STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676238	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - North	11020 Dessau Rd Austin, TX 78754

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to care for residents in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for three (Resident #3, Resident #31, and Resident #106) out of 10 residents reviewed for resident rights. The facility failed to knock on Resident #3's, Resident #31's and Resident # 106's doors prior to entry when going into the residents' rooms. The deficient practice could place residents at risk of feeling like their privacy is being invaded or the facility is not their home. Findings included: Review of Resident #3's Face Sheet dated 04/23/26 revealed he was a [AGE] year-old male who was readmitted to the facility on [DATE]. Resident #3's diagnoses included OTHER ACUTE OSTEOMYELITIS of LEFT ANKLE AND FOOT, (a rapid-onset bone infection), TYPE 2 DIABETES MELLITUS, (A condition results from insufficient production of insulin, causing high blood sugar.) and SCHIZOAFFECTIVE DISORDER, (includes bouts of hypomania or mania and sometimes major depression.) Record review of Resident #3's Quarterly MDS assessment dated [DATE] revealed that Resident #3's BIMS score was 15 indicating Resident #3 had intact cognitive response. Record review of Resident #3's Care Plan dated 04/01/26 reflected that he is at risk for falls r/t gait/balance, decreased safety awareness, and increased confusion. The goal is he will be free of falls through the review date of 04/26/26. Interventions: Be sure the call light is within reach and encourage him to use it to call for assistance as needed. Review of Resident #31's Face Sheet dated 04/22/26 revealed she was a [AGE] year-old female who was readmitted to the facility on [DATE]. Resident #31's diagnoses included HEMIPLEGIA AND HEMIPARESIS, (Hemiplegia is a symptom that involves one-sided paralysis. Hemiplegia affects either the right or left side of your body.) FOLLOWING CEREBRAL INFARCTION, (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 EPILEPSY, (A neurological disorder that causes seizures or unusual sensations and behaviors). Record review of Resident #31's Quarterly MDS dated [DATE] revealed that Resident #31's BIMS score could not be obtained. Resident # 31 was Dependent (helper does all the effort) regarding ADLs. Record review of Resident #31's Care Plan dated 02/09/26 reflected that she is at risk for impaired cognitive function or impaired thought process r/t stroke and brain injury. The goal is she will maintain current level of cognitive function through the review dated 4/20/26. Interventions: Identify yourself at each interaction. Face when speaking and making eye contact. Review of Resident #106's Face Sheet dated 04/22/26 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #106's diagnoses include: Unspecified Dementia, (A group of symptoms that affects memory, thinking and interferes with daily life.), Anxiety, (feeling of uneasiness or worry), Major Depressive Disorder, (A mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep, feelings of guilt or inadequacy, and suicidal thoughts.) Review of Resident # 106's Quarterly MDS dated [DATE] revealed that Resident #106's BIMS score could not be obtained. Resident # 106 was Dependent (helper does all the effort) regarding ADLs. Record review of Resident #106's Care (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
	676238	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - North	11020 Dessau Rd Austin, TX 78754

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan dated 04/07/26 reflected that she is at risk for impaired cognitive function/dementia or impaired thought processes r/t dementia. The goal is she will maintain current level of cognitive function through the review dated 5/10/26. Interventions: Identify yourself at each interaction. Face when speaking and making eye contact. Observation on 200-hall on 04/21/26 at 06:29 am revealed that HK G did not knock on Resident #31's and Resident # 106's doors before entering. Observation of lunch trays being passed on 300-hall on 04/21/26 at 12:17 p.m., revealed that CNA H did not knock on Resident #3's door before entering. An interview on 04/21/26 at 12: 15 p.m., revealed Resident # 3 was dining and refused to be interviewed. An interview with Resident # 106 on 04/21/26 at 1:02 p.m., revealed that Resident # 106 was not aware that Housekeeping and other staff are required to knock on her door before coming into the room. Resident # 106 stated, she would like for staff to knock first so she is not surprised when she sees staff enter. An interview with Resident #31 on 04/23/26 at 2:49 p.m., revealed that staff did not always knock on the door when going into her room. She stated that the staff should knock before they enter the room. She said, sometimes I am surprised by an unannounced visit. An interview with HK G on 04/21/2026 at 6:29 a.m., revealed that HK G did not know why she forgot to knock on doors while she was working the 200 hallways. She said, residents could feel like they are not given privacy if we don't knock on doors. An interview with CNA H on 04/23/2026 at 1:29 p.m., revealed that she had been trained on resident rights. She stated the policy for knocking was that all staff were to knock before entering the resident's room. She said that a resident may feel like his or her privacy was being invaded or may feel as if the facility was not their home. She said nurses were responsible for monitoring to ensure staff were knocking. She said it was monitored by observations and when the facility did skill checks. She said she did not realize she did not knock because she was probably in a rush to do something. An interview with DON on 04/23/2026 at 2:02 p.m., revealed that knocking on the resident's door is part of the Residents Rights Policy. She stated, we always tell them, knock on the door and introduce yourself before entering. DON stated, This is the Residents home, and they have a right to privacy and respect She said, staff knocking on doors is monitored by the Management staff and if I see staff not knocking, I will stop and educate them. An interview with ADM on 04/23/2026 at 3:00 p.m., revealed, ADM understands that knocking on the resident's door is considered a resident right. He said, the purpose for staff being required to knock on doors before entering a resident's room is so the facility staff will comply with the residents' right to privacy. He said, we are training staff each and every day to ensure the staff remember to knock on doors before entering a resident's room. He stated, residents may not feel respected if we do not knock on the resident's door. ADM said he did not know why housekeeping staff failed to knock on Resident # 31's and Resident # 106's doors. Record Review of Resident Rights and Responsibilities Policy amended 07/13/17 revealed: Privacy and Confidentiality: You have the right to personal privacy and confidentiality of your personal and medical records. You have the right to:Personal privacy, including accommodation, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Secure and confidential personal and medical records.Personal privacy, including the right to privacy in your oral, written, and electronic communications. Safe Environment.Grievances. Resident Rights:. You have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676238	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - North	11020 Dessau Rd Austin, TX 78754

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow menus for 3 (Resident #2, Resident #23, and Resident #88) of 3 residents reviewed for a pureed diet. The facility failed to use a large enough scoop when serving residents on a pureed diet on 4/21/26, 4/22/26, and 4/23/26. This failure placed residents at risk for decreased intake and weight loss.Findings included: A record review of Resident #2's face sheet dated 4/23/2026 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of cerebral infarction (stroke), atrial fibrillation (irregular heartbeat), dysphagia (difficulty swallowing), pneumonitis (inflammation of the lung) due to inhalation of food and vomit, muscle wasting and atrophy (muscle loss), cognitive communication deficit (difficulty communicating), gastrostomy status, (presence of feeding tube) and need for assistance with personal care. A record review of Resident #2's MDS assessment dated [DATE] reflected that she could not be assessed for BIMS because she was rarely/never understood. A record review of Resident #2's care plan last revised on 3/30/2026 reflected that she had nutritional problems related to dysphagia and protein calorie malnutrition. Interventions included a pureed diet as ordered by the physician. A record review of Resident #2's physician order dated 3/30/2026 reflected she was on a pureed diet. A record review of Resident #2's weight history reflected that she weighed 145.9 pounds on 3/22/2026 and 135.4 pounds on 4/22/2026. A record review of Resident #23's face sheet dated 4/23/2026 reflected a [AGE] year-old male readmitted on [DATE] with diagnoses of Parkinson's disease (progressive neurological disorder), unspecified dementia, muscle wasting and atrophy (muscle loss), dysphagia (difficulty swallowing), cognitive communication deficit (difficulty communicating), and need for assistance with personal care. A record review of Resident #23's MDS assessment dated [DATE] reflected that he had not yet been assessed for a BIMS score. A record review of Resident #23's care plan revised on 4/22/2026 reflected that he had a potential nutritional problem related to dysphagia and newly diagnosed aspiration pneumonia. Interventions included a pureed diet as ordered by the physician. A record review of Resident #23's diet order dated 4/22/2026 reflected that he required a pureed diet. A record review of Resident #23's weight record reflected that he weighed 133.9 pounds on 4/22/2026 and 134.8 pounds on 2/25/2026. A record review of Resident #88's face sheet dated 4/23/2026 reflected a [AGE] year-old female admitted on [DATE] with diagnoses of psychotic disturbance, diverticulitis of intestine (pouches in colon), dementia, muscle wasting and atrophy (muscle loss), dysphagia (difficulty swallowing), cognitive communication deficit (difficulty communicating), anorexia, and need for assistance with personal care. A record review of Resident #88's MDS assessment reflected a BIMS score of 15, which indicated intact cognition. A record review of Resident #88's care plan revised on 9/08/2024 reflected that she had a nutritional problem or potential nutritional problem related to dysphagia. Interventions included giving supplements as ordered. A record review of Resident #88's physician order dated 9/21/2025 reflected that she was on a pureed diet. A record review of Resident #88's weight record reflected that she weighed 124 pounds on 4/08/2026 and she weighed 126 pounds on 3/09/2026. During an observation of breakfast on 4/21/2026 at 7:23 AM, CK F was serving breakfast using a blue #16 scoop for pureed scrambled eggs and a yellow #20 scoop for pureed sausage. During an observation of lunch on 4/21/2026 at 12:27 PM, CK F was serving lunch using a green #12 scoop for pureed beef goulash, pureed squash, and pureed peppers & onions. During an observation and interview on 4/22/2026 at 8:38 AM, Resident #88 was observed lying in bed. Resident #88 stated that the food had improved in the past few months. An observation on 4/22/2026 at 9:05 AM revealed that CK F used a blue #16 scoop to serve pureed scrambled eggs. During an observation on 4/22/2026 at 10:17 AM, Resident #2 was observed lying in bed with her call light in reach. Resident #2 was non-interviewable, and she did not respond to questions. During an observation on 4/22/2026 at 12:24 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676238	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - North	11020 Dessau Rd Austin, TX 78754

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PM, Resident #23 was observed lying in bed with his lunch in front of him on a bedside table. Resident #23 was non-interviewable and did not respond to questions. An observation of lunch on 4/22/2026 at 12:33 PM revealed CK F served lunch using a green #12 scoop for pureed vegetables. An observation on 4/23/2026 at 12:02 PM revealed that CK F was serving lunch using a green #12 scoop for pureed spinach and a yellow #20 scoop for pureed bread. An observation of the kitchen on 4/23/2026 at 12:03 PM revealed a chart with different scoop sizes, their number, their volume, and their color number was posted on the wall of the kitchen. The chart reflected the following:A yellow #20 scoop had a capacity of 1 and 5/8 ounces. A blue #16 scoop had a capacity of 2 ounces. A green #12 scoop had a capacity of 2 and 2/3 ounces. A tan #10 scoop had a capacity of 3 ounces. A grey #8 scoop had a capacity of 4 ounces. A white #6 scoop had a capacity of 5 and 1/3 ounces. During an interview on 4/23/2026 at 12:59 PM, the DS stated that cooks knew which scoop to use based on the diet spreadsheet. The DS stated, we have a sheet posted with the color of the scoop. The DS said the scoop color corresponded to its size, and the scoop number was written on the back of the scoop. The DS stated that she taught staff how to read the number on the scoop and which color corresponded to which size. The DS stated, every day I tell them to check the diet spreadsheet and said she monitored staff every day. When asked how residents could be affected if the incorrect scoop size was used, the DS stated, they won't have what they need and they could lose weight. During an interview on 4/23/2026 at 1:45 PM, the DON stated that kitchen staff should follow the menu, and she did not know much about serving sizes. The DON stated that the DS was responsible for monitoring staff. When asked how residents could be affected if portions were not adequate, the DON stated, weight loss. The DON stated that Resident #23's weight loss was probably related to his recent hospitalization, and she was not sure what Resident #2's and Resident #88's weight loss was related to. During an interview on 4/23/2026 at 3:15 PM, the ADM stated the facility had just changed dietary companies and the menus had recently changed. The ADM stated that the sizes were a hair different on the new menu. When asked how residents could be affected by receiving in adequate portions, the ADM stated they could not get the nutrients they needed and weight loss. A record review of the facility's cycle menu reflected that the following menu items were to be served: Week 3 Day 17 (Tuesday, 4/21/2026) -Breakfast: a #8 scoop for pureed eggs and a #16 scoop for pureed sausage. -Lunch: a #6 scoop for pureed beef goulash, #10 scoop for pureed squash, and a #10 scoop for pureed soft, cooked vegetables. Week 3 Day 18 (Wednesday, 4/22/2026) -Breakfast: a #8 scoop for pureed egg -Lunch: a #10 scoop for pureed soft-cooked vegetables. Week 3 Day 19 (Thursday, 4/23/2026) -Lunch: a #10 scoop for pureed spinach and a #10 scoop for pureed honey kissed roll. A record review of the facility's policy titled Food and Nutrition Service Menus dated September 2017 reflected the following: PolicyIt is the policy of this facility to ensure that menus are developed and prepared to meet the nutritional needs of the residents and resident choices including their nutritional, religious, cultural, and ethnic needs while using established national guidelines.Procedure.5. Menus shall provide a variety of foods and indicate standard portions at each meal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676238	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - North	11020 Dessau Rd Austin, TX 78754

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents could call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside for 4 of 17 residents (Resident #31, #41, # 42 and # 76) reviewed for the ability to call for staff assistance. The facility failed to provide a working communication system that was easily at reach, which would allow Resident #31, # 41, #42 and # 76 the ability to safely call for staff for assistance. This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they needed support for daily living.Findings include: Review of the face sheet for Resident #41 reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included PRIMARY OSTEOARTHRITIS (the protective cartilage that cushions the ends of the bones wears down over time.), CARPAL TUNNEL SYNDROME related to Right wrist, (an Irritation or damage inside the carpal tunnel in your wrist causes it when swelling presses on your median nerve), AGE-RELATED COGNITIVE DECLINE (memory loss, difficulty with decision -making). Review of Resident #41's Quarterly MDS dated [DATE] reflected a BIMS Score of 15, which indicated she was intact. The MDS also reflected Resident #41 needs Supervision or touching assistance for lying to sitting on bed and positioning of sitting to standing. Record review of Resident #41's Care Plan dated 03/25/26 reflected she has ADL Self Care Performance Deficit related to weakness. The goal indicated Resident #41 will maintain current level of function in Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene; Intervention reflected Be sure the call light is within reach and encourage to use it to call for assistance as needed. An observation and interview on 04/21/26 at 6:41 a.m., reflected Resident #41 was lying in her bed and call light was observed wrapped around the right bed frame out of reach of Resident #41. Resident #41 stated, she could not reach the call light. Review of the face sheet for Resident #31 reflected a [AGE] year-old female readmitted to the facility on [DATE]. Her diagnoses included HEMIPLEGIA AND HEMIPARESIS (Hemiplegia is a symptom that involves one-sided paralysis. Hemiplegia affects either the right or left side of your body.) FOLLOWING CEREBRAL INFARCTION, (refers to the long-term, late effects or conditions that can occur after a cerebral infarction (ischemic stroke) , Primary AFFECTING LEFT NON-DOMINANT SIDE, EPILEPSY, (A neurological disorder that causes seizures or unusual sensations and behaviors.) and COGNITIVE COMMUNICATION DEFICIT (difficulties in communication that arise from impairments in cognitive processes such as attention, memory, perception, and executive function). Review of Resident #31's Quarterly MDS dated [DATE] reflected Resident #31's functional ability was ?dependent', and helper does all the effort for ADLs. Record review of Resident #31's Care Plan dated 03/25/26 reflected she has ADL Self Care Performance Deficit related to weakness. The goal indicated Resident #31 will safely perform Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene) with 1 person assist or supervision, through the review date. Interventions reflected Occupational, Physical, Speech-Language Therapy evaluation and treatment per physician orders. An observation and interview on 04/21/26 at 6:37 a.m., reflected Resident #31 was lying in her bed and call light was observed on the floor, out of resident's reach. Resident # 31 stated she could not reach the call light. Review of the face sheet for Resident #42 reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included PRIMARY UNSPECIFIED DEMENTIA (memory, thinking, difficulty), UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PERSONAL HISTORY OF TRANSIENT ISCHEMIC ATTACK (temporary blockage of blood flow to the brain), AND CEREBRAL, DEPRESSION (brain experiences insufficient oxygen during or immediately after birth, leading to impaired neurological function). And Cognitive communication Deficit (ability to communicate effectively is impaired due to underlying cognitive dysfunction rather than a primary language or speech problem.). Review of Resident #42's Quarterly MDS dated [DATE] reflected Resident #42 is (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676238	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - North	11020 Dessau Rd Austin, TX 78754

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dependent; helper does all the efforts needed for ADLs. Record review of Resident #42's Care Plan dated 02/12/26 reflected that she is at risk for impaired cognitive function/dementia or impaired thought processes r/t Dementia. Goal indicated Resident #42 will maintain current level of cognitive function through the review date. Intervention reflected communication: Identify yourself at each interaction. Face when speaking and making eye contact. Reduce any distractions- turn off TV, radio, closed door etc. Use simple, directive sentences. Provide with necessary cues- stop and return if agitated. An observation and Interview on 04/21/26 at 6:43 a.m., revealed Resident #42 was lying in her bed and her call light was observed wrapped around the left bedframe, out of resident's reach. Resident #42 stated she could not reach the call light button. Review of the face sheet for Resident #76 reflected an [AGE] year-old female readmitted to the facility on [DATE]. Her primary diagnoses included HEMIPLEGIA AND HEMIPARESIS (Hemiplegia is a symptom that involves one-sided paralysis. Hemiplegia affects either the right or left side of your body.) FOLLOWING CEREBRAL INFARCTION or stroke, (a sudden interruption of blood flow to the brain.) AFFECTING RIGHT DOMINANT SIDE and PARKINSON'S DISEASE (A movement disorder of the nervous system). Review of Resident #76's Quarterly MDS dated [DATE] reflected Resident #76 is dependent; helper does all the efforts made for ADLs. Record review of Resident #76's Care Plan dated 03/24/26 reflected that she is at risk for impaired cognitive function/dementia or impaired thought processes r/t Dementia. Goal indicated Resident #76 will maintain current level of cognitive function through the review date. Intervention reflected Engage in simple, structured activities that avoid overly demanding tasks. An observation on 04/21/26 at 6:18 a.m., revealed Resident #76 was lying in her bed and she could not be interviewed. Resident # 76's call light was observed hanging off the left side of the bed out of her reach while she was in bed. During an interview on 04/23/2026 at 1:29 PM CNA H revealed CNAs are responsible for placement of call lights so that residents have access to their call lights. CNA H stated that the location and placement of a call light may be different for each resident. She stated, ?it depends on the condition of that resident as to where it is placed for them.' She stated, ?it is never ok for a call light to be on the floor because the residents will not be able to use it to get the care they need. During an interview on 04/23/2026 at 1:25 p.m., MA E revealed that she has been trained in call light placement. MA E stated, ?all staff are responsible for ensuring that call lights are placed within the residents' reach. She stated if a call light button is not located properly for that resident, the staff may not be able to meet the needs of that resident. MA E explained that ADM and Managers do rounds in the morning and they check on call light placement. During an interview on 04/23/2026 at 2:02 p.m., DON revealed that the facility policy and procedure subject: Call Light/ Bell states, the call device should be within residents' reach before staff leave the room. She stated the nursing staff are responsible for determining what type of call light will be used for each resident. She said, some residents cannot maneuver the button, so they provide a flat call one to them. She stated, the call lights should be within reach of the residents, or their needs may not be met. During an interview on 04/23/2026 at 3:00 p.m., ADM revealed the call lights should be within reach of the residents. He said, ?every morning we do Angel rounds we check on the resident's wellbeing including the availability of the call light for each resident. ADM said every resident is different so the location and type of call device may be different. He said it must be within reach of the resident. Review of the facility Policy & Procedure for Call Light/Bell dated May 2007 reflected, It is the policy of this facility to provide a means of communication with nursing staff. 1. Answer the light/bell within a reasonable time.2. Turn off the call light/bell.3. Listen to the president's request/need.4. Respond to the request. If the item is not available or you are not able to attend, explain to the residents and notify the charge nurse for further instruction.5. Leave the resident comfortable. Place the call device within the resident's reach before leaving room. If the call light/ bell is defective, immediately report this information to the unit supervisor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676238	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - North	11020 Dessau Rd Austin, TX 78754

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 1 of 15 residents (Resident #79) reviewed for ADLs. The facility failed to ensure Resident #79 was provided with incontinent care after staff got her out of bed.This failure could place residents at risk of not receiving care services, diminished quality of life, and decreased self-esteem.Findings Included: Record review of Resident #79's face sheet, dated 04/22/2026, reflected a [AGE] year-old female, admitted [DATE] with diagnoses that included respiratory failure, heart failure, non-pressure chronic ulcer of skin of other sites with muscle involvement without evidence of necrosis (chronic skin loss often on the limbs extending to the muscle layer without tissue death), resistance to multiple antimicrobial drugs (when pathogens like bacteria, viruses, fungi or parasites no longer respond to several antimicrobial treatments), reduced mobility, morbid obesity with alveolar hypoventilation (severe obesity that causes breathing difficulty resulting in low oxygen and high carbon dioxide while awake), muscle weakness and irritable bowel syndrome (chronic function disorder of the large intestine causing abdominal pain, cramps bloating and diarrhea or constipation). Record review of Resident #79's quarterly MDS dated [DATE], reflected a BIMS Score of 15, which indicated intact cognitive response. The MDS also indicated that the resident did not have behavior of rejecting care. The resident was dependent on staff for toileting hygiene, bed mobility, and transfers.Record review of Resident #79's Care Plan, dated 02/17/2026, reflected Resident #79 Has potential for pressure ulcer development related to incontinence. The goal was Will have intact skin, free of redness, blisters or discoloration by/through review date. Interventions were Educate resident, family/caregivers as to causes of skin breakdown; including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. During an interview with Resident #79 on 04/21/2026 at 11:55a.m., she said that staff get her up around 10:30a.m. She said once staff got her up staff would not provide her with incontinent care until she laid back down. She said she usually did not get back in bed until the 2-10 shift. She said there were times she asked to be changed and staff told her she had to wait for the next shift. During an interview with CNA D on 04/21/2026 at 1:58 p.m. he said that he changes the residents every two hours. He said he would put residents back down after lunch. He said with Resident #79 he would get her up around 10:30 a.m. or 11:00 a.m. He said if he could not get her up by that time he would let her know. He said once he got Resident #79 out of her bed and in her wheelchair he does not change her again for the rest of his shift. He said he did not know what time the second shift would change her. He said Resident #79 does not ask him to change her. He said the expectation was for him to change Resident #79 every two hours. During an interview with the DON on 04/22/2026 at 9:43a.m., she said Resident #79 preferred to get up around 11:00a.m. She said she would inform the nurse when Resident #79 was getting up so the nurse could watch incontinent care. During an observation of Resident #79 on 04/22/2026 at 11:11a.m., she was provided with incontinent care and transferred into her wheelchair. During an interview with Resident #79 on 04/22/2026 at 2:13pm., she said she was not feeling good and wanted to go back to her room and lay down. During an observation of Resident #79 on 04/22/2026 at 2:21p.m., revealed she was provided with incontinent care and put back in her bed. During an interview with CNA D on 04/23/2026 at 10:15a.m., he said he had been trained on incontinent care. He said the policy was staff were to change the residents every two hours or more if needed. He said the CNAs were responsible for providing incontinent care to the residents. He said if incontinent care was not provided regularly the resident could have skin breakdown or get a rash. He said the nurse monitored to ensure the CNAs were providing the residents with incontinent care. He said the nurses monitored by doing observations on the halls and looking at the residents. He said he did not change Resident #79 because she would be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676238	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - North	11020 Dessau Rd Austin, TX 78754

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moving around the facility or in an activity. He said because of her being in an activity or moving around the facility Resident #79 would have to wait until the next shift to get changed. He also said he did not ask the resident if she needed to be changed. During an interview with the DON on 04/23/2026 at 2:17p.m., she said she had been trained on incontinent care. She said the policy for incontinent care was the staff needed to provide the service to meet the needs of the resident. She said staff were supposed to check the resident every two to three hours to see if they needed to be changed. She said some urinate more frequently and staff needed to change the resident accordingly. She said the CNAs and nurses were responsible for providing incontinent care. She said if staff did not provide incontinent care the resident could get an infection or a pressure sore. She said the staff need to change the residents when they are wet and need to at least offer to change them. She said all staff monitored to ensure staff are giving incontinent care. She said she monitored by looking at her pressure sores report. She said she did not know why CNA D would not change Resident #79 after he got her up from her bed. During an interview with the ADM on 04/23/2026 at 3:11p.m., revealed he had been trained on incontinent care. He said the policy for incontinent care was the staff should be checking on the residents and changing them when needed. He said all nursing staff was responsible for providing incontinent care. He also said that all staff should be monitored to ensure the residents were being changed. He said the resident could have skin breakdown if the staff did not provide incontinent care. He said he did not know why CNA D did not provide incontinent care to Resident #79 after he got her out of bed. Record review of Policy/Procedure- Nursing Administration- Nursing Services- ADL Policy dated 05/2007 revealed Nursing service staff cares for its residents in manner and in an environment that promotes maintenance or enhancement of each residents' quality of life and promotes care for residents in a manner and in an environment that maintains or enhance each resident's dignity and respect in full recognition of his or her individuality.Each Resident:Receives or is provided the necessary care and services enabling him/her to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.Residents receive assistance as needed to manage their physical needs which includes personal hygiene grooming, dressing, toileting, transferring, ambulating, and eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676238	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - North	11020 Dessau Rd Austin, TX 78754

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents received proper treatment and care to maintain mobility and good foot health for 1 (Resident #67) of 8 residents reviewed for foot care. The facility failed to obtain podiatry services for Resident #67. This failure placed residents at risk for toenail loss, pain, and infection.Findings included: A record review of Resident #67's face sheet dated 4/23/2026 reflected a [AGE] year-old male admitted on [DATE] with diagnoses of acute and chronic respiratory failure, morbid (severe) obesity, primary osteoarthritis (deterioration of cartilage), hypertensive heart and chronic kidney disease with heart failure, obstructive sleep apnea (sleep disorder), gout (form of arthritis), difficulty walking, unsteadiness on feet, cognitive communication deficit (difficulty communicating) and need for assistance with personal care. A record review of Resident #67's MDS assessment dated [DATE] reflected a BIMS score of 15, which indicated no cognitive impairment. A record review of Resident #67's care plan revised on 3/23/2026 reflected that he had potential for skin breakdown. Interventions included daily body checks and a weekly head-to-toe assessment. A record review of Resident #67's physician orders reflected an order dated 3/20/2026 that reflected ?May consult Podiatry service of resident choice'. A record review of Resident #67's progress note dated 3/23/2026 reflected very long toenails. During an interview and observation on 4/21/2026 at 9:10 AM, Resident #67 was observed lying in bed. Resident #67 stated that he had not been doing physical therapy due to foot pain. Resident #67 stated he had not seen a podiatrist in the past, but that the facility told him he would see one. Resident #67 stated, I don't know if I just missed him, or what. During an interview and observation on 4/21/2026 at 1:47 PM, Resident #67 was lying in bed. Resident #67's toenails extended at least one inch past the edge of the nailbed. Resident #67 stated that his foot pain was a 10 out of 10, but he was not sure how much it was related to his toenails and said he did not know if trimming his nails would help. Resident #67 stated that the NP was working with the SW to get him scheduled with podiatry, but no they did not give him a timeframe. During an interview on 4/22/2026 at 3:41 PM, the SW stated that the Podiatrist came to the facility twice a month and Resident #67 was referred to podiatry upon admission. The SW stated the process of referring residents to podiatry involved obtaining consent, having the resident sign, and forwarding it to the podiatry so the resident could start services The SW stated she was having a hard time with Resident #67's primary insurance because they were not authorizing podiatry services. The SW stated that the last option she had was to talk with the ADM to see if they could pay for Resident #67 to see the Podiatrist because he needed services. The SW stated that Resident #67 had not seen the podiatrist since he was admitted . The SW stated that she had seen Resident #67's toenails and he really needs the service. The SW stated they looked like they had been neglected for a long time and were in growing. The SW stated she began the back-and-forth with Resident #67's insurance on 3/27/2026. The SW stated that she had never encountered an insurance plan that denied podiatry services and that Resident #67's insurance was not contracted with the facility. During an interview on 4/22/2026 at 3:23 PM, LVN A stated she had seen Resident #67's toenails and said she could not cut his nails because of the thickness. LVN A stated she was pretty sure she notified the SW about the issue with Resident #67's nails. LVN A stated, he must be on the waiting list. LVN A stated that if residents were not used to having long nails, it could make them uncomfortable. LVA A stated she did not think that Resident #67's foot pain was related to his toenails. During an observation and interview on 4/22/2026 at 4:06 PM, CNA C was observed walking into Resident #67's room. CNA C put gloves on and examined Resident #67's feet. CNA C stated that Resident #67 had two toenails on the left foot and one toenail on the right foot that were curved over into the skin. During an interview on 4/23/2026 at 10:51 AM, the NP stated she told the SW to put Resident #67 on the top of the list for podiatry. The NP stated she usually wrote a progress note when it was that bad. The NP stated she (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676238	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - North	11020 Dessau Rd Austin, TX 78754

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	first requested that Resident #67 be seen by a podiatrist on 3/25/2026 when she sent an email to the SW. The NP stated that Resident #67 had refused showers and had psych issues, but she did not think he had refused podiatry care. During an interview on 4/23/2026 at 10:45 AM, the Podiatrist stated that Resident #67's toenails were 5 inches long, extremely thick, and he could not wear his socks because the toenails were too long. The Podiatrist stated that Resident #67 had onychomycosis (fungal infection causing the toenails to become thick). The Podiatrist stated that the left second toe was curled over and there was an indentation on the skin, but no breakage. The Podiatrist stated that there was potential for Resident #67's toenails to get caught on a sock and he could have a traumatic avulsion (injury in which a body part or tissue is forcibly torn away). The Podiatrist stated that Resident #67 complained of right great toe pain, but she thought it was tendonitis. The Podiatrist stated that risks associated with traumatic avulsion included pain and infection. The Podiatrist stated that it was her first time seeing Resident #67 that day (4/23/2026) and there was an insurance problem. During an interview on 4/23/2026 at 1:45 PM, the DON stated that residents were assessed for the need for podiatry when they came in, it was communicated to the SW, and the SW made the referral. The DON stated that when the Podiatrist came in on 4/10/2026, Resident #67's insurance had not been verified. The DON stated that the Podiatrist came in that day (4/23/2026) and the facility paid to have Resident #67's toenails taken care of. The DON stated it looked like 10 years of growth. The DON stated that nails could get torn off if they were too long, and that could be painful. During an interview on 4/23/2026 at 3:15 PM, the ADM stated that he would expect residents to receive podiatry services as soon as possible. The ADM stated that if anyone was not covered, he paid for it. The ADM stated that Resident #67 missed the Podiatrist's visit last month and his VA insurance would not allow him to see the in-house Podiatrist. The ADM stated that once he was made aware of an issue, there was no delay. When asked what a clinical implication of long, thick toenails was, the ADM stated infection. A record review of the Podiatrist's schedule for 4/23/2026 reflected a list of residents scheduled to be seen by the Podiatrist on 4/23/2026. Resident #67 was not on the list, and he had a ?do not treat' note dated 3/27/2026 that reflected Cannot verify appropriate insurance information. A record review of the facility's policy titled Nursing Services - ADLs dated May 2007 reflected the following: Policy: Nursing service staff cares for its residents in manner and in an environment that promotes maintenance or enhancement of each residents' quality of life and promotes care for residents in a manner and in an environment that maintains or enhance each resident's dignity and respect in full recognition of his or her individuality.Each resident.-Residents receive assistance as needed to manage their physical needs which includes personal hygiene, grooming, dressing, toileting, transferring, ambulating, and eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676238	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - North	11020 Dessau Rd Austin, TX 78754

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident for 2 (Resident #51 and Resident #88) of 10 residents reviewed for medication administration. The facility failed to ensure Resident #51 took her medication while staff were present. Staff left Resident #51's medication on her bedside table for her to take. Resident #51 had not been assessed for self-administration.The facility failed to put Resident #88's inhaler back in the medication cart.The failure placed residents at risk of not taking their medication, or another resident getting the medication and taking the pills or the inhaler.Findings included: Record review of Resident #51's face sheet, dated 04/23/2026, reflected an [AGE] year-old female, admitted [DATE] with diagnoses that included dementia (memory, thinking, difficulty), muscle weakness, age-related cognitive decline, unsteadiness on feet, dysphagia oropharyngeal phase (inability to empty from the throat to the esophagus), muscle wasting, and need for assistance with personal care.Record review of Resident #51's quarterly MDS dated [DATE], reflected a BIMS Score of 11, which indicated moderate cognitive impairment.Record review of Resident #51's Care Plan, dated 04/15/2026, reflected Resident #51 did not have anything on her care plan related to her being able to self-administer medications. Record review of Resident #51's Assessments revealed the resident did not have a Medication Self-Administer Assessment. Record review of Resident #88's face sheet, dated 04/22/2026, reflected a [AGE] year-old female, admitted [DATE] with diagnoses that included dementia (memory, thinking, difficulty), muscle weakness, unsteadiness on feet, dysphagia oropharyngeal phase (inability to empty from the throat to the esophagus), muscle wasting, respiratory failure, hearing loss, and need for assistance with personal care.Record review of Resident #88's quarterly MDS dated [DATE], reflected a BIMS Score of 15, which indicated intact cognitive response.Record review of Resident #88's Care Plan, dated 02/09/2026, reflected Resident #88 did not have anything on her care plan related to her being able to self-administer medications. Record review of Resident #88's Assessments revealed the resident did not have a Medication Self-Administer Assessment. Observation of Resident #51 on 04/22/2026 at 8:45a.m., revealed she was eating her breakfast and had a cup with three white pills and one brown pill sitting on her bedside table. During an interview with Resident #51 on 04/22/2026 at 8:45a.m., she said the nurse that gave her the medication left it for her so she could eat her breakfast and take her pills. She would not answer if the staff left her pills all the time. She said she did not have any concerns and would not talk about the pills. During an observation of Resident #88 on 04/22/2026 at 8:46a.m. revealed she had an Albuterol HFA (used to treat breathing problems) on her bedside table. During an interview with Resident #88 on 04/22/2026 at 8:46a.m., revealed staff left it with her. She said she did not know the name of the staff member, but it was one on the overnight shift. She said staff normally did not leave medication with her. During an interview with MA E on 04/23/2026 at 8:30 AM, she said she was trained on medication administration. She said the policy for medication administration was to let the resident know what medication the resident was being given. She said staff were not allowed to leave medication with the resident. She said staff must watch and make sure the resident took the medication. She said the MA was responsible for making sure the resident took their medication. She said she did not have any residents who could self-administer their own medication. She said if medication was left without watching the resident take the medication, staff would not know if the resident took the medication. She added the resident may even throw the medication away. She said the nurse on the hall monitored to ensure the MA was not leaving medication with the residents. She said the nurse monitored through observations. She said the training MA took Resident #51 her (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676238	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - North	11020 Dessau Rd Austin, TX 78754

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	medication and the resident told her she would take them with breakfast and leave the medication. She said the training MA did not inform her that she left the medication. Attempted interview with LVN B on 04/23/2026 at 12:19p.m., was unsuccessful. Left voicemail for a return call and did not get a call back. During an interview with the DON on 04/23/2026 at 2:00p.m., she said she had been trained on medication administration. She said the policy for medication administration was that staff were not to leave the medication with the resident and staff needed to watch the resident take the medication. She said the nurses and the MA were responsible for giving the residents their medication. She said there were probably some residents who could self-administer their medication, but they have not had the assessments done. She said because the self-administer assessments have not been done the facility did not have any resident that could self-administer the medication. She said if the medication was left in the resident's room, another resident could take the medication or throw the medication away. She said the DON and ADON and nurses should be checking on the MAs and monitor to ensure staff were not leaving medication. She said the DON, ADON and nurses monitored by doing observation rounds. She said the new MA told her the resident asked her to leave the medication. She said the new MA did not communicate that with MA E. She said the nurse on the overnight shift sat the inhaler down and forgot to get it when she left the room. During an interview with the ADM on 04/23/2026 at 3:17p.m., revealed he had been trained on medication administration. He said the policy for administering medication was that staff were not to leave medication with the resident. He said the MAs and nurses are responsible for ensuring the resident got their medication. He said he did not have any residents that self-administered medication. He said many things could happen if medication was left with a resident. He said if not secure someone could take the medication. He said all the nursing administration staff monitored to ensure staff were not leaving medication with the resident. He said if a staff saw someone leaving medication with a resident that staff member should say something to a nurse. He said nursing administration monitored through observation or doing room rounds. He said he did not know why the staff member left the medication with Resident #51 and Resident #88. Record review of Oral Medication Administration Procedure Policy dated 11/13/2018 revealed Administer medication and remain with resident while medication is swallowed.