STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676312	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - West S	222 Bertetti Dr San Antonio, TX 78227

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 treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 (Resident #1) out of 6 residents reviewed for dignity. The facility failed to comply with Resident #1's request not to have CNA G assigned to her care and to not enter her room. This failure could place residents at risk of diminished dignity and affect their quality of life.The findings included: Record review of Resident #1's admission Record, dated 06/11/2026, revealed an [AGE] year-old female admitted [DATE] and re-admitted [DATE]. Resident #1 was listed as her own responsible party. Record review of Resident #1's Medical Diagnoses, undated and accessed 06/11/2026 at 3:54 p.m., revealed diagnoses including heart failure (chronic condition where the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), hypertension (condition where the force of blood against the artery walls is consistently too high), acute kidney failure (kidneys suddenly stop working), Transient Ischemic Attack (TIA) (temporary blockage of blood flow to the brain), anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #1's quarterly MDS assessment, dated 06/01/2026 and signed 06/14/2026 as completed, reflected a BIMS score of 15 indicating cognition intact. Resident #1 was documented as having not exhibited any behavioral symptoms. Resident #1 was documented as requiring incontinence care. Resident #1's functional abilities were documented as requiring dependent to set up or clean-up assistance and requiring a wheelchair for mobility. Record review of Resident #1's care plan, undated and accessed 06/11/2026 at 4:24 p.m., revealed, . [Resident #1] has bladder incontinence r/t [related to] Impaired Mobility and goal . [Resident #1] Will remain free from skin breakdown due to incontinence and brief use through the review date. and interventions .BRIEF USE: uses disposable briefs. Change q 2-3 hrs. [every 2 to 3 hours] and prn [as needed] . INCONTINENT: Check as required for incontinence. Wash, rinse and dry perineum. date initiated 05/08/2024 and revised on 10/29/2024. Record review of Resident #1's progress notes, dated 04/10/2026 (CNA G's date of hire) to 06/11/2026 (EMR access date) revealed no progress notes were found mentioning Resident #1's reported incident or preferences regarding CNA G and the request to not have him provide her with direct care. Record review of Resident #1's EMR Misc. tab on 06/11/2026 did not reveal documentation of NF Incident Report or Grievance Request. During an observation and interview on 06/10/2026 at 2:11 p.m. Resident #1 was noted to be sitting in her wheelchair outside of her room socializing with a male resident. She was dressed well, groomed appropriately and had no odors. Resident #1 had clear thinking and reasoning, she was able to communicate fluently, express thoughts clearly, and understand others. She was aware of time, place, and person, without disorientation. Resident #1 stated that she does not have a preference in gender of staff to provide care, but she does not like one male aide due to an incident that occurred less than one month back. She stated a male aide (name unknown) and described as tall, Columbian, (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	who usually works evenings was providing her with incontinence care and he saw chocolates on her bedside table and told her she was eating too many chocolates and that was why she was fat. She stated the incident was reported to NF staff, but the same male aide was on shift last night (06/09/2026) and he tried to provide her with incontinence care after she used the call light for assistance. She stated he does not know how to provide care. She stated she was a retired RN, and she was a Director of Nursing for 18 years and you do not talk to residents in this manner. Resident #1 revealed that she reported the incident to the NF staff immediately after it occurred. She stated she has notified NF staff several times and the ADON A that she does not want this male aide in her room providing her with care. Said stated she does not trust this male aide and she held her bowels overnight to avoid receiving care from him. During an interview on 06/11/2026 at 12:00 p.m. the Wound Care Nurse stated staff were expected to report ANE immediately to Administrator who was the Abuse Coordinator. She stated if she were to witness staff being inappropriate, rude, or talking to residents disrespectfully she would report it immediately. She stated all grievances or complaints should be reported to the charge nurse and the Social Worker for follow-up. During an interview on 06/11/2026 at 1:30 p.m., CNA B revealed she was knowledgeable of ANE and resident rights and provided examples. She stated she was to report ANE immediately to the Administrator. CNA B stated if she were to witness or hear staff being rude or disrespectful to a resident, she would report this behavior immediately and stated that this could impact a resident and make them fearful of staff if left unreported. During an interview on 06/11/2026 at 2:53 p.m., CNA C revealed she was knowledgeable of ANE and resident rights and provided examples. She stated she was to report ANE immediately to the Administrator. She stated violations of ANE, and resident rights of a resident could cause them to become depressed, sad, not want to engage in activities, or refuse to eat. CNA C stated she was familiar with Resident #1's care, she requires incontinence care, requires person assist, cognition was intact and she can express her needs and wants. She recalled that the previous week Resident #1 reported to her that she did not trust an overnight aide (name unknown). She stated an incident occurred, but she was not provided with details, but that she had already reported it to the charge nurse on shift the day of the incident and LVN D. She stated that Resident #1 notified her that the incident had already been reported and the male aide (name unknown) was not allowed back in her room and she did not believe it had to be reported further. She stated she did not recall the name of the male aide, but she did recall he was new and he worked overnight. During an interview on 06/11/2026 at 3:13 p.m., CNA E revealed he was knowledgeable of ANE and resident rights and provided examples. He stated he was to report all ANE immediately to the Administrator. He stated violations of ANE, and resident rights of a resident could cause them emotional stress, anxiety, and loss of sleep. CNA E stated while providing Resident #1 care about 2-3 weeks back she revealed to him that an overnight aide was being rude to her and saying she was overweight and made her feel uncomfortable. He stated he told her to let the nurse know. He stated Resident #1 stated she reported the incident to the overnight charge nurse (unidentified) and believed it may have been passed on to the morning charge nurse. He stated he did not report it as he believed it was reported. CNA E stated he does not know the outcome of this incident. He stated he had not worked with the new male aide but that he works overnight and had an odd name. He stated two aides were hired recently with odd names. During an interview on 06/11/2026 at 4:00 p.m., the Director of Nursing stated she had two Assistant Directors of Nursing that worked LTC and Rehab sides of NF. She stated they both stay in sync to cover each other's halls when one was out on leave. During an interview on 06/11/2026 at 4:02 p.m., ADON F stated she was not aware of any resident complaints made against a staff member. She stated ADON A worked on the LTC side of NF, and she would have more information for residents in these halls. She stated she was not made aware of Resident #1 making a complaint against a staff member. During an interview on 06/11/2026 at 4:10 p.m., ADON A stated she provided the nursing staff with ANE and resident rights education. She stated nursing staff were required to report ANE immediately to the Administrator who was the Abuse Coordinator. She stated all complaints or (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	grievances were usually reported to the staff they were comfortable with, which was typically the aide providing care to residents and then the aide should report to the charge nurse to follow up. She stated the impact of not reporting allegations of ANE could negatively impact a resident and cause emotional harm and needs not being met. She stated she recalled that months back she was informed of Resident #1's complaint from a former staff and she followed up with Resident #1 and went to discuss the complaint. She stated Resident #1 mentioned to her that she was not fond of a male night staff. She stated Resident #1 knew the night staff had just finished his training. She stated Resident #1 stated she preferred he did not go into her room and provide her with care. She stated since Resident #1 mentioned this to her the male night staff had not been in her room. She stated Resident #1 stated to her that there was nothing bad about the night male staff just that she was not fond of new employee providing her with care. ADON A stated she took the appropriate measures and talked to the male night staff. She identified the male night staff as CNA G who began employment on 04/02/2026. She stated it had been a while when this complaint was reported and could not recall the date. She stated she may have written a progress note, but this incident was more of a statement, not a grievance and no incident report and no grievance were documented. ADON A stated she pulled CNA G to the side and had a verbal conversation with him. She stated she informed him that Resident #1 was requesting that he not go in her room or provide her with care and stated she requested more females. She stated there have been times in the past that Resident #1 had been demanding and she liked things done immediately and she would become upset. ADON A denied Resident #1 made ANE allegations against CNA G and denied a complaint was filed by Resident #1. She stated if this occurred, she would have reported it immediately to the Administrator. She stated the Director of Nursing was responsible for staff schedules. She stated she would not remove CNA G from Resident #1's hall, she just spoke with him about not going into her room per her preference and he would get someone to assist him and switch out. She stated this information was passed on to staff verbally, but nothing specific was documented on care plans or shift reports. During an interview on 06/11/2026 at 4:40 p.m. Human Resources stated that he assisted the team and provided the nursing staff upon hire with ANE and resident rights education. He stated the nursing staff were required to report ANE immediately to the Administrator who was the Abuse Coordinator. He stated resident rights education covered the nursing staff attending to the resident's needs and what they may ask for at times. He stated the impact of not being treated properly could cause residents to act out, death or to stop having the quality of life they were hoping for and wanting. He stated any complaints made against staff would be followed up on immediately. The staff would be brought in to speak with management and an investigation would begin. He stated that depending on the severity of the complaint, Human Resources, the Director of Nursing and the Administrator would all be notified. He stated that if ANE was not properly reported it could cause the resident to have a change in condition, health decline or potentially death. The Human Resources stated there were no counseling or write-ups or any issues brought to management's attention for the (4) sampled personnel files including CNA G. He stated there have been no reports from residents or staff regarding specific residents. The Human Resources stated that if a resident were to have a specific preference for staff providing direct care, then this would be honored. He stated the specific staff would not be allowed into the residents' room any further, NF would have a different CNA assigned to the resident's room, NF would ensure information was put on the staffing schedule, the scheduler and charge nurse would be aware and know not to assign the specific staff to the hall or resident's room. He stated the specific nursing staff would know moving forward not to go into the resident's room. He said there was no difference than when a new resident was admitted and makes a preference for male or female staff it would be documented and aides would all be made aware to accommodate this resident's preferences. He stated with all the aides aware of this information they would swap out if they knew they were not to provide care to a specific resident and they would be the ones to manage this. He denied Resident #1 reporting any complaint regarding the nursing staff. Attempted interview with CNA (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G on 06/11/2026 at 5:08 p.m., male Spanish speaker answered and stated in a rude tone that he does not speak English and while trying to speak in Spanish to him he abruptly hung up. Attempted interview with CNA G on 06/11/2026 at 5:10 p.m., no return call received. Record review of CNA G's personnel records, undated and accessed 06/11/2026 at 5:35 p.m., revealed CNA G was hired on 04/10/2026, certificate of Nurse Aid program was completed 03/20/2026, criminal history rendered no results, registry employee misconduct rendered no results, required orientation (State) training was completed and did not reveal need for counseling or write-ups. During a joint interview on 06/12/2026 at 9:30 a.m., the Administrator and Director of Nursing revealed they talked to Resident #1 regarding the incident with CNA G and stated they initiated their ANE investigation. The Director of Nursing stated that Resident #1 stated that the previous night on 06/09/2026 she pressed the call light and CNA G went into her room to offer her direct care and she refused. She stated Resident #1 revealed to her that roughly a week ago she called for assistance and CNA G answered the call light and while he was providing her incontinence care he made a comment in Spanish about chocolates. She stated the comment was chocolates are very good, but they do cause weight gain. The Director of Nursing stated she interviewed CNA G and he stated he did make a statement to Resident #1 about chocolates and weight gain, but it was not directed at her or to insinuate she was fat. The Administrator stated he spoke with the nursing staff and the failure to report Resident #1's statements of concern. The Director of Nursing stated LVN D said Resident #1 reported to her that CNA G insinuated she was fat. The Director of Nursing stated the management team have started the abuse in-service, safe surveys for residents in 300 hallways, and have requested psych service visit for Resident #1. During an interview on 06/12/2026 at 9:55 a.m., LVN D revealed she was knowledgeable of ANE and resident rights and provided examples. She stated ANE was to be reported immediately to the Administrator, the Abuse Coordinator. She stated ANE includes insulting residents. She stated the impact of ANE, or resident rights violations of a resident can lower self-esteem, cause depression, cause residents to withdraw, and they would lose confidence in the staff to take care of their needs. She stated the impact of not following the reporting procedures could make residents feel violated, like they cannot go to the staff for anything and do not want to report or feel retaliation. LVN D stated that she recalled an incident a few weeks ago where CNA H reported to her that while providing Resident #1 with direct care, she reported to her that CNA G called her fat and she felt embarrassed. She stated she went to speak to Resident #1 about CNA G calling her fat. She stated Resident #1 paused and responded no to CNA G calling her fat. LVN D stated she does not know why Resident #1 had a different answer when she went in to ask her about it. She stated the incident did not go any further and was not reported. LVN D stated she was not aware that Resident #1 did not want CNA G providing her with direct care and stated he worked last Wednesday and was assigned to Resident #1's room. She stated she was not informed by management that CNA G should not be assigned to Resident #1's room and she did not know she preferred male or female direct car staff. She stated if she was provided with this information, she would have made sure it was addressed. Record review of policy titled, Resident Rights, undated, revealed .It is the policy of this facility that Our residents have certain rights and protections under federal and state law that help ensure they receive the care and services necessary. One essential job function is to protect and promote our residents' rights. 1. Be treated with respect and dignity. 5. Make complaints to staff or any other person without fear of being punished for exercising his/her right to voice grievances. We must address these concerns promptly. Relay all complaints to the Social Services Director, Director of Nursing, Wellness Director or Administrator. Record review of policy titled, Incontinence Care, undated, revealed It is the policy of this facility to provide incontinence care for those residents requiring assistance with bladder and/or bowel incontinence. Staff providing incontinence care will do so while maintaining the dignity of the resident and providing care in a respectful manner. Record review of resident board document, titled, Residents' Rights, undated, revealed . Dignity and respect You have the right to: Be free from abuse, neglect and exploitation. Be treated with dignity, courtesy, (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consideration and respect. Receive all care necessary to have the highest possible level of health. Complain about care or treatment and receive a prompt response to resolve the complaint without fear of reprisal or discrimination.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources are reported immediately but not later than 2 hours (for an injury of unknown origin involving serious bodily injury) or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures, for 1 (Resident #1) out of 6 residents reviewed for abuse. The facility failed to report an alleged violation of verbal abuse of Resident #1 to the Administrator of the facility and the Administrator failed to report the violation of verbal abuse of Resident #1 immediately, but not later than 2 hours to other officials including to the State Survey Agency) in accordance with State law through established procedure. This failure could place residents at risk of harm by not having verbal abuse of a resident investigated.The findings included: Record review of Resident #1's admission Record, dated 06/11/2026, revealed an [AGE] year-old female admitted [DATE] and re-admitted [DATE]. Resident #1 was listed as her own responsible party. Record review of Resident #1's Medical Diagnoses, undated and accessed 06/11/2026 at 3:54 p.m., revealed diagnoses including heart failure (chronic condition where the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), hypertension (condition where the force of blood against the artery walls is consistently too high), acute kidney failure (kidneys suddenly stop working), Transient Ischemic Attack (TIA) (temporary blockage of blood flow to the brain), anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #1's quarterly MDS assessment, dated 06/01/2026 and signed 06/14/2026 as completed, reflected a BIMS score of 15 indicating cognition intact. Resident #1 was documented as having not exhibited any behavioral symptoms. Resident #1 was documented as requiring incontinence care. Resident #1's functional abilities were documented as requiring dependent to set up or clean-up assistance and requiring a wheelchair for mobility. Record review of Resident #1's care plan, undated and accessed 06/11/2026 at 4:24 p.m., revealed, . [Resident #1] has bladder incontinence r/t [related to] Impaired Mobility and goal . [Resident #1] Will remain free from skin breakdown due to incontinence and brief use through the review date. and interventions .BRIEF USE: uses disposable briefs. Change q 2-3 hrs. [every 2 to 3 hours] and prn [as needed] . INCONTINENT: Check as required for incontinence. Wash, rinse and dry perineum. date initiated 05/08/2024 and revised on 10/29/2024. Record review of Resident #1's progress notes, dated 04/10/2026 (CNA G's date of hire) to 06/11/2026 (EMR access date) revealed no progress notes were found mentioning Resident #1's reported incident alleging verbal abuse by CNA G. Record review of Resident #1's EMR Misc. tab on 06/11/2026 did not reveal documentation of NF Incident Report. During an interview on 06/11/2026 at 4:10 p.m., ADON A stated she provided the nursing staff with ANE and resident rights education. She stated nursing staff were required to report ANE immediately to the Administrator who was the Abuse Coordinator. She stated all complaints or grievances were usually reported to the staff they were comfortable with, which was typically the aide providing care to residents and then the aide should report to the charge nurse to follow up. She stated the impact of not reporting allegations of ANE could negatively impact a resident and cause emotional harm and needs not being met. She stated she recalled that months back she was informed of Resident #1's complaint from a former staff and she followed up with Resident #1 and went to discuss the complaint. She stated Resident #1 mentioned to her that she was not fond of a male night staff. She stated Resident #1 knew the night staff had just finished his training. She stated Resident #1 stated (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she preferred he did not go into her room and provide her with care. She stated since Resident #1 mentioned this to her the male night staff had not been in her room. She stated Resident #1 stated to her that there was nothing bad about the night male staff just that she was not fond of new employee providing her with care. ADON A stated she took the appropriate measures and talked to the male night staff. She identified the male night staff as CNA G who began employment on 04/02/2026. She stated it had been a while when this complaint was reported and could not recall the date. She stated she may have written a progress note, but this incident was more of a statement, not a grievance and no incident report and no grievance were documented. ADON A stated she pulled CNA G to the side and had a verbal conversation with him. She stated she informed him that Resident #1 was requesting that he not go in her room or provide her with care and stated she requested more females. She stated there have been times in the past that Resident #1 had been demanding and she liked things done immediately and she would become upset. ADON A denied Resident #1 made ANE allegations against CNA G and denied a complaint was filed by Resident #1. She stated if this occurred, she would have reported it immediately to the Administrator. She stated the Director of Nursing was responsible for staff schedules. She stated she would not remove CNA G from Resident #1's hall, she just spoke with him about not going into her room per her preference and he would get someone to assist him and switch out. She stated this information was passed on to staff verbally, but nothing specific was documented on care plans or shift reports. During an interview on 06/11/2026 at 12:00 p.m. the Wound Care Nurse stated staff were expected to report ANE immediately to the Administrator who was the Abuse Coordinator. She stated if she were to witness staff being inappropriate, rude, or talking to residents disrespectfully she would report it immediately. During an interview on 06/11/2026 at 1:30 p.m., CNA B revealed she was knowledgeable of ANE and provided examples. She stated she was to report ANE immediately to the Administrator. CNA B stated if she were to witness or hear staff being rude or disrespectful to a resident, she would report this behavior immediately and stated that this could impact a resident and make them fearful of staff if left unreported. During an interview on 06/11/2026 at 2:53 p.m., CNA C revealed she was knowledgeable of ANE and provided examples. She stated she was to report ANE immediately to the Administrator. She stated violations of ANE of a resident could cause them to become depressed, sad, not want to engage in activities, or refuse to eat. CNA C stated she was familiar with Resident #1's care, she required incontinence care, required one person assist, cognition was intact and she could express her needs and wants. She recalled that the previous week Resident #1 reported to her that she did not trust an overnight aid (name unknown). She stated an incident occurred, but she was not provided with details, but that she had already reported it to the charge nurse on shift that day, LVN D. She stated that Resident #1 notified her that the incident had already been reported and the male aid (name unknown) was not allowed back in her room and she did not believe it had to be reported further. She stated she did not recall the name of the male aid, but she did recall he was new and he worked overnight. During an interview on 06/11/2026 at 3:13 p.m., CNA E revealed he was knowledgeable of ANE and provided examples. He stated he was to report all ANE immediately to the Administrator. He stated violations of ANE of a resident could cause them emotional stress, anxiety, and loss of sleep. CNA E stated while providing Resident #1 care about 2-3 weeks back she revealed to him that an overnight aid was being rude to her and saying she was overweight and made her feel uncomfortable. He stated he told her to let the charge nurse know. He stated Resident #1 stated she reported the incident to the overnight charge nurse (unidentified) and believed it may have been passed on to the morning charge nurse. He stated he did not report it as he believed it was reported. CNA E stated he does not know the outcome of this incident. He stated he had not worked with the new male aide but that he works overnight and had an odd name. He stated two aides were hired recently with odd names. During an interview on 06/11/2026 at 4:02 p.m., ADON F stated she was not aware of any resident complaints made against a staff member. She stated ADON A worked on the LTC side of NF, and she would have more information for residents in these halls. She stated she was not made aware of Resident #1 making a (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	complaint against a staff member. During an interview on 06/11/2026 at 4:10 p.m., ADON A stated she provided the nursing staff with ANE education. She stated nursing staff were required to report ANE immediately to the Administrator who was the Abuse Coordinator. She stated all complaints or grievances were usually reported to the staff they were comfortable with, which was typically the aide providing care to residents and then the aide should report to the charge nurse to follow up. She stated the impact of not reporting allegations of ANE could negatively impact a resident and cause emotional harm and their needs not being met. She stated she recalled that months back she was informed of Resident #1's complaint from a former staff and she followed up with Resident #1 and went to discuss the complaint. She stated Resident #1 mentioned to her that she was not fond of a male night staff. She stated Resident #1 knew the night staff had just finished his training. She stated Resident #1 stated she preferred he did not go into her room and provide her with care. She stated since Resident #1 mentioned this to her the male night staff had not been in her room. She stated Resident #1 stated to her that there was nothing bad about the night male staff just that she was not fond of new employee providing her with care. ADON A stated she took the appropriate measures and talked to the male night staff. She identified the male night staff as CNA G who began employment on 04/02/2026. She stated it had been a while when this complaint was reported and could not recall the date. She stated she may have written a progress note, but this incident was more of a statement, not a grievance and no incident report and no grievance were documented. ADON A stated she pulled CNA G to the side and had a verbal conversation with him. She stated she informed him that Resident #1 was requesting that he not go in her room or provide her with care and stated she requested more females. She stated there have been times in the past that Resident #1 had been demanding and she liked things done immediately and she would become upset. ADON A denied Resident #1 made ANE allegations against CNA G and denied a complaint was filed by Resident #1. She stated if this occurred, she would have reported it immediately to the Administrator. She stated the Director of Nursing is responsible for staff schedules. She stated she would not remove CNA G from Resident #1's hall, she just spoke with him about not going into her room per her preference and he would get someone to assist him and switch out. She stated this information was passed on to staff verbally, but nothing specific was documented on care plans or shift reports. During an interview on 06/11/2026 at 4:40 p.m. Human Resources stated that he assisted the team and provided the nursing staff upon hire with ANE education. He stated the nursing staff were required to report ANE immediately to the Administrator who was the Abuse Coordinator. He stated any complaints made against staff would be followed up on immediately. The staff would be brought in to speak with management and an investigation would begin. He stated that depending on the severity of the complaint, Human Resources, the Director of Nursing and the Administrator would all be notified. He stated that if ANE was not properly reported it could cause the resident to have a change in condition, health decline or potentially death. Attempted interview with CNA G on 06/11/2026 at 5:08 p.m., male Spanish speaker answered and stated in a rude tone that he does not speak English and while trying to speak in Spanish to him he abruptly hung up. Attempted interview with CNA G on 06/11/2026 at 5:10 p.m., no return call received. Record review of CNA G's personnel records, undated and accessed 06/11/2026 at 5:35 p.m., revealed CNA G was hired on 04/10/2026, certificate of Nurse Aide program was completed 03/20/2026, criminal history rendered no results, registry employee misconduct rendered no results, required orientation (State) training was completed and did not reveal need for counseling or write-ups. During a joint interview on 06/12/2026 at 9:30 a.m., the Administrator and Director of Nursing revealed they talked to Resident #1 regarding the verbal allegations incident with CNA G and stated they initiated their ANE investigation. The Director of Nursing stated that Resident #1 stated that the previous night on 06/09/2026 she pressed the call light and CNA G went into her room to offer her direct care and she refused. She stated Resident #1 revealed to her that roughly a week ago she called for assistance and CNA G answered the call light and while he was providing her incontinence care he made a comment in Spanish about chocolates. She stated the comment was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676312	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - West S	222 Bertetti Dr San Antonio, TX 78227

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chocolates are very good, but they do cause weight gain. The Director of Nursing stated she interviewed CNA G and he stated he did make a statement to Resident #1 about chocolates and weight gain, but it was not directed at her or to insinuate she was fat. The Administrator stated he spoke with the nursing staff and the failure to report Resident #1's statements of concern. The Director of Nursing stated LVN D said Resident #1 reported to her that CNA G insinuated she was fat. The Director of Nursing stated the management team have started the abuse in-service, safe surveys for residents in 300 hallways, and have requested psych service visit for Resident #1. During an interview on 06/12/2026 at 9:55 a.m., LVN D revealed she was knowledgeable of ANE and provided examples. She stated ANE was to be reported immediately to the Administrator, the Abuse Coordinator. She stated ANE includes insulting residents. She stated the impact of ANE of a resident can lower their self-esteem, cause depression, cause resident to withdraw, and they would lose confidence in the staff to take care of their needs. She stated the impact of not following the reporting procedures could make residents feel violated, like they cannot go to the staff for anything and do not want to report or feel retaliation. LVN D stated that she recalled an incident a few weeks ago where CNA H reported to her that while providing Resident #1 with direct care, she reported to her that CNA G called her fat and she felt embarrassed. She stated she went to speak to Resident #1 about CNA G calling her fat. She stated Resident #1 paused and responded no to CNA G calling her fat. LVN D stated she does not know why Resident #1 had a different answer when she went in to ask her about it. She stated the incident did not go any further and was not reported. Record review of policy titled, Abuse Prevention, date revised 11/28/2016, revealed .PREVENTION - All personnel, residents, visitors, etc. are encouraged to report incidents and grievances without the fear of retribution. Identify events, such as but not limited to, suspicious bruising of events, occurrences, patterns, and trends that may constitute abuse. REPORTING/RESPONSE - All alleged violations will be reported via phone or in writing within 24 hours to the State Licensing Agency. Mental Abuse - This includes, but not limited to humiliation, harassment. Verbal Abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representatives, or within their hearing distance. Record review of policy titled, Resident Rights, undated, revealed .It is the policy of this facility that Our residents have certain rights and protections under federal and state law that help ensure they receive the care and services necessary. One essential job function is to protect and promote our residents' rights. 1. Be treated with respect and dignity. each resident has a right to a dignified existence and to be free from verbal, sexual, physical or mental abuse. Verbal abuse: oral, written, or gestured language, including sarcastic remarks and derogatory statements, directed to residents. Family members or significant others. Mental abuse: humiliation, sarcasm, harassment, ignoring, favoritism to others, degradation, criticism, threats, deprivation, punishment, ridicule. Record review of policy titled, Reporting Reasonable Suspicion of a Crime, date revised 10/2022, revealed .It is the policy of this Facility to protect its residents from abuse, neglect, exploitation and misappropriation of resident property. Record review of resident board document, titled, Residents' Rights, undated, revealed . Dignity and respect You have the right to: Be free from abuse, neglect and exploitation. Be treated with dignity, courtesy, consideration and respect. Receive all care necessary to have the highest possible level of health.