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	12/12/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure residents received necessary treatment and services, consistent with professional standards of practice to promote wound healing and to prevent new pressure ulcers from developing for one (Resident #90) of five residents reviewed for pressure injuries. The facility failed to ensure Resident #90 received wound care treatments for eight days after admission, from 11/26/2025 to 12/04/2025. This failure could place residents at risk of improper wound management, the development of new pressure injuries, deterioration in existing pressure injuries, infection, and pain.Findings included: Record review of Resident #90's undated face sheet reflected a [AGE] year-old female admitted on [DATE]. Her diagnoses included end stage renal disease (a life-threatening disease in which the kidneys no longer filter the blood), diabetes mellitus II (a problem producing the hormone insulin to metabolize carbohydrates), and congestive heart failure (a condition in which the heart cannot pump blood effectively, leading to fluid accumulation in the lungs and legs). Record review of Resident #90's admission MDS assessment, dated 11/29/2025, reflected a BIMS score of 15, indicating no cognitive impairment. Section M (Skin Conditions) reflected Resident #90 was at risk of developing pressure ulcers, but had no unhealed pressure ulcers at the time of this assessment. Record review of Resident #90's care plan, dated 12/08/2025, reflected the following: I have pressure ulcer or potential for pressure ulcer development r/t stage 3 to coccyx. Pressure ulcer would show signs of healing and remain free from infection by/through review date. -Administer medications as ordered. Monitor/document for side effects and effectiveness. -Administer treatments as ordered and monitor for effectiveness. Assess/record/monitor wound healing. Measure length, width and depth where possible. -Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. -Call light within reach. If refuses treatment, meet with resident, IDT and family to determine why and try alternative methods to gain compliance. Document alternative methods. -Monitor dressing to ensure it is intact and adhering. Report lose dressing to treatment nurse. -Monitor nutritional status. Serve diet as ordered, monitor intake and record. -Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. -Treat pain as per orders prior to treatment/turning etc. to ensure comfort. Turn and reposition as tolerated.-Use Enhanced Barrier Precautions. -Weekly head to toe skin at risk assessment. Record review of Resident #90's clinical admission assessment, dated 11/26/2025, not completed by LVN I, reflected, Pt has pressure ulcer at sacrum. typed in under the skin assessment area. Record review of Resident #90's clinical admission assessment, dated 11/28/2025, and completed by LVN I, reflected, No skin issues under the skin assessment area. Record review of Resident #90's Skin Issues assessment, dated 12/01/2025, reflected resolved for redness documented to Buttocks-generalized. Record review of Resident #90's Skin Issues assessment, dated 12/03/2025, reflected, New Issue for Coccyx [tailbone] with pressure ulcer/injury indicated for skin issue. Progress reflected Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging reflected Stage 3 Pressure Ulcer/Injury: Full-thickness skin loss. Acquired reflected Present on admission. Onset reflected Chronic >3 months. Presences of wound pain reflected no. Staged by: reflected In-house nursing. (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 0686 Level of Harm - Actual harm Residents Affected - Few	Length reflected 4.5. Width reflected 2.5. Depth reflected 2. Granulation [healthy tissue that has formed] reflected 80%. Slough [dead tissue that sits on top of a wound] reflected 20%. Exudate [drainage] amount reflected Moderate. Exudate type reflected Serosanguineous: mixtures of serous [clear fluid] and sanguineous [resembles blood] fluid, typically pale, red, and watery. Record review of Resident #90's Skin Issues assessment, dated 12/10/2025, reflected Evaluated for Coccyx [the tailbone] with Pressure ulcer/injury indicated for skin issue. Progress reflected Deteriorating: wound characteristics deteriorated. Pressure ulcer staging reflected Stage 3 Pressure Ulcer / Injury: Full-thickness skin loss. Acquired reflected Present on admission. Onset reflected Chronic >3 months. Signs and symptoms of infection reflected Increased exudate [drainage] and Smell increased. Staged by: reflected In-house nursing. Measurements not documented as part of this assessment was documented on the form with reasoning previous measurement. Granulation [healthy tissue that has formed] reflected 30%. Slough [dead tissue that sits on top of a wound] reflected 70%. Exudate[drainage] amount reflected Heavy. Exudate type reflected Seropurulent [mix of clear fluid with pus]: mixture of purulent[pus] and serous [clear fluid], usually watery, yellow, green, tan or brown. Record review of Resident #90's Skin Committee IDT (documented by the WCN) note, dated 12/04/2025, reflected has stg 3 to coccyx that she reports having for long time. Treatment in place. Repositions self. On dialysis, hx of left leg amputation. Record review of Resident #1's progress notes reflected the following:11/28/2025 at 3:00 a.m. (documented by LVN I) Pressure ulcer to sacrum, discoloration to left arm that had fistula (surgical port of entry in the skin for hemodialysis) , surgical wounds covered by dressing to right femur (thigh bone including hip ball);12/01/2025 at 02:06 AM (documented by LVN L) skin note: skin warm and dry. X8 surgical wounds (meaning there were eight surgical wounds) on right leg. Bottom wounds.12/11/2025 17:26 [05:26 PM] (documented by the WCN) upon wound care to coccyx, foul odor noted with slough [dead tissue that sit on top of the wound] present to wound bed. Continues with calcium alginate for large amt of drainage. NP notified, will evaluate in the morning. Resident currently on air mattress. w/c cushion in place. Resident educated on increased pressure d/t staying up in w/c for prolonged periods at a time. States understanding but reports not wanting to be transferred with [mechanical lift] multiple times a day and would prefer to stay up in chair. Record review of Resident #90's order summary, dated 12/10/2025, reflected the following:Stg 3 coccyx: cleanse with wound cleanser, pat dry, apply calcium alginate, cover with dry dressing as needed for dislodgement and/or soilage. Order date and implementation 12/04/2025.Stg 3 coccyx: cleanse with wound cleanser, pat dry, apply calcium alginate, cover with dry dressing ever day shift. Order date and implementation 12/04/2025. Record review of Resident #90's shower sheets from 11/26/2025 to 12/04/2025 reflected she received a shower on 11/27/2025, 11/29/2025, 12/01/2025, and 12/02/2025. There were no skin issues documented on any of these shower sheets. During an interview on 12/09/2025 at 01:37 p.m., Resident #90 stated she had a wound to her sacrum before admission and did not feel it was cared for appropriately. She stated they did wound care treatments to the site, but she was unsure what was done or if the wound looked better or worse than when she was admitted to the facility. During an interview on 12/10/2025 at 03:56 PM with the WCN she stated she had worked at the facility four years and took over as the treatment nurse within the past year. She stated Resident #90 was admitted with a pressure wound to her coccyx. She stated the wound had not increased in size since admission. The WCN stated the wound had a lot of serosanguineous (mixture of clear serum and blood) drainage upon admission so they started putting calcium alginate to dry the wound up some. She stated wound treatment for the wound to Resident #90's coccyx started on 12/04/2025. She stated the normal protocol for new residents who are admitted with wounds was for the admitting nurse to contact the MD and initiate an order for wound care treatments. The WCN stated she was not notified about the wound until 12/03/2025 and she assessed the wound that day. She stated the wound currently had more slough than when she first assessed it on 12/03/2025. She stated she felt the wound had deteriorated because Resident #90 sat up in her wheelchair for extended periods of (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	time despite education. She stated they had a wheelchair cushion in place and she had an air mattress on her bed. The WCN stated the wound care specialist would see Resident #90 on the upcoming Monday after she returned from dialysis. She stated the wound appeared to be infected to her and she was planning on contacting the NP after the interview. The WCN stated if a pressure ulcer went 8 days without being treated then the wound could deteriorate quicker than if it were being treated, increased pain to the resident, and/or infection. Attempted phone interview on 12/11/2025 at 10:01 AM with LVN I without return call prior to exit. During a phone interview on 12/11/2025 at 10:03 AM with the MD, she stated she was the provider for Resident #90. She stated she assessed Resident #90 the previous Thursday and they discussed the wound to Resident #90's coccyx. She stated it was an existing wound prior to admission because Resident #90 was getting wound care through home health prior to admission. She stated she expected the nurses to communicate wounds on new residents through their nursing notes. She stated she observed the area with the wound the week prior during her visit with Resident #90. The MD stated Resident #90's coccyx had some superficial maceration [the softening and breakdown of the skin due to prolonged exposure to moisture]. She stated she expected nursing to do what nursing does when asked about her expectations for assessment of the wound and if she expected measurements for open wounds. During a phone interview on 12/11/2025 at 10:30 AM with the NP, she stated she was one of the responsible providers for Resident #90. The NP stated she first assessed Resident #90 on 12/02/2025 and she did not document any knowledge of a wound. She stated she had not observed any wounds to Resident #90's coccyx, but she was aware Resident #90 had a wound and was scheduled to observe the wound on her rounds that day. She stated the WCN had contacted her yesterday related to the wound, but she told the WCN that she would see the resident during her next rounds and make any decisions then. She stated if a resident was admitted with a wound, she expected the nurse to do an initial assessment of the wound and initiate wound care orders. She stated the pressure ulcer staging was based off the initial assessment of the wound. The NP stated calcium alginate was an appropriate treatment for a stage 3 pressure ulcer. The NP stated she did weekly wound care rounds with the WCN to monitor the progress of the wounds in the facility. She stated she could not say how it might affect a resident if a pressure ulcer went without treatment for eight days because that was not typical of the facility. During an interview on 12/11/2025 at 10:42 AM, C.N.A. D stated she remembered Resident #90 but did not remember anything about the condition of her skin during incontinent care or showering. She stated she could not remember whether there was a wound on or near her coccyx or sacrum. During an interview on 12/11/2025 at 10:50 AM, C.N.A. C stated she provided incontinent care and showers to Resident #90 but did not remember if Resident #90 had any skin issues. She stated she had cared for so many residents and had so much work to do that she could not recall experiences she had in previous weeks with residents no longer in her care. During an interview on 12/11/2025 at 11:08 AM with the DON, she stated she had worked at the facility for about 15 years as the DON. She stated she was a little familiar with Resident #90. She stated she had answered Resident #90's call light on occasion and had a few small conversations with her. She stated Resident #90 had denied any concerns to her during their conversations. The DON stated she was notified of Resident #90's pressure ulcer to the coccyx the week prior. She stated she was notified by an unknown nurse, and she had the WCN assess Resident #90 and initiate orders. The DON stated she was not sure if the wound was present upon admission. The DON stated she had not personally assessed the pressure ulcer to Resident #90's coccyx. She stated she had discussed the wound with the WCN about a week ago and was told that the wound was not getting any worse. After reviewing Resident #90's electronic health record she stated the nurses' notes were conflicting on if a wound was present on admission. She stated if a wound was present upon admission, then she expected the admitting nurse to perform a full skin assessment, notify the provider to obtain wound care orders, initiate the orders and notify the WCN. She stated she then expected the WCN to assess the wound including obtain measurements of the wound, stage the wound, and adjust the orders for (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	wound care as needed. The DON stated she expected the admitting nurse to describe the wound including measurements and location if the WCN was unavailable or they are unsure how to obtain the measurements. The DON stated she expected all skin issues to be documented in the skin assessment upon admission. She stated she expected to be notified if a wound had deteriorated. The DON stated she expected to be notified of all new residents with wounds. She stated she expected staff to notify her by any means, email, phone call, or teams. The DON stated after reviewing all the nursing notes in the electronic health record, she believed the new electronic health record was compiling records and the nurses did not fill out all portions of the assessments. She stated the new electronic health record was still a little confusing to her. She stated if a wound went without treatment for eight days, then it could get bigger, worse or infected. During an observation on 12/11/2025 at 01:14 PM of Resident #90's wound care, a malodorous wound to Resident #90's coccyx was observed with measurements provided by the WCN of 4.2cm x 6.5cm x 3cm with 70% light green colored slough. The old dressing that was removed was saturated in a brown colored drainage. During an interview on 12/11/2025 at 01:24 PM, the NP stated Resident #90 was scheduled to be seen by the wound care specialist on the following Monday. She stated she was unsure if the wound was infected and she was going to consult with the MD and if an antibiotic were started it would be for empirical [the practice of administering antibiotics based on the most likely pathogen causing the infection] treatment only. During an interview on 12/11/2025 at 01:27 PM, the DON stated, there is no way that wound was there, and no one did anything about it. She stated she knew Resident #90 had a history of a pressure ulcer to the area of the coccyx and through her investigation she gathered that Resident #90 had incurred some moisture associated skin damage to the scar tissue to her coccyx and it opened back up. She stated she observed some granulation to the wound base with a lot of slough. She stated she did not get to observe the old dressing due to her stepping out of the room briefly during the wound care. The DON stated the wound was very malodorous. She stated she expected the WCN to perform measurements weekly on all wounds. During an interview on 12/12/2025 at 11:18 AM with the MDS Coordinator, she stated she fills out the MDS by collecting data from the electronic health record. She stated she looked at the clinical assessment and a wound was not identified, so she did not include it in the admission MDS. She stated the admitting nurse should have put surgical incisions on the skin assessment, but they were not included either. She stated she used the orders for monitoring and treatment of the surgical incisions to know Resident #90 had surgical wounds as indicated on the admission MDS. The MDS Coordinator stated she did not have any role in monitoring or training floor staff. She stated if a wound went eight days without treatment, then it could get worse or get infected. During an interview on 12/12/2025 at 11:50 AM with MD K, he stated he looked over Resident #90's hospital records prior to admission and he stated based off records it was hard to say if a pressure wound existed prior to admission to the facility. He stated the hospital records indicated Resident #90 had dry skin, but the records only referenced a healing/healed bedsore. He stated if there was a stage 3 pressure wound, then the hospital would have orders for treatment of the wound. MD K stated a healed pressure wound could open up to a really large wound for someone with Resident #90's health conditions. MD K stated based off the information he had, he could not determine if the wound was unavoidable for Resident #90. During an interview on 12/12/2025 at 01:08 PM with ADON A, she stated she was unsure if Resident #90 was admitted to the facility with any pressure ulcers. She stated it was policy for the nurses to perform a skin assessment within 24 hours of a new admission, initiate orders and notify management and the WCN if there was a wound present upon admission. ADON A stated wounds should be assessed with every dressing change. She stated all residents were scheduled to have a skin assessment weekly. She stated the CNAs were trained see something, say something, meaning if they saw something new then they were to inform their nurse, verbally was appropriate. ADON A stated a wound could get worse and even cause death if it went untreated for eight days. During an interview on 12/12/2025 at 1:43 PM with the DON, she stated that she felt there was an original discrepancy on the admission documentation because the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	shower sheets did not reflect a wound. She stated the treatments were initiated for the surgical sites and she felt if there was a wound then there would have been orders initiated too. She stated she was able to talk to LVN I and LVN I stated she did not see any wounds on admission. The DON stated she questioned LVN I about why she indicated pressure on the clinical assessment but did not give an answer to why pressure was indicated. The DON stated she in-serviced LVN I about accurate documentation according to policy. The DON stated the nurses were expected to do a complete skin assessment and describe any abnormalities upon any resident admission to the facility. She stated if there were any wounds upon assessment then she expected the nurse to contact the provider and obtain and initiate orders for treatment of the wound. The DON stated they also relied on the shower sheets to identify new skin issues. She stated the shower sheets should continue to reflect the skin issue until it resolved. During an interview on 12/12/2025 at 02:08 PM with the ADM, he stated he was not familiar with Resident #90 until that morning when he had a conversation with her. He stated he was not a clinician but expected the nurses to contact the DON and provider if a resident was admitted to the facility with wounds. He stated he would expect the nurse to document the wounds upon admission including a detailed description and measurements of the wound. He stated the DON and ADONs were responsible for reviewing all new admissions the day after the admission to ensure accuracy and completion of the admission. He stated staff were available on holidays and weekends to review admissions. The ADM stated if a pressure wound went eight days without treatment, then there could be a negative outcome including potential damage to the site of the wound. Record review of in-services for 2025 reflected one conducted on 04/15/2025 titled Skin Integrity and Prevention. The in-service material did not include information related to admission skin assessments Notify charge nurse on any new skin issues. Continue with skin shower sheets for wound care and charge nurse to review. Review of facility policy titled Skin and Wound Monitoring and Management, dated 03/2015 and last revised 04/2025, reflected the following: It is the policy of this facility that:1. A resident who enters the facility without pressure injury does not develop pressure injury unless the individual's clinical condition or other factors demonstrate that a developed pressure injury was unavoidable; and2. A resident having pressure injury(s) receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing.The purpose of this policy is that the facility provides care and services to:1. Promote interventions that prevent pressure injury development;2. Promote the healing of pressure injuries that are present (including prevention of infection to the extent possible); and3. Prevent the development of additional, avoidable pressure injury.Current evidence documents that, in certain circumstances, the development of pressure injury is an unavoidable occurrence. In accordance with the guidance issued by the National Pressure Ulcer Advisory Panel (March 2010), the facility recognizes that an unavoidable pressure injury is one that developed even though the provider evaluated the individual's clinical condition and pressure injury risk factors; defined and implemented interventions that are consistent with individual needs goals and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.Facility nursing staff will identify and document in the resident's clinical records, the condition and pressure injury risk factors related to the development of unavoidable pressure injury. This identification and implementation of a plan of care will begin at admission with the initial care plan and be completed throughout assessment process for developing a comprehensive plan of care.Procedurea. Resident Assessment: the nurse responsible for assessing and evaluating the resident's condition on admission and readmission is expected to take the following actions:a. Complete Initial admission Record and Braden Scale to identify risk and to identify any alterations in skin integrity noted at that time.c. Identify risk factors which relate to the possibility of skin breakdown and/or the development of pressure injury which include, but are not limited to: Impaired/decreased mobility and decreased functional ability Co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus Drugs, such as steroids, that may affect wound healing Impaired diffuse or localized blood flow, generalized (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	atherosclerosis or lower extremity arterial insufficiency Resident refusal of some aspects of care and treatment Cognitive impairment Exposure of skin to urinary and fecal incontinence Nutrition, malnutrition, and hydration deficits History of a healed pressure injury and its stage (if known)d. Risk factors identified on assessment should be documented in the resident's clinical record and, when appropriate, be addressed through a care plan.e. Develop an individualized person-centered care plan based on the assessment and designed to minimize the possibility of skin breakdown.f. Skin and wound assessment on admission and readmission: A licensed nurse must assess/evaluate a resident's skin on admission. All areas of breakdown, excoriation, or discoloration, or other unusual findings, will be documented on the Initial admission Record. A licensed nurse will assess/evaluate each pressure injury and/or non-pressure injury that exists on the resident. This assessment/evaluation should align with the scope of practice and include but not limited to:1) Measuring the skin injury2) Staging the skin injury (when the cause is pressure)3) Describing the nature of the injury (e.g., pressure, stasis, surgical incision)4) Describing the location of the skin alteration5) Describing the characteristics of the skin alterationg. Ongoing Skin and Wound Assessments: A licensed nurse will assess/evaluate a resident's skin at least weekly. Areas of breakdown, excoriation, or discoloration, or other unusual findings (either initially identified at the time of admission or as new findings) must be documented in the nursing notes or on the appropriate weekly assessment form. A licensed nurse will assess/evaluate at least weekly each area of alteration/injury, whether present on admission or developed after admission, which exists on the resident. This assessment/evaluation should include but not be limited to:1) Measure the skin injury2) Staging the skin injury (when the cause is pressure)3) Describing the nature of the injury (e.g., pressure, stasis, surgical incision)4) Describing the location of the skin alteration5) Describing the characteristics of the skin alteration6) Describing the progress with healing, and any barriers to healing which may exist7) Identifying any possible complications or signs/symptoms consistent with the possibility of infectionh. It is understood that a resident may experience pain associated with the presence of a skin injury and/or any form of skin compromise. Therefore, the nursing staff shall be responsible to assess the resident for complaints of pain on assessment, prior to treatment, and as appropriate.i. Once an area of alteration in skin integrity has been identified, assessed, an documented, nursing shall administer treatment to each affected area as per the Physician's Order.j. Treatments per physician order, should be documented in the resident's clinical record at the time they are administered.4. Documentationa. Pressure Ulcer, Non-pressure Ulcer, and PRN/Weekly skin assessment/evaluation forms: If the clinical assessment/evaluation indicates a change in condition or decline in the wound, the assessing/evaluating nurse will notify the physician and create a narrative note documenting that notificationb. Weekly Skin Check Licensed nurse should document skin evaluations in accordance with this policy and document on the appropriate skin assessment/evaluation weekly/PRN form.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store and prepare food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food safety. 1. The deep fryer was dirty on 12/09/2025.2. The commercial dishwasher did not meet the minimum required threshold for chemical sanitizing on 12/09/2025. This failure could place residents at risk of food-borne illnesses.Findings included: 1. Observation on 12/09/2025 at 9:03 a.m. revealed the deep fryer in the facility kitchen was covered in cornmeal breading crumbs. There were crumbs on the rim of the fryer as well as floating in the oil inside the fryer. There were streaks of dark brown substances on the inside walls of the fryer, and the fry baskets contained crumbs and other solid matter inside the basket and embedded in the basket wires. During an interview on 12/09/2025 at 9:05 AM, the DS stated the deep fryer was deep cleaned weekly and food particles from use were cleaned daily after each meal. He stated the last time the deep fryer was used was the day prior, 12/08/2025, and the crumbs seen on it were from the fish cakes they made for lunch the day before. Observation on 12/09/2025 at 11:37 AM revealed DM, the dietary manager for a sister facility, cleaning and scrubbing the deep fryer. When he finished, there were no more crumbs, and the brown streaks were gone. 3. Observation and interview on 12/09/2025 at 9:10 AM revealed the DA ran the mechanical dishwasher and tested the water on dishes as well as in the bottom of the dishwasher after the rinse cycle. The test strip that measured chlorine PPM became the color that indicated 25 PPM. The DA stated he thought the PPM had to be at 50. The DA stated he had just done something to ensure the chemicals were flowing freely into the dishwasher but did not explain what he had done when asked. He stated he was frustrated that the effort he had made was not effective. He stated he tested the dishwasher sanitizer every day. He stated when he tested it this morning, it was after running the machine two or three times and he noticed the test strip was not dark enough. He stated he would have to call the company that furnished their dishwashing chemicals, the name of which was embossed in the metal outside of the dishwasher. He stated he did not know where to find the model number for the unit. The DS entered the dishwashing area at this time, and he tested the dishwasher again. The color of the test strip was the same as before, the DS stated he would call the company that provides their supplies and ask them to come service the machine right away. He stated they would sanitize dishes in the three-compartment sink in the meantime. A test of the quaternary ammonium solution (ammonia-based cleaner) in the rinse compartment of the three-compartment sink revealed the PPM was high enough for sanitizing thoroughly. Neither the DS, the DA, nor the surveyor could locate a model number for the unit. Observation on 12/09/2025 at 11:35 AM revealed the chlorine test strip measured consistent with 50 PPM when run through the commercial dishwasher rinse water. During an interview on 12/10/2025 at 2:44 PM, the DS stated he was the person responsible for ensuring the kitchen dishwasher was sanitizing effectively and the deep fryer was cleaned according to their policy. He stated he monitored for compliance by conducting daily walkthroughs of the kitchen when he first arrived each morning, and part of that was de-liming (removing the limestone deposits left on the machine by the area's hard water) and checking sanitization levels. He stated the dishwasher technician came to the facility on [DATE] and determine that one of the hoses delivering chlorine sanitizer had disconnected. The DS stated the technician fixed the problem. He stated the potential negative outcome was it could be an outbreak of food-borne illness. He stated the policy for cleaning the deep fryer was a deep clean once per week, and the staff were also supposed to clean the deep fryer after every use. He stated he monitored for compliance by conducting his walkthroughs. He stated the deep clean of the deep fryer was assigned as his responsibility on the checklist, and he did not think he had done the deep clean on (12/05/2025). He stated the potential negative outcome of a dirty deep fryer was food-borne illness. (continued on next page)

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	676272	A. Building B. Wing	12/12/2025

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/12/2025 at 2:07 PM, the ADM stated the DS was responsible for ensuring the dishwasher sanitized the dishes adequately and the deep fryer was cleaned. He stated he oversaw the process by monitoring logs and resources and giving the DS feedback (did not elaborate). He stated there was also a regional resource staff who visited and gave feedback on the conditions of the kitchen. He stated the potential negative outcome of the dishwasher not sanitizing was the residents could get some kind of illness, and he did not know what the potential negative outcome of a dirty deep fryer would be. Review of an undated document posted in the kitchen and titled Friday Weekly Deep Cleaning Day reflected the DS was responsible for cleaning the fryer machine. Review of a document dated December 2025 and titled Dishwasher Log reflected the sanitizer PPM was marked at 50 for every meal (breakfast, lunch, and dinner) for every day in December. The wash and rinse temperatures for every entry were at 120 degrees Fahrenheit. The facility policy provided by the ADM on 12/11/2025 in response to a request for policy related to food storage and preparation reflected no specific guidance about food preparation, clean equipment, or dishwasher sanitation. Review of the Texas Food Establishment Rules dated August 2021 reflected the following: (2) Mechanical. Cleaning and sanitizing may be done by spray-type or immersion dishwashing machines or by any other type of machine or device if it is demonstrated that it thoroughly cleans and sanitizes equipment and utensils either by chemical or mechanical sanitization.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to conduct an accurate assessment of each resident's functional capacity for 1 of 24 residents (Resident #90) reviewed for comprehensive assessments. The facility failed to ensure Resident #90's pressure wound, present on admission, was included in the admission MDS assessment. This failure placed residents at risk of wound deterioration.Findings included: Review of Resident #90's undated face sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included end stage renal disease (a life-threatening disease in which the kidneys no longer filter the blood), diabetes mellitus II (a problem producing the hormone insulin to metabolize carbohydrates), and congestive heart failure (a condition in which the heart cannot pump blood effectively, leading to fluid accumulation in the lungs and legs). Review of Resident #90's admission MDS assessment, dated 11/29/2025, reflected a BIMS score of 15, indicating no cognitive impairment. Section M (Skin Conditions) reflected Resident #90 was at risk of developing pressure ulcers, but had no unhealed pressure ulcers at the time of this assessment. Record review of Resident #90's care plan, dated 12/08/2025, reflected the following: I have pressure ulcer or potential for pressure ulcer development r/t stage 3 to coccyx. Pressure ulcer would show signs of healing and remain free from infection by/through review date.-Administer medications as ordered. Monitor/document for side effects and effectiveness.-Administer treatments as ordered and monitor for effectiveness. Assess/record/monitor wound healing. Measure length, width and depth where possible.-Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD.-Call light within reach. If refuses treatment, meet with resident, IDT and family to determine why and try alternative methods to gain compliance. Document alternative methods.-Monitor dressing to ensure it is intact and adhering. Report lose dressing to Treatment nurse.-Monitor nutritional status. Serve diet as ordered, monitor intake and record.-Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated.-Treat pain as per orders prior to treatment/turning etc. to ensure comfort. Turn and reposition as tolerated.-Use Enhanced Barrier Precautions.-Weekly head to toe skin at risk assessment. Review of Resident #90's clinical admission assessment, dated 11/26/2025, not completed by LVN I, reflected, Pt has pressure ulcer at sacrum. typed in under the skin assessment area. Review of Resident #90's clinical admission assessment, dated 11/28/2025, and completed by LVN I, reflected, No skin issues under the skin assessment area. Review of Resident #1's progress notes reflected the following:11/28/2025 at 3:00 a.m. (documented by LVN I) Pressure ulcer to sacrum, discoloration to left arm that had fistula (surgical port of entry in the skin for hemodialysis) , surgical wounds covered by dressing to right femur (thigh bone including hip ball);12/01/2025 at 02:06 AM (documented by LVN L) skin note: skin warm and dry. X8 surgical wounds (meaning there were eight surgical wounds) on right leg. Bottom wounds. Review of Resident #90's Skin Issues assessment, dated 12/03/2025, reflected, New Issue for Coccyx [tailbone] with Pressure ulcer/injury indicated for skin issue. Progress reflected Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging reflected Stage 3 Pressure Ulcer/Injury: Full-thickness skin loss. Acquired reflected Present on admission. Onset reflected Chronic >3 months. Presences of wound pain reflected no. Staged by: reflected In-house nursing. Length reflected 4.5. Width reflected 2.5. Depth reflected 2. Granulation [healthy tissue that has formed] reflected 80%. Slough [dead tissue that sits on top of a wound] reflected 20%. Exudate [drainage] amount reflected Moderate. Exudate type reflected Serosanguineous: mixtures of serous [clear fluid] and sanguineous [resembles blood] fluid, typically pale, red, and watery. Review of Resident #90's Skin Issues assessment, dated 12/10/2025, reflected Evaluated for Coccyx [the tailbone] with Pressure ulcer/injury indicated for skin issue. Progress reflected Deteriorating: wound characteristics (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	deteriorated. Pressure ulcer staging reflected Stage 3 Pressure Ulcer / Injury: Full-thickness skin loss. Acquired reflected Present on admission. Onset reflected Chronic >3 months. Signs and symptoms of infection reflected Increased exudate [drainage] and Smell increased. Staged by: reflected In-house nursing. Measurements not documented as part of this assessment was documented on the form with reasoning previous measurement. Granulation [healthy tissue that has formed] reflected 30%. Slough [dead tissue that sits on top of a wound] reflected 70%. Exudate[drainage] amount reflected Heavy. Exudate type reflected Seropurulent [mix of clear fluid with pus]: mixture of purulent[pus] and serous [clear fluid], usually watery, yellow, green, tan or brown. Observation and interview on 12/11/2025 at 11:00 AM, revealed Resident #90 seated in her wheelchair in her room. She had an above knee amputation of her left leg and surgical scars were visible on her right leg. She stated the pressure ulcer to her coccyx had been there for over a year, but it was healed at some point. She stated she started feeling a burning sensation to the area and thought the wound to her coccyx reopened a week prior to admission to the hospital and the facility. During an interview and record review on 12/12/2025 AM 1:18 p.m., the MDS Coordinator stated she learned what needed to go on the skin section of the MDS assessment by looking at the admission skin assessment. She said the skin assessment was found in the Clinical admission Assessment. She reviewed the two assessments for Resident #90 and said she saw the pressure ulcer to the sacrum on the assessment dated [DATE], but that assessment had not been completed and submitted, so she reviewed the assessment completed and submitted 11/28/2025. She stated the surgical incisions Resident #90 had from the hospital were also not in the Clinical admission assessment dated [DATE], so it seemed LVN I did not do a skin assessment at all for that version. She stated she included the surgical sites to the admission MDS because she reviewed the orders. The MDS Coordinator stated she had no role in training the floor staff to do assessments or anything else. She stated the potential negative impact of a wound present on admission not reflected in the MDS was the wound could worsen and/or become infected. During an interview on 12/12/2025 at 1:07 PM, ADON A stated she assisted in training the floor nurses on the clinical admission process. She stated LVN I worked as a night nurse and was at their skills fair, which included training on the clinical admission process. She stated she conducted in-services regularly. She stated the nurses needed to complete the clinical admission assessment thoroughly and correctly because otherwise the resident may not receive important interventions for clinical problems. She stated she had not investigated the situation regarding Resident #90's pressure wound not being on the MDS or clinical admission assessment, but she assumed LVN I did not fill out the admission assessment correctly. She stated the person responsible for making sure a wound present on admission was documented on the admission MDS assessment was the MDS Coordinator, but she (ADON A) also had a role because she was part of the IDT and involved in scrubbing the chart, which was a process their team used to review all the medical records and ensured nothing fell through the cracks. She stated they had not scrubbed Resident #90's chart yet. She stated the potential negative outcome of a pressure wound present on admission not listed on the admission MDS was worsening of the wound. She stated it was also possible there could be less financial reimbursement for the residents while in the facility. During an interview on 12/12/2025 at 1:31 p.m., ADON B stated she assisted in training nurses to complete the clinical admission tool when they were hired, and they asked her questions afterward if they needed help. She stated she trained them to perform a full skin assessment and to identify anyone at risk of skin breakdown. She stated she did not have a role in assuring information was on the admission MDS assessment. She stated she did not know what the potential negative outcome was to the resident for a wound present on admission not added to the admission MDS. During an interview on 12/12/2025 at 1:43 p.m., the DON stated she felt there was a discrepancy on the initial clinical admission assessment for Resident #90 when LVN I added pressure ulcer to sacrum it was a mistake. She stated she reviewed the shower sheets and there were no skin issues documented, which was inconsistent with the surgical incision present on admission. The DON stated she had spoken to LVN I (continued on next page)

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	676272	A. Building B. Wing	12/12/2025

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about the discrepancy and LVN I stated she did not see a wound on Resident #90 upon admission. The DON stated LVN I did not answer when asked why she documented pressure ulcer on the initial version of the admission assessment. The DON stated the person responsible for ensuring conditions present on admission were included in the admission MDS assessment was the MDS Coordinator, but she relied on the charge nurses to include the essential information in the clinical admission assessment. The DON stated a potential negative outcome to a wound present at admission not included in the admission MDS assessment was not as many people would know about the wound. During an interview on 12/12/2025 at 2:16 p.m., the ADM stated the person responsible for ensuring clinical conditions present on admission were included in the MDS assessment was the MDS nurse. He stated he did not have a role in ensuring compliance with that process as it was the responsibility of the clinical team. He stated a potential negative impact of Resident #1's pressure wound not b coded on the MDS was the nursing staff would not have an accurate picture of what care the resident needed. Record review of facility policy, dated 07/2023, titled Admission reflected the following: PolicyIt is the policy of this facility to have well defined guidelines for processing the resident's entry into the nursing facility and the resident's right guaranteed under federal and state law are protected.PURPOSE4. Obtain information about the resident to establish baseline data for the MDS and provide the basis for interdisciplinary assessment, care, planning, and rehabilitation of each resident.PROCEDURE4. The resident shall be admitted , according to procedure by the licensed nurse.Licensed Nurse Procedure2. Initiate any treatments as ordered4. Initiate admission assessments. Record review of facility policy, dated 04/2025, titled Skin and Wound Monitoring and Management reflected the following: Procedurea. Resident Assessment: The nurse responsible for assessing and evaluating the resident's condition on admission and admission is expected to take the following actions:f. Skin and wound assessment on admission and readmissionA licensed nurse must assess/evaluate a resident's skin on admission. All areas of breakdown, excoriation, or discoloration, or other unusual findings will be documented on the initial admission record.A licensed nurse will assess/evaluate each pressure injury and/or non-pressure injury that exists on the resident. This assessment/evaluation should align with the scope of practice and include, but not be limited to:1. Measuring the skin injury2. Staging the skin injury (when the cause is pressure)3. Describing the nature of the injury (e.g. pressure, stasis, surgical incision)4. Describing the location of the skin alteration5. Describing the characteristics of the skin alteration i. Once an area of alteration in skin integrity has been identified, assessed, and documented, nursing shall administer treatment to each affected area as per the Physician's Order.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections for 2 (Resident #2, Resident #5) of 10 residents reviewed for infection control. The facility failed to properly use EBP personal protective equipment during perineal care for Resident #2 and Resident #5. This failure could place residents at risk for infection transmission, sepsis, and hospitalization. Findings included:Record review of Resident 5's face sheet, dated 12/10/2025, revealed a [AGE] year-old male admitted on [DATE]. His diagnoses included AC, BPH, anemia, glaucoma, recurrent falls, and persistent pain in both hips.Review of Resident 5's physician orders dated 12/01/2025, revealed that this resident was on contact precautions for wounds, indwelling medical devices, infection, and/or MDRO status (indwelling). Review of Resident 5's physician orders dated 12/06/2025, revealed that PPE was required for high resident contact care activities, indicated for wounds, indwelling medical devices, infection, and/or MDRO status (wound) every shift. Record review of Resident 2's face sheet, dated 12/12/2025, revealed a [AGE] year-old female admitted on [DATE]. Her diagnoses included cognitive communication deficit, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, vascular dementia of unspecified severity. Review of Resident 2's physician orders dated 4/18/2024, revealed that PPE was required for high resident contact care activities, indicated for wounds, indwelling medical devices, infection, and/or MDRO status (wound) every shift. Observation on 12/10/2025, at 8:39 a.m. revealed that LVN J and C.N.A. D did not put on the PPE personal protective equipment (gown) provided outside of Resident 5's room before starting perineal care. It was also observed that when LVN J exited Resident 5's room with the waste, a blue gown could not be seen in the clear waste bag carried to the trash can in an undisclosed area. Observation on 12/10/2025 at 10:22 a.m. revealed that LVN J and C.N.A. D did not put on the personal protective equipment (gown) provided outside of Resident 2's room. In an interview on 12/03/2025, at 8:48 a.m., Resident 5's daughter stated that LVN J and C.N.A. D performed perineal care for Resident #5 without the blue gowns on kept at the residents' door for enhanced barrier precautions EBP. Resident #5's family member stated staff sanitized their hands but only wore gloves to perform the care. In an interview on 12/11/2025, at 10:58 a.m., LVN J stated she was in-serviced on enhanced barrier precautions and contact precautions protocol with infection control policies and wound care summer 2025 She said that enhanced barrier precautions included wearing a gown and gloves when conducting perineal care on residents with an order for enhanced barrier precautions. She stated that this will be listed outside the residents' rooms and an orange dot on the resident nameplate. She understood the negative effects of not following proper enhanced barrier precautions and noted that if these precautions were not followed, residents and staff were at risk for contamination. In an interview on 12/11/2025, at 10:58 a.m., C.N.A. D, stated that she provides resident care, such as helping them shower and handling their daily care. She mentioned that the enhanced barrier precautions for the facility entail sanitizing hands and wearing a gown while providing care. She also stated that if the enhanced barrier precautions are not followed, both the residents and staff could be at risk of disease. In an interview on 12/11/2025, at 11:16 a.m., C.N.A. F, stated she has worked at the facility for over a year and assisted residents with their daily care. She stated that the enhanced barrier precautions protocol requires all staff to wear the blue gowns that are attached to all resident doors with enhanced barrier precautions. She stated that staff must knock on the resident's door before entering, wash their hands, and wear gloves while performing care. If this is not done correctly, residents may be placed at risk. In an interview on 12/11/2025, at 11:25 a.m., C.N.A. C, stated she has worked at the facility for six months and helped residents with daily activities such as feeding, showering, cleaning nails, and reporting any changes in condition. She stated she received in-service training that day 12/11/2025 on enhanced barrier precautions. This (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	training covered that all enhanced barrier precautions rooms will have an orange dot for wounds. She stated that if she has a resident with enhanced barrier precautions, she knocked on the door, put on a gown, a mask, and face shield before entering the room to minimize risk to both the residents and the aides. In an interview on 12/11/2025, at 11:35 a.m., LVN H, stated she is a supervisor and monitors the medication aides. She stated she received in-service training that morning 12/11/2025 on abuse and neglect and was able to provide the name of the abuse and neglect coordinator. She named two types of abuse and noted that enhanced barrier precautions are for residents with wounds and pic lines, requiring staff to wear gown and gloves. She reiterated that she received in-service training that morning on enhanced barrier precautions and emphasized that failure to follow these procedures could place residents and staff at risk for disease. In an interview on 12/11/2025, at 11:35 a.m., ADON B, stated she is responsible for all training related to enhanced barrier precautions. She mentioned that she also serves as the facility's Infection Control Prevention Nurse. She stated that enhanced barrier precautions training is provided monthly to staff and that these precautions are necessary for residents with indwelling devices. An orange dot is placed on their room door to protect others and inform them of their condition. Hand hygiene must be performed before and after care, and all staff must wear gowns. She noted there is a section in the PCC titled Special Requirement where enhanced barrier precautions can be found; it is also listed in the orders. If enhanced barrier precautions were not executed correctly, according to ADON B, this placed residents and staff at risk and compromised infection control measures. In an interview on 12/12/2025, at 2:26 p.m., ADM stated that the ICP nurse is responsible for all the enhanced barrier precautions training in his facility. He mentioned they have been trying to train staff monthly on enhanced barrier precautions.Review of facility's IPCP Standard and Transmission-Based Precautions, dated 10/2022, reflected: 3. Enhanced Barrier Protection (EBJ): expand the use of PPE refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of [NAME] to staff hands and clothing then indirectly transferred to residents or from resident-to-resident.(e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. PPE: The use of gown and gloves for high-contact resident care activities is indicated, whenContact Precautions do not otherwise apply, for nursing home residents with:i. Wounds and/or indwelling medical devices regardless of [NAME] colonization as well as forresidents ii. [NAME] infection or colonization.Multi-drug-Resistant Organisms ([NAME])- the MDROs for which the use of EBP applies are based onlocal epidemiology. At a minimum, they should include resistant organisms targeted by CDC but canalso include other epidemiologically important MDROs i. Examples of MDROs Targeted by CDC include: Pan-resistant organisms, Carbapenemase-producing carbapenem-resistant Enterobacterales, Carbapenemase-producing carbapenem-resistant Pseudomonas spp., Carbapenemase-producing carbapenem-resistant Acinetobacter baumannii, and Candida auris ii. Additional epidemiologically important MDROs may include, but are not limited to: Methicillin-resistant Staphylococcus aureus (MRSA), ESBL-producing Enterobacterales, Vancomycin-resistant Enterococci (VRE), Multidrug-resistant Pseudomonas aeruginosa, Drug-resistant Streptococcus pneumoniae Examples of high-contact resident care activities requiring gown and glove use for EnhancedBarrier Precautions include:i. Dressingii. Bathing/showeringiii. Transferringiv. Providing hygienev. Changing linensvi. Changing briefs or assisting with toiletingvii. Device care or use: central vascular line (including hemodialysis catheters}, indwellingurinary catheter, feeding tube, tracheostomy/ventilator Devices that are fully embedded in the body, without components thatcommunicate with the outside, such as pacemakers, would not be considered an indication forEnhanced Barrier Precautions.viii. Wound care: any skin opening requiring a dressingix. In general, gown and gloves would not be required for resident care activities other than thoselisted above, unless otherwise necessary for adherence to Standard Precautions.d. Room restriction: Residents are not restricted to their rooms or limited from participation ingroup activities while on EBP. Although a private room is not required for residents on EBP, thefollowing may be implemented: i. At least 3 feet of separation between beds