lower limb (a bacterial skin infection) and morbid obesity. Record review of Resident #18's history and physical dated 3/10/25 revealed diagnoses to include obstructive sleep apnea. Record review of Resident #18's hospital Discharge summary dated [DATE] revealed a past medical history of chronic obstructive pulmonary disease (COPD): a lung condition caused by damage to the airway. Record review of Resident #18's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18's Brief Interview for Mental Status (BIMS) (a score used to assess cognitive function) was 13 out of 15 which indicated intact cognition. Further review revealed she received respiratory treatments: oxygen and non-invasive mechanical ventilator. Record review of Resident #18's active physician's orders as of 06/05/25 revealed an order for vent settings for the non-invasive ventilator (NIV) with oxygen at 2 liters/min every evening at bedtime for COPD and keep on. Remove at 8:00 AM and start date was 04/03/25. Record review of Resident #18's June 2025 MAR/TAR, revealed on 6/4/25 at 8:00 AM revealed LVN-E removed the NIV mask from Resident #18. Record review of Resident #18's undated care plan revealed oxygen therapy and the need for the BiPAP was not addressed. 2. (continued on next page)

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	676137	A. Building B. Wing	06/06/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's undated admission face sheet revealed an [AGE] year-old admitted to the facility on [DATE]. Her diagnoses included hemiplegia (one sided paralysis) and hemiparesis (paralysis to one side of body) following a stroke; diabetes; morbid obesity and obstructive sleep apnea. Record review of Resident #2's admission MDS dated [DATE] revealed a BIMS score of 8 out of 15 indicating moderate cognitive impairment. Further review revealed she received respiratory treatments: oxygen and non-invasive mechanical ventilator. Record review of Resident #2's active physician's orders as of 06/05/25 revealed vent settings for the non-invasive positive pressure ventilator with oxygen at 2 liters/min every day at bedtime for NIV (non-invasive ventilation) off at 8:00AM, start date was 06/04/25. Record review of Resident #2's undated care plan revealed: Focus - Resident #2 received oxygen therapy r/t ineffective gas exchange, OSA, asthma; often refuses her BiPAP at night despite health teaching. Date created on 3/27/25 and revised on 5/07/25. Goal - Will have no s/sx of poor oxygen absorption through the review date. Interventions included - assist with applying the NIV at nighttime per MD orders. Oxygen settings via nasal prongs at 2L/m continuously. In an observation on 06/04/25 at 10:22 AM, revealed Resident #18's mask for the BiPAP NIV was not stored in a bag. The mask was on top of the nightstand and the plastic bag was under the mask. In an interview on 06/04/25 at 10:50 AM, MA-R stated Resident #18's mask for the BiPAP should be in a plastic bag when not in use to keep dirt and dust off and keep from cross-contamination. MA-R stated she did not know why it was not stored properly and who would have left it out. In an interview on 6/4/25 at 1:35 PM, LVN-D was not assigned to Resident #18 and stated the BiPAP mask should be stored in a plastic bag when not in use d/t contaminants could get in the mask leading to resident inhaling contaminants and potential infection. LVN-D states she did not know why it was not in a plastic bag. In an interview on 6/04/25 at 1:45 PM, LVN-E stated she was assigned to Resident #18 and stated the BiPAP mask should be stored in a bag when not in use d/t infection control and a wandering resident could pick it up and put it on their face and mouth. LVN-E stated, the facility did have residents who wander. LVN-E stated she did not know why the mask was not stored properly. In an observation and interview on 6/5/25 at 10:35 AM, revealed Resident #2 was resting on the bed and alert. Resident #2 was not in distress her respirations were even, her skin color was normal and nothing abnormal was observed. The mask for the NIV was draped over the ventilator which was on top of the nightstand. The mask was not stored in a bag. The empty plastic bag was on the wall hook next to the ventilator. Resident #2 did not answer when asked if she knew why she used the NIV. (continued on next page)

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	676137	A. Building B. Wing	06/06/2025

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Legend Oaks Healthcare and Rehabilitation Center -	8902 West Rd Houston, TX 77064

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/5/25 at 11:37 AM, the DON stated she expected BiPAP masks to be inside a plastic bag when not in use for infection control purposes. The DON stated when left out open to air, dust and other contaminants could get on it and could enhance allergies or cause shortness of breath. The DON stated Resident #18 uses the BiPAP because she has COPD and was not sure but maybe Resident #18 may have been the one to remove the mask and place it on the nightstand. The DON stated she visited the resident almost every morning when doing rounds and had seen the mask stored properly. The DON stated she did not know why the mask for Resident #2 was not stored properly. In an interview on 6/6/25 at 7:59 AM, Resident #18 stated she had seen on many occasions that staff would place the mask into a plastic bag after it was taken off her. Record review of the facility's ongoing in-service training report dated 2/13/25 for Infection Control; Oxygen Supplies, conducted by the DON indicated the topic included: every nurse must ensure masks/nasal cannulas must be kept in bags when not in use. Further review revealed that LVN-D signed the in-service and LVN-E's signature was not on the training report. Record review of the facility's policy and procedure for Infection Control, revised on October 2022, revealed in part: The infection prevention and control program is a facility-wide effort involving all disciplines and individuals Goals .decrease the risk of infection to residents and personnel. Recognize infection control practices while providing care .Ensure compliance with state and federal regulations related to infection control . Record review of the facility policy and procedure for Oxygen Equipment, Licensed Nurse Procedures revised on May 2007, revealed in part: It is the policy of this facility to maintain all oxygen therapy equipment in a clean and sanitary manner .Procedures .E. When mask or cannula is temporarily not being used, it will be covered loosely to prevent contamination from airborne microorganisms. It will not be covered tightly .

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	676137	A. Building B. Wing	06/06/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for one (Resident #84) of four residents reviewed for pharmacy services. The facility failed to ensure all of Resident #62's medications were administered as ordered by the physician resulting the incorrect medication of Multivitamin. This failure could place residents at risk of not receiving medications as ordered by their physicians and exacerbations of their medical conditions. Findings included: Record review of Resident #62's face sheet dated 06/05/25 revealed an [AGE] year-old female admitted to the facility on [DATE] and initially admitted on [DATE]. Resident #62's diagnoses included Osteoporosis (a condition that weakens bones and increases the risk of fractures), difficulty in walking, muscle weakness, diabetes, hypertension, and dementia. Record review of Resident #62's quarterly MDS dated [DATE] indicated she had short term and long-term memory problems. She had severely impaired cognitive skills for daily decision making. Record review of Resident #62's active orders as of 07/24/24 included a physician's order for Multivitamin-Minerals Oral Tablet (Multiple Vitamins w/ Minerals) give 1 tablet via mouth daily. Date started was 07/24/24. Record review of Resident #62's undated care plan included: Focus - Resident #62 was at risk for a nutritional deficit related to diagnosis of anorexia, and diabetes. Interventions - Monitor/record/report to MD PRN signs and symptoms of malnutrition. In an observation on 06/04/25 at 7:55 AM, revealed MA-Q prepared medications for Resident #62. MA-Q sanitized her hands and placed the following medications into a medication cups: Multivitamin, one tablet; Loratadine 10 mg one tablet; Famotidine 10 mg 2 tablets; and Amlodipine 5 mg 2 tablets. ; MA-Q washed her hands at the sink, put on clean gloves and administered the medications to Resident #62. Record review of Resident #62's May 2025 MAR/TAR revealed MA-Q documented administration of a Multivitamin-Minerals Oral Tablet (Multiple Vitamins w/ Minerals), 1 tablet on 06/04/25 in the morning. In an interview on 06/05/2025 at 12:45 PM with MA-Q, requested that she show me the medication she had given to Resident #62 on 06/04/2025. , MA-Q showed the surveyor both bottles and pointed to the multivitamin with minerals. MA-Q stated she gave the multivitamin with minerals yesterday not the multivitamin. MA-Q stated I am positive I did give the correct medication. (continued on next page)

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	676137	A. Building B. Wing	06/06/2025

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/05/2025 at 12:45 PM with MA-R she stated, giving the right medicine to the resident wasis important because giving the wrong medication could cause a bad reaction or the resident may not receive the beneficial effect of the correct medication. She stated the five rights appropriately. MA-R stated there was a difference between a multivitamin and a multivitamin with minerals because a multivitamin with minerals hads minerals. She stated a recent in-service was this morning regarding medication administration. In an interview on 06/05/2025 at 2:25 PM with LVN S, she stated it is important resident gets correct medication because resident could potentially have side effects and adverse reactions, the wrong medicine could cause more serious illness. LVN S stated the correct medication will ease the symptoms, cure and be beneficial with the disease process. LVN S was able to verbalize the five rights for medication administration. LVN S stated there is a difference between a multivitamin and a multivitamin with minerals, and the minerals in the multivitamin with minerals will assist with nutrition and healing. LVN S stated a recent in-service was this morning regarding medication administration. In an interview on 06/05/2025 at 2:30 PM with the Director of Nursing (DON), she stated the correct medication is very important so it can have a positive effect on the resident. The DON stated if the resident receives the wrong medication, it could have an adverse effect. The DON stated the difference between a multivitamin and a multivitamin with minerals was, the multivitamin with minerals is given to supplement resident for wound healing and nutrition. The DON stated in-services are given daily regarding medication administration. The DON stated she, the Assistant Director of Nurses (ADON) or pharmacist are responsible to ensure med aides and nurses administer medication correctly. Record review of facility's Policy for Administering Medications through an Enteral Tube Level III Preparation revealed Purpose: The purpose of this procedure is to provide guidelines for the safe administration. Preparation 1. Verify that there is a physician's medication order. 2. Review the resident's care plan to assess for any special needs of the resident. General Guidelines: Follow the medication administration guidelines. Steps in the procedure: 6. Check the label and confirm the medication name and dose with the EMAR (electronic medical administration record). 7. Check the expiration date on the medication. Properly dispose of expired medications. 8. Prepare the correct dose of medication.

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	676137	A. Building B. Wing	06/06/2025

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys for one of 8 residents (Resident #18) reviewed for storage of medications. The facility failed to ensure Resident #18's Fluticasone inhaler medication used for shortness of breath, was secured, and not left at the bedside. This deficient practice could place residents at risk for loss of biologicals and place residents at risk of access to hazards. Findings included: Record review of Resident #18's undated admission face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. She was initially admitted on [DATE]. Resident #18's diagnoses included: acute respiratory failure with hypoxia (inadequate gas exchange by the respiratory system), pneumonia, heart failure, and morbid obesity. Record review of Resident #18's hospital Discharge summary dated [DATE] revealed a past medical history of chronic obstructive pulmonary disease (COPD): a lung condition caused by damage to the airway. Record review of Resident #18's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18's Brief Interview for Mental Status (BIMS) (a score used to assess cognitive function) was 13 out of 15 which indicated intact cognition. Further review revealed she received respiratory treatments: oxygen and non-invasive mechanical ventilator. Record review of Resident #18's active physician's orders as of 06/05/25 revealed an order for Flovent Diskus Inhalation aerosol powder breath activated 250 MCG/ACT (Fluticasone Propionate (inhalation), I puff inhale orally as needed for SOB, rinse mouth and spit out after use, start date 5/04/25. Further review revealed no physician's order for self-administration of Flovent or any other medications . Continued review of Resident #18's chart revealed there was no self-administration assessment. Record review of Resident #18's June 2025 MAR printed on 6/6/25 revealed therevealed the last time Resident #18 received Fluticasone Propionate (inhalation) was on 6/1/25 at 7:05 PM by LVN-F. In an observation on 06/04/25 at 10:22 AM, the medication with Resident #18's name on the pharmacy label for Flovent Diskus Inhalation aerosol powder breath activated 250 MCG/ACT for Resident #18 was on top of the nightstand behind the mechanical ventilator. Resident #18 had humidified oxygen via nasal cannula and oxygen concentrator set at 2L/m. The resident was on her back with the head of bed raised, alert and oriented with no signs of distress. Resident #18 denied knowing anything about the box of medication on the nightstand. (continued on next page)

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	676137	A. Building B. Wing	06/06/2025

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 06/04/25 at 10:50 AM, MA-R stated medications should not be left in a resident's room and did not know why Resident #18's inhaler medication was left in the room. MA-R stated that medication was given by the nurses and not the medication aides. MA-R stated the only individuals who could administer medications were the nurses and medication aides. Residents could not self-administer unless they had a doctor order. MA-R stated the risk was that residents who wandered may pick up and ingest the medication that was not for them. MA-R removed the medication from the room. In an interview on 06/04/25 at 1:35 PM, LVN-D stated medications should not be left in resident rooms unless there is a doctor order for the resident to self-administer. LVN-D stated the risk to the resident would be overmedication and misuse of the medications. LVN-D stated she was not assigned to care for Resident #18 and did not know why the medication was left at the bedside. In an interview on 06/04/25 at 1:45 PM, LVN-E stated medications should not be left in resident rooms unless there is an order for self-administration. LVN-E stated she was assigned to Resident #18, checked her chart, and stated that Resident #18 did not have an MD order for self-administration of meds. LVN-E stated she did not know why it was left in the room and that she did not give the inhaler on her shift. LVN-E stated the risk would be the medication could be given to the wrong resident, anyone such as another resident could come into the room take it and can overdose, it can be a choking hazard or can be taken incorrectly. LVN-E stated it would be an infection control issue and the facility does have residents who wander. In an interview on 06/04/25 at 11:37 AM, the DON stated, unless the resident has MD orders to keep medications in the room, they should not be left at the bedside. When asked who was responsible, the DON stated typically the nurses do not leave medications in the room. The DON stated the risk could be if another resident picks up the medication, ingests it they may have a reaction. The DON stated there were residents who wander in the building. The DON stated a resident could overuse their medication and not follow the MD orders if it was left in their room. The DON stated going forward she would conduct in-services for the nurses to understand medications should not be left at the bedside without first obtaining a doctor order, assessing, and educating the resident. The DON stated if a resident has orders to self-administer medications, the medication should be stored appropriately. Record review of the facility policy for Storage of Medications, revised on April 2007, revealed in part: The facility shall store all drugs and biologicals in a safe, secure and orderly manner 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner . 7. Compartments .containing drugs and biologicals shall be locked when not in use .

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	06/06/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews the facility failed to properly store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed. The facility failed to ensure bulk foods were stored in a manner to prevent contamination. The facility failed to ensure foods were sealed properly in the pantry and freezer. The failures could place residents at risk for food contamination and foodborne illness. Findings included: Observation 06/03/2025 8:29 AM of the kitchen for initial observation revealed the following: 8:30 AM the dry storage area contained: 1 plastic bag of dry spiral noodles not sealed , exposed to air. 8:34 AM the freezer contained: 1 cardboard box of frozen hamburger patties not sealed , exposed to air. 1 cardboard box of frozen breakfast patties not sealed , exposed to air. 1 cardboard box of frozen biscuits not sealed , exposed to air. IInterview with Dietary Manager on 6/3/25 8:40 AM, she stated all food should be closed when stored in the dry food area, or the refrigerator or freezer to maintain freshness, prevent frostbite and contamination. The Dietary Manager stated the residents could get food poisoning or sick if the food was contaminated and the food would not taste good if it was frostbitten. The Dietary Manager stated it was the kitchen staff responsibility to seal and label food items and she did not know who failed to seal and label to the food items. Record Review of the policy on Refrigerators and Freezers copyright 2001 MED-PASS, Inc. (revised December 2014) revealed: Policy Statement: This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. Policy Interpretation and Implementation 7. All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 8 residents (Resident #18) reviewed for infection control practices. -The facility failed to ensure CNA-A and CNA-B followed proper infection control and hand hygiene practices during incontinent care for Resident #18. CNA-A failed to change both gloves and perform hand hygiene after cleaning the resident and prior to touching clean items. CNA-A and CNA-B failed to perform hand hygiene prior to leaving Resident #18's room after incontinent care. This failureThis failure could place residents at risk of infection or a decline in health. Findings included: 1. Record review of Resident #18's undated admission face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. She was initially admitted on [DATE]. Resident #18's diagnoses included: acute respiratory failure with hypoxia (inadequate gas exchange by the respiratory system), pneumonia, heart failure, cellulitis of the right lower limb (a bacterial skin infection) and morbid obesity. Record review of Resident #18's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18's Brief Interview for Mental Status (BIMS) (a score used to assess cognitive function) was 13 out of 15 which indicated intact cognition. Resident #18 was always incontinent of urine and frequently incontinent of bowel. Resident #18 was dependent on staff assistance for toileting hygiene and required substantial assistance with showers or bathing self. Record review of Resident #18's undated care plan revealed: Focus - ADL (basic self-care tasks) self-care performance deficit r/t anemia, depression, atrial fibrillation (irregular heartbeat), coronary artery disease (a type of heart disease affecting the major blood vessels to the heart), hypertension (elevated blood pressures), congestive heart failure (a condition where the heart is unable to pump enough blood to meet the body's needs), cellulitis. Date initiated and created was 03/10/2025. Goal - will maintain the highest level of function in bed mobility, transfers, eating, dressing, grooming, toilet use and personal hygiene. Interventions included - encourage to participate to the fullest extent possible with each interaction; resident will receive the required assistance with transferring. Date initiated and created was 03/10/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/04/25 at 10:00 AM, during incontinent care, revealed Resident #18 was alert and oriented, lying in bed with the head of bed raised. CNA-A and CNA-B washed their hands at the sink, put on clean gowns and clean gloves. CNA-A and CNA-B lowered the head of the bed and adjusted the bedding. CNA-B assisted by unfastening Resident #18's adult brief. CNA-A used cleansing wipes to clean inside the groin area and vaginal area. CNA-A used one clean wipe per each stroke. CNA-A, using both gloved hands, lifted Resident #18's left leg over the right leg to aid in turning the resident to her right side. CNA-B assisted with turning. CNA-A used one clean wipe per stroke to cleans the peri-anal area from front to back and to cleanse the buttocks. The brief had urine and CNA-A rolled it up and disposed it into the trash bag. CNA-A did not remove used gloves, perform hand hygiene or put on clean gloves. CNA-A then touched the clean brief and positioned it under the resident. CNA-A placed barrier cream onto her right gloved hand and applied cream to Resident #18's peri-anal area and buttocks. Resident #18 turned onto her back and CNA-A applied barrier cream using her right gloved hand to Resident #18's groin area. CNA-A removed the glove on the right hand, disposed it into the trash, did not remove the glove on the left hand and did not perform hand hygiene. CNA-A then put on a clean glove to the right hand only. CNA-A fastened Resident #18's brief with assistance from CNA-B. CNA-A and CNA-B touched the bedding and covered the resident. CNA-A and CNA-B removed their gloves and gown, placed them into the trash bag and secured the trash bag. CNA-A placed the trash bag into the bin in the hallway just outside Resident #18's doorway. CNA-A and CNA-B did not perform hand hygiene prior to leaving Resident #18's room. CNA-A walked to the nearest hand sanitizer dispenser in the hallway and performed hand hygiene and then walked into another resident's room across the hall, where two nurses were assisting a resident back into bed. CNA-B walked down the hallway and out of sight, no hand hygiene was observed while in the immediate area. In an interview on 6/4/25 at 1:00 PM, CNA-A stated after the dirty steps are completed during incontinent care, she would put all the soiled and dirty items into a bag, then put the clean brief on the resident, she would then put the trash bag into the dirty barrel outside the door. CNA-A stated that she did change the glove on the right hand prior to continuing with the clean procedure and used her left gloved hand because it was still clean. CNA-A stated she could touch the clean brief and bed linen at this point. CNA-A then walked away to attend to a resident. In an interview on 6/4/25 at 1:05 PM, CNA-C was not assigned to Resident #18. CNA-C stated when she performs incontinent care, she would change gloves each time they are soiled or used and would perform hand sanitization with each glove change. CNA-C stated it was important for infection control and would not use dirty/used gloves to touch clean briefs. CNA-C stated she would wash hands before stepping out of the room because it was facility policy. CNA-C stated used gloves were dirty and even if soilage is not visible there could be bowel movement on the gloves and it could transfer to clean items. CNA-C stated it was important to keep things clean and hygienic. CNA-C stated the risk would be to other residents if the resident she was just caring for had C-diff in the stool, then it could be transferred to others, infecting them. In an interview on 6/4/25 at 2:00 PM, CNA-B stated she put on gown and gloves when doing incontinent care for Resident #18 because the resident was in EBP d/t sores on the legs. CNA-B stated dirty gloves are still dirty even though they were not visibly dirty. CNA-B stated the risk was cross contamination, if she had dirty gloves and touched the remote control/bed control for example the resident could get an infection if they touch the controls, put their hands in their mouth and they could get sick. When ask why she did not perform hand hygiene prior to leaving Resident #18's room when she was assisting with incontinent care, she stated she was in a rush to get to her next resident and stated she went straight to the sink and washed her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/5/25 at 11:37 AM, the DON stated during incontinent care she expected that the CNAs did not break infection control process, work the dirty area, remove dirty gloves, perform hand hygiene, and put on clean gloves. The DON stated the purpose was to prevent spread of infection and they should not touch clean items with dirty gloves. The DON stated she expected staff to hand sanitize/hand wash prior to leaving a resident room. The DON stated with the use of barrier cream she would expect the staff to remove gloves, hand sanitize, put on clean gloves, and then apply the cream to the resident's skin. The DON stated there was no excuse for CNAs not to follow protocol, as they know better and have had in-service on infection control. Record review of the facility's In-Service Training Report dated 4/16/25, for Incontinent/Perineal Care, conducted by the Staffing Coordinator and IP nurse, indicated CNA-A and CNA-B signed the training report. Record review of the facility's policy and procedure for Hand Hygiene, revised in October 2022 revealed in part: It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards. Purpose: Hand hygiene is one of the most effective measures to prevent the spread of infection .All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors Procedure: 2. Use an alcohol-based hand rub .or, alternatively, soap .and water for the following situations: .b. Before and after direct contact with residents .h. Before moving from a contaminated body site to a clean body site during resident care .m. after removing gloves .r. After removing and disposing of personal protective equipment Record review of the facility policy and procedure for Perineal Care, revised on May 2007, revealed in part: It is the policy of this facility to: 1. Cleanse perineum .3. Prevent irritation or infection .Procedures: .5. Wash hands properly .6. Use gloves properly Record review of the facility's policy and procedure for Infection Control, revised on October 2022, revealed in part: The infection prevention and control program is a facility-wide effort involving all disciplines and individuals Goals .decrease the risk of infection to residents and personnel. Recognize infection control practices while providing care .Ensure compliance with state and federal regulations related to infection control .