STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676174	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation	2202 N Travis Ave Cameron, TX 76520

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the right to be free from Misappropriation of Resident Property for 3 of 5 residents (Residents #1, #2 and #3) The facility failed to prevent the misappropriation of Resident #1's discontinued Hydrocodone/ Tylenol 7.5mg/ 325mg when 10 tablets could not be accounted for and Resident #2's hydromorphone liquid 1mg/ml when 120 ml could not be accounted for, and Resident #3's Hydrocodone/ Tylenol 10 mg/ 325mg when 56 tablets could not be accounted for. The noncompliance was identified as PNC. The past noncompliance began on 05/29/2025 and ended on 06/04/2025. The facility had corrected the noncompliance before the investigation began. This failure had the potential to affect the residents in the facility by placing them at risk for misappropriation of resident medication and drug diversion. Findings included: Review of Resident #1's face sheet reflected she was admitted on [DATE] and discharged from the facility on 05/29/2025 with the following diagnoses COPD (disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough.), and left femur fracture (fracture of left hip). Review of Resident #1's Medicare 5-day MDS assessment reflected she was assessed to have a BIMS score of 14 indicating she was cognitively intact. Resident #1 was assessed to have pain and be on an opioid. Review of Resident #1's comprehensive care plan reflected Resident #1 was discharged from the facility with her family member on 05/29/2025. Further review of Resident #1's care plan reflected she had a focus area related to chronic pain syndrome. Interventions included administer pain mediation as ordered. Review of Resident #1's physician's orders reflected an order for Hydrocodone-Acetaminophen 7.5mg/ 325mg every 6 hours as needed for pain with the start date 05/13/2025 and discontinued on 05/29/2025. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676174	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation	2202 N Travis Ave Cameron, TX 76520

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's face sheet reflected she was admitted on [DATE] and readmitted on [DATE] and discharge date of 05/26/2025. Resident #2's diagnoses included cerebral infarction (the pathologic process that results in an area of necrotic (dead tissue) tissue in the brain. It is caused by disrupted blood supply (ischemia) and restricted oxygen supply (hypoxia).) and vascular dementia (A group of symptoms that affects memory, thinking and interferes with daily life.). Review of Resident #2's discharge MDS (death in facility) reflected Resident #2 was assessed to be on hospice services. Review of Resident #2's comprehensive care plan reflected Resident #2 had a plan of care for pain and hospice with interventions that included pain medication. Review of Resident #2's physician's orders reflected an order hydromorphone HCL liquid 1mg/ml every 2 hours as needed for pain with a discontinuation date of 05/26/2025. Review of Resident #3's face sheet reflected she was admitted on [DATE] with the following diagnoses cerebral infraction (the pathologic process that results in an area of necrotic tissue in the brain. It is caused by disrupted blood supply (ischemia) and restricted oxygen supply (hypoxia).) and diabetes mellitus type 2 (A condition results from insufficient production of insulin, causing high blood sugar.). Review of Resident #3's Quarterly MDS assessment reflected a BIMS score was not conducted indicating she had severe cognitive impairment. Resident #3 was assessed to have scheduled pain medication regimen. Review of Resident #3's comprehensive care plan reflected a focus area for hospice care and routine pain medication. Review of Resident #3's physician's orders reflected Resident #3 Hydrocodone-Acetaminophen 10 mg/ 325mg with a discontinuation date of 05/30/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676174	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation	2202 N Travis Ave Cameron, TX 76520

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's investigation report dated 05/29/2025 reflected on 05/29/2025 the ADON took Resident #1's discontinued medication Hydrocodone-Acetaminophen 10 mg/ 325mg off the medication cart from the charge nurse LVN A. LVN A was concerned regarding the way the ADON took the discontinued medication off her cart without signing for it. LVN A informed her DON. When the DON requested the ADON produce the discontinued mediation, the count sheet had been modified from the last accurate count of 49 (which was documented with two nursing signatures at morning shift change on 05/29/2025) to 39. The ADON had no explanation for the discrepancy except that she did not follow the facility's procedure. Further review of the facility's investigation report reflected that during an audit of all discontinued medications the facility found 2 additional medications missing for Resident #2 and Resident #3 (Resident #2's hydromorphone liquid 1mg/ml when 120 ml could not be accounted for, and Resident #3's Hydrocodone/ Tylenol 10 mg/ 325mg when 56 tablets could not be accounted for). The facility terminated the ADON because she did not follow narcotic policies and procedures that she knew. She stated that in her statement and she was the last in chain of custody for Resident #1's discontinued medication. It was also decided to in -service all staff to not release medications without a signature or give keys to anyone, no matter their position (ADON follows same policies and procedures and everyone else.) LVN A, even though she identified the concern was counseled individually by the DON because she released the medications without proper procedures being followed. The facility further put a new policy in place that two signatures were required when placing discontinued medications in storage that are waiting for destruction. The facility's investigation team decided that this drug diversion was confirmed because the ADON was in possession as the last in the chain of custody and the count was off. She validated that she did not follow the facility policy and took full responsibility. The ADON was terminated 06/04/2025 while on suspension for not following proper narcotic policy and procedures. Review of the facility's individual patient's antibiotic/ narcotic record for Resident #1's hydrocodone reflected the count for the medication was documented as 49 on 05/29/2025, then there were an additional three entries on the narcotic log dated 05/28/2025 with one-tab documented. However, the ending count was 39. With a total of 10 pills missing. Review of Resident #1's MAR dated May 2025 reflected the last dose given to Resident #1 was given at 1:00 am on 05/29/2029. Review of Resident #1's narcotic record log for the medication (not dated ongoing log) reflected three entries after that with the count going down 10 pills. The signature on the form was not readable. In an interview on 06/17/2025 at 1:00 PM the ADON stated she took Resident #1's narcotics off the medication cart and took them to her office and put them in a drawer because she did not think the resident was supposed to take narcotic medication home with them once they discharged . She stated she did not count the medication when she removed them from the cart. She stated she had worked at other facility's where the residents were not able to take the medication home. The ADON denied taking any of the medication and stated she did not know about the other missing discontinued narcotics. She stated all she did was remove the medication and put it in a locked drawer in her office. She stated she did not have a chance to take it to the discontinued drug drawer that was why it was in her office. She stated she knew she was supposed to take all discontinued meds to the discontinued lock up which had two locks and a log for the medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676174	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation	2202 N Travis Ave Cameron, TX 76520

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/17/2025 at 1:20 PM LVN A stated she was discharging Resident #1 when the ADON came to her and stated she needed the keys to her medication cart and did not say what she needed the keys for. LVN A stated she followed the ADON to her medication cart and saw she took Resident #1's narcotic medication and stated to her that the resident could not take them home with her. LVN A stated the ADON took the medication to her office. LVN A stated it did not sit well with her that the ADON did not sign the medication out. LVN A further stated she always sent all the resident's medications home on discharge. LVN A stated once the DON came in, she went and told her what the ADON did. She stated the DON told her that yes, the medications were supposed to go home with the resident. She stated her and the DON went to the ADON's office to get the medication. LVN A stated the ADON was fumbling around like she did not know where the medications were and then finally, she took them out of a drawer where they were in the back of the drawer. Observation on 06/17/2025 at 1:25 pm of the narcotic count and signature sheets of south side nurse cart revealed no discrepancies and the medications were counted at shift change. In an interview on 06/17/2025 at 1:30 pm the DON stated when she came in to work on 05/29/2025 LVN A came to her and told her the ADON removed medications from her cart, and she felt like it was not right. The DON stated she went with LVN A to the ADON's office to get the medications. The DON stated when they got to her office the ADON at first acted like she did not have the medication, then removed them from the back of her desk drawer from behind some files. The DON stated the ADON told her she knew the procedure for discontinued medications and that they were supposed to go to the discontinued drug file cabinet. The DON stated the ADON did tell her that she did not think the medications could go home with the resident. The DON stated she did not have an explanation of why the count was not correct or who's signature was on the narcotic sheet for the last three sign outs that were not given. In an interview on 06/17/2025 at 1:35 pm the DON stated she did not recognize the signature on Resident #1's narcotic record. The DON stated she compared the signature with all her nurse signatures, and they did not match. Observation on 06/17/2025 at 1:40 pm of the discontinued medication file cabinet revealed the cabinet was double locked. Review of the medication count reflected no discrepancies. Review of the facility's Disciplinary report dated 06/04/2025 reflected the ADON was terminated on 06/04/2025 related to failure to follow the facility's narcotic policy and procedures. Review of the facility's Inservice training dated 05/29/2025 reflected staff were in serviced on the facility's narcotics policy and procedure, prevention of drug diversion and safe medication practices. In an interview on 06/17/2025 at 1:50 PM LVN B stated she was in serviced on narcotics policy and procedures to ensure you always have two nurses signing for narcotics and to make sure when drugs are discontinued the medications are given to the DON and placed in the discontinued storage with two nursing signatures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676174	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation	2202 N Travis Ave Cameron, TX 76520

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/17/2025 at 1:50 PM LVN C stated she was in serviced on narcotics policy and procedures to ensure you always have two nurses signing for narcotics and to make sure when drugs are discontinued the medications are given to the DON and placed in the discontinued storage with two nursing signatures. In an interview on 06/17/2025 at 2:51 pm the Administrator stated moving forward the facility would have two nurses sign out discontinued medications. The Administrator further stated the ADON told him that if he drug tested her that she would be positive because she had a prescription. The Administrator stated she would not tell him what her prescription was. The Administrator stated he reported the incident to the police, but no report was provided to him the police stated to him that without further evidence they would not be able to do anything. Review of the ADON's personnel file reflected a background check was conducted prior to hire on 03/26/2025. Further review of the ADON's personnel file reflected her RN license was checked. Review of the license checked from the BON website reflected the ADON's RN license was current and had formal charges filed as of 11/18/2024. In an interview on 06/17/2025 at 3:00 pm the DON stated that when the ADON was hired, and her license was checked it did not say she had formal charges filed. The DON stated she ran her license again after the incident and saw the formal charges filed statement. The DON stated she called the BON, and they told her the ADON license did not have stipulations as the charges were still under investigation and they were not able to tell her what they were. Review of the facility's policy Narcotics policy and procedure (not dated) reflected All controlled substances shall be counted at the change of each shift. The amount of each controlled substance on hand shall be listed on the Narcotic Count Sheet. PROCEDURE: 1. One (1) licensed nurse from the off-going shift and one (1) licensed nurse from the oncoming shift must count and sign the Narcotic Count Sheet in front of the narcotic box.2. The off-going nurse shall write and observe counting; the counting nurse shall count each shift.3. If the count is wrong, the off-going nursing staff member must stay until the discrepancy is found,4. The cart and medication sheets shall be reviewed to recover the narcotic. 5. The total of each drug found in the controlled substance drawer shall be listed on the Narcotic Count Sheet. 6. The oncoming nurse shall sign his/her name on the count sheet. 7. The off-going nurse shall sign his/her name on the count sheet . All discrepancies shall be reported immediately to the Nurse Manager/Charge Nurse, who will advise the Director of Nursing. 10. The Nurse Manager/Charge Nurse shall assist the nurses in determining what happened to the controlled substance, by following these steps: a. Review controlled substance storage b. Review resident records c. Review controlled substance records d. Each specific fact-finding task shall be listed on the Controlled Substance Discrepancy Record by the Charge Nurse or the designee . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676174	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Nursing and Rehabilitation	2202 N Travis Ave Cameron, TX 76520

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's undated Abuse prevention and probation policy reflected Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals .7. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. At least one of the following elements must be present for an incident to be reportable: Identity theft. Theft of money from the resident's bank account. Unauthorized purchases on the resident's credit card or from the resident's funds. A resident who provides a gift to staff in order to receive ongoing care, based on staff's persuasion. A resident who provides monetary assistance to staff, after staff had made residents believe that staff was in a financial crisis, and Drug Diversion: Diversion of resident medication, including, but not limited to, controlled substances for staff use or personal gain .