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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676272	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation-Kyle	1640 Fairway Kyle, TX 78640

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents had the right to be informed of, and participate in, his or her treatment which included, the right to be informed in advance, by the physician or other practitioner or other professional, of the risks and benefits of proposed care, treatment and treatment alternatives or treatment options to choose the alternative or option he or she preferred for one of (Resident #1) of four residents review for medication changes. The facility failed to ensure Resident #1 was made aware that he was prescribed oseltamivir phosphate (for influenza A prophylaxis) on 01/20/2026. This failure could place residents at risk of receiving medications without their prior knowledge or consent, being unaware of the benefits and risks of the medications prescribed and place residents at risk of diminishing their right to autonomy.Findings included: Review of Resident #1's face sheet dated 01/29/2026 reflected a [AGE] year-old male admitted on [DATE] with diagnoses of other cerebral infarction due to occlusion or stenosis of small artery (type of stroke caused by blockage or narrowing in deep-brain arteries), and hemiplegia and hemiparesis following cerebral infarction (motor impairments affecting one side of body following a stroke). Review reflected FM B and FM C were listed as POA - financial. There was no indication that FM B or FM C were Resident #1's MPOA or RP for medication decisions. Review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 12 which indicated moderate cognitive impairment. Review of Resident #1's January 2026 MAR reflected an order for Tamiflu Oral Capsule (oseltamivir phosphate) 75 MG with instructions to take 1 capsule by mouth for influenza A prophylaxis for 14 days with a start date of 01/21/2026. Review of Resident #1's care plan dated 08/13/2026 reflected Resident #1 was at risk for impaired cognitive function with intervention to engage in simple structured activities. Review of Resident #1's POA dated 04/29/2021 reflected FM B and FM C could act as agents in matters regarding banking, insurance and funeral arrangements. There was no medical authority noted. Review of Resident #1's immunization record reflected he receive the influenza vaccine on 10/01/2025. Review of Resident #1's nursing progress note by LVN A reflected date of 01/20/2026 at 2:01 PM for Tamiflu oral capsule 75 MG, Give 1 capsule by mouth in the evening for influenza A. Review of Resident #1's nursing progress note dated 01/21/2026 by ADON reflected Resident recently exposed to influenza a in the facility. Currently no symptoms reported. Resident was not tested for influenza at this time [per] protocol. New order received from in-house provider to start Influenza A Prophylaxis.Notified RP and approves of medications Review of Resident #1's chart reflected there were no notes from 01/21/2026 to 01/29/2026 that reflected NP, ADON , LVN A or any other facility staff notified Resident #1 a medication was being added to his regimen. During an interview on 01/29/2026 at 11:05 AM, Resident #1 stated that he was started on flu medication and did not find out what it was for until three days after. Resident #1 stated that FM B asked Resident #1 if he knew he was started on Tamiflu and that the facility had reached out to FM C to ask for permission for Resident #1 to start Tamiflu. Resident #1 stated (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	that he was not a vejito (little old man) who was crazy and that he could still make his own decisions. Resident #1 stated that he would have preferred to discuss what the medication was for. Resident #1 stated he was still in his right mind and only wanted the facility to reach out to FM B or FM if he was completely out of it and unable to make decisions. Resident #1 stated no one came in to ask him about getting the medication or if he wanted to take it. During an interview on 01/29/2026 at 1:07 PM, LVN A stated that she usually worked 6:00 AM to 6:00 PM shift. LVN A stated that there were a few residents with the flu and Tamiflu was given to other residents prophylactically as prescribed by the nurse practitioner. LVN A stated when there was a new medication order that the resident and their family were notified. LVN A stated that the nurse administered the first dose of the new medication. LVN A stated that it was important to notify the resident of medication changes because they were taking the medication and to be aware if they wanted to take the medication or not and to have an opportunity to ask questions or not. LVN A stated typically both the resident and family are notified depending on their BIMS score and if they can understand. LVN A stated Resident #1 was able to consent to his own treatment. LVN A stated Resident #1 was oriented to person, time, place and situation. LVN A stated that she does not recall if Resident #1 was notified of his new order for Tamiflu. LVN A stated she knew she told some residents, but could not recall who. LVN A stated someone helped with notification to families, but could not recall who. LVN A stated that resident rights included the right to take medication or not and the right to be notified of any changes in their treatment. During an interview on 01/29/2026 at 1:26 PM, RN B stated that the facility did prophylactic treatment to treat the flu. RN B stated that when there was a new order for medication she talked to the resident and also communicated with the provider and contact the family member listed on the resident's profile. RN B stated usually she would put in a progress note and specify that the family was contacted, ADON/DON, provider and that it was discussed with family. RN B stated that it was important to discuss changes in medication for the resident's autonomy, so they were aware of their care and to keep them involved of their care. RN B stated cognition level does not affect whether or not they are involved, and the resident should be notified regardless. During a telephone interview on 01/29/2026 at 2:02 PM, the ADON stated she was at training. The ADON stated that residents were started on Tamiflu prophylactically. The ADON stated she helped with notifying the families of the change. The ADON stated that the nurse or nurse practitioner was responsible to speak with the resident and tell the resident they were going to start Tamiflu. The ADON stated that sometimes Resident #1 was forgetful, but he recognized faces and sometimes had to be reminded of things that were done. The ADON stated it was important to notify residents of new medications so they were aware of what they were taking and what to expect. During an interview on 01/29/2026 at 2:08 PM, DON A stated that DON B was at a training and she was helping at the facility. DON A stated that the protocol for new medications would be for the nurse to notify the family member and if the resident was alert and oriented then the resident would be notified as well. DON A stated that it should be documented in a progress note and that included if the resident was notified as well. DON A stated notification to the resident depended on if they were aware of the medications they took, they can recall their daily routine, voice their needs and their BIMS score. DON A stated it was important to notify of any changes in medication so that the resident was aware of their plan of care. During an interview on 01/29/2026 at 2:42 PM, the ADM stated that he would defer notification of medications changes to the DON and it was not within his scope to answer. The ADM stated that documentation of notifications were also deferred to the DON. The ADM stated that it was important for the resident to be made aware of medications because it was apart of their place of care. The DON stated if the resident was alert and (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 3 of 4 residents (Resident #1, Resident #2, and Resident #3) reviewed for homelike environment. The facility failed to ensure Resident #1's, Resident #2's and Resident #3's privacy curtains were free of stains. This failure could place residents at risk of living in an unclean or unsanitary environment, decreased quality of life, or shame. Findings included: Review of Resident #1's face sheet dated 01/29/2026 reflected a [AGE] year-old male admitted on [DATE] with diagnoses of other cerebral infarction due to occlusion or stenosis of small artery (type of stroke caused by blockage or narrowing in deep-brain arteries), and hemiplegia and hemiparesis following cerebral infarction (motor impairments affecting one side of body following a stroke). Review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 12 which indicated moderate cognitive impairment. Observation on 01/29/2026 at 9:40 AM, revealed HSK on a ladder in Resident #1's room. Observation revealed privacy curtain in the middle of Resident #1's room was removed and replaced with a different curtain. During an interview on 01/29/2026 at 9:40 AM, Resident #1 stated that they were just now putting a new curtain up and that it had been dirty for at least three weeks. During a subsequent interview on 01/29/2026 at 11:05 AM, Resident #1 stated that his curtain was dirty for about 2 1/2 weeks. Resident #1 sated that CNA C changed his roommate and splattered bowel movement on the privacy curtain. Resident #1 stated CNA C tried to wipe it, but it stayed there. Resident #1 stated no one made an effort to clean it after that. Resident #1 stated that something similar happened once before. Resident #1 stated that FM B reported it to someone, but it was not changed until this morning (01/29/2026). Resident #1 stated that when his family visited they did not want to sit near the curtain. Resident #1 stated he does not want his room to be dirty. Review of Resident #2's face sheet revealed dated 01/29/2026 an [AGE] year-old female admitted on [DATE] with diagnoses of paroxysmal atrial fibrillation (type of irregular heart beat where heart rhythms start and stop on their own), muscle weakness and cognitive communication deficit (communication impairment caused by disruption in cognitive process like memory, attention and problem-solving). Review of Resident #2's annual MDS reflected a BIMS score of 14 no cognitive impairment. During an observation and interview on 01/29/2026 at 9:16 AM, it was revealed that Resident #2's privacy curtain between her and her roommate had several brown splattered dots. Resident #2 stated she did not know what was on her curtain and she wished it could be washed. Resident #2 stated that since she had been in her room she was not sure that the curtain was ever washed. Review of Resident #3's face sheet dated 01/29/2026 revealed a [AGE] year-old male admitted on [DATE] with diagnoses of post polio syndrome (neurological condition affecting polio survivors causing muscle weakness, fatigue, pain years after initial infection), major depressive disorder (mood disorder characterized by persistent sadness), and need for assistance with personal care. Review of Resident #3's quarterly MDS dated [DATE] reflected a BIMS of 15 which indicated no cognitive impairment. During an observation and interview on 01/29/2026 at 9:23 AM, it was revealed that Resident #3's privacy curtain in the middle of the room had brown streaks and spots. Resident #3 stated that he did not think the curtain got laundered very often, and he thought it was food. During an interview on 01/29/2026 at 12:44 PM, CNA D stated that when privacy curtains were soiled, they request to have the curtain taken down and laundered. This request was put into TELS (work order system). CNA D stated that TELS allowed for documentation as to why the curtain needed to be laundered and stated it was usually taken down the same day. CNA D stated she had no observed curtains with stains or that were soiled. (continued on next page)

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