

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation - West S		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for 3 of 6 residents (Resident #17, Resident #78, and Resident #108) who were reviewed for resident assessments. 1.The facility failed to correctly document Resident #17's use of insulin injections on the quarterly MDS assessment. 2.The facility failed to correctly document Resident #78's use of insulin injections on the quarterly MDS assessment. 3.The facility failed to correctly document Resident #108's use of insulin injections on the quarterly MDS assessment. These failures could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being.The findings included: 1. Record review of Resident #17's admission sheet dated 11/13/2025 with an original admission date of 11/04/2020 documented a [AGE] year-old female resident with diagnoses including cerebral ischemia (insufficient blood flow to brain possibly leading to a stroke), type 2 diabetes mellitus, dementia, schizoaffective disorder, depression, and hypertension (high blood pressure). Record review of Resident #17's MDS assessment dated [DATE] documented a BIMS score of 2 indicating severe cognitive impairment and recorded the use of antipsychotic, antidepressant, antiplatelet, and hypoglycemic medications. Further review of the MDS noted an answer of 7 in Section N - Medications N0350 Insulin A. Insulin injections Record the number of days that insulin injections were received during the last 7 days or since admission if less than 7 days. Record review of Resident #17's order summary included an order for the insulin Humalog with an order date of 9/30/2025. Humalog was ordered as Humalog 100 Unit/mL, Inject as per sliding scale: if 200-249=2 UNITS; 250-299=4 UNITS; 300-349=6 UNITS; 350-399=8 UNITS; 400-999=10 > 400 GIVE 10 UNITS AND CALL MD. Record review of Resident #17's November 2025 MAR documented the resident received insulin injections on 4 days (11/09/2025, 11/10/2025, 11/14/2025, and 11/15/2025) during the 7 day look back period from 11/09/2025 through 11/15/2025. Record review of Resident #17's care plan with an initiation date of 11/28/2020 documented the resident Has diabetes mellitus. with interventions including Diabetes medications as ordered by doctor. Monitor/document for side effects and effectiveness. 2. Record review of Resident #78's admission sheet dated 10/14/2022 with an original admission date of 9/19/2022 documented a [AGE] year-old female resident with diagnoses including kidney disease, cerebral infarction (stroke), hypertension, hyperlipidemia (high cholesterol), heart disease, and peripheral vascular disease (a narrowing of the blood vessels reducing blood flow to the limbs). Record review of resident #78's MDS assessment dated [DATE] documented a BIMS score of 11 indicating moderate cognitive impairment and recorded the use of opioid and anticonvulsant medications. Further review of the MDS noted an answer of 7 in Section N - Medications N0350 Insulin A. Insulin injections Record the number of days that insulin infections were received during the last 7 days or since admission if less than 7 days. Record review of Resident #78's order summary included an order for the insulin NovoLog with an order date of 7/28/2025. NovoLog was ordered as NovoLog 100 Unit/mL, Inject as per sliding scale: if 151-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; 401-999=10 units notify md. Record review of Resident #78's December 2025 and January 2026 MARs documented the resident received insulin injections on 4 days (12/31/25, 01/01/26, 01/02/26, and (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/03/26) during the 7 day look back period from 12/29/2025 through 01/04/2026. Record review of Resident #78's care plan with an initiation date of 11/22/2022 documented the resident Has diabetes., with interventions including Administer medications as ordered Medications Novo log. and Monitor/document/report to MD PRN s/sx of hypoglycemia., and Monitor/document/report to MD PRN s/sx of hyperglycemia. 3. Record review of Resident #108's admission sheet dated 01/10/2024 with an original admission date of 12/01/2021 documented a [AGE] year-old female resident with diagnoses including type 2 diabetes mellitus, cerebral infarction, dementia, hyperlipidemia, hypertension, and heart disease. Record review of Resident #108's MDS dated [DATE] documented that a BIMS should not be conducted due to the resident rarely or never being understood and recorded the use of antidepressant, antiplatelet, and hypoglycemic medications. Further review of the MDS noted an answer of 7 in Section N - Medications N0350 Insulin A. Insulin injections Record the number of days that insulin injections were received during the last 7 days or since admission if less than 7 days. Record review of Resident #108's order summary documented an order for the insulin Admelog with an order date of 02/24/2024. Admelog was ordered as Admelog 100 unit/mL, Inject as per sliding scale: if 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351-400 = 10 > than 400 = 10 units and report MD. Record review of Resident #108's December 2025 and January 2026 MARs documented that the resident had not received any injections of insulin during the seven day look back period from 12/27/2025 through 01/02/2026. Record review of Resident #108's care plan with an initiation date of 12/20/2021 documented Resident #108 was at risk for liable blood sugars, infection, impaired skin integrity, multisystem complications, and side effects to medications r/t Diabetes Mellitus., with interventions including Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. During an interview with the MDS Nurse on 1/29/26 at 10:12 AM, the MDS Nurse stated the assessment should be checked for accuracy by the nurse gathering the information before it is sent to the DON for submission. The MDS Nurse stated it was important for the MDS to be accurate because they want to make sure, they have a full, complete picture of the resident to care plan correctly and to monitor any significant changes in a resident's status. During an interview with the DON on 1/29/26 at 11:52 AM, the DON stated the MDS should be accurate, because that was how they submit for billing. The DON further stated if the MDS was inaccurate, there could be negative outcomes for a resident. The DON stated her expectation was that the data in the assessments be accurate and include all the information from a resident's medical record. Review of the facility policy titled Resident Assessment and Associated Processes with the most recent revision date of 4/2025 noted It is the policy of this facility that resident will be assessed, and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified. The policy further noted An accurate Comprehensive Assessment will be made of the resident's needs, strengths, goals, life history and preferences, using the RAI (Resident Assessment Instrument) and will include at least the following: Medications.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 2 of 7 nurse medication cart (200/300 hall medication cart and 300 hall nurse medication cart) and 1 of 4 Residents (Resident #148) reviewed for storage of drugs. 1. The facility failed to ensure an insulin pen in the 300-hall cart was dated with an open date once it was removed from the fridge and placed in the cart for use. 2. The facility failed to ensure the 300-hall nurse medication cart did not contain loose pills. 3. The facility failed to ensure the 200/300 medication hall cart did not contain a pill cutter with an unknown white residue. 4. The facility failed to ensure Resident #148 did not have medication in her room. These deficient practices could place residents at risk of medication misuse and diversion. The findings were: 1 and 2. Observation and interview on [DATE] at 8:46 a.m. the 300-hall nurse medication cart was in possession of LVN D. LVN D opened the top drawer and immediately removed an insulin pen. LVN D went to write on the pen. This surveyor asked what he was writing and LVN D stated he was going to date the pen. LVN D stated he should have dated the pen. LVN D then stated he had not used the pen and did not need to date it. LVN D then placed the pen back in the drawer. LVN D then opened the 2nd drawer of the cart. 4 loose pills were observed under the residents' blister packs of medication. LVN D stated he was unaware of the loose pills and did not know what they were. LVN D stated no loose pills should be in the cart because they did not know where they came from, or if they were expired. LVN D stated loose pills should be discarded. 3. During an observation and interview on [DATE] at 8:57 a.m. MA E was in possession of the 200/300 hall medication cart. The cart contained a pill cutter. The pill cutter had a white residue on the blade and cutting surface. MA E stated she had not used the pill cutter. MA E stated the pill cutter could not be dirty because it could cause cross contamination. During an interview on [DATE] at 11:48 a.m. the DON stated she believed the loose pills occurred during the night shift and should have been discarded. The DON stated the loose pills should have been administered to residents and it was known if they were. The DON stated insulin pens were dated once they were used and the pen had not been dated. The DON agreed that insulin pens should be dated once removed from the fridge to ensure they are used by the manufactures date or discarded after. The DON stated the pill cutter should be cleaned or cross contamination could occur. 4. Record review of Resident #148's face sheet dated [DATE] revealed a [AGE] year-old female admitted to the facility with diagnoses that included aftercare following joint replacement surgery, migraines, and hypertension (high blood pressure). Record review of Resident #148's BIMS's evaluation dated [DATE] documented a BIMS of 14 out of 15 indicating independent decision making. Record review of Resident #148's in progress MDS dated [DATE] revealed the functional abilities section had not been completed yet. Record review of Resident #148's care plan provided on [DATE] recorded a focus area for the (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following: [Resident #148] is at risk for impaired cognitive function/dementia or impaired thought processes r/t new environment, initiated on [DATE], with interventions including Social Services to provide psychosocial support as needed initiated on [DATE]. During an observation on [DATE] at 3:38 p.m., in Resident #148's room there was one container of Mentholatum ointment on their bedside table. During an interview on [DATE] at 3:38 p.m., Resident #148 they used the Mentholatum ointment for their nose when they are congested. Resident #148 stated staff were aware and that she had not been told anything about the ointment. Resident #148 stated they had [NAME] the Mentholatum ointment from home. During an interview on [DATE] at 10:14 a.m., Resident #148 stated they (Resident #148) were still in possession of the Mentholatum ointment which they had put in their bag. During an interview on [DATE] at 4:24 p.m., CNA G stated Resident #148 should not have medication in their room and if they brought it with them while admitting the medications need to go to the nurse. CNA G stated they were unaware Resident #148 had Mentholatum ointment. CNA G stated the danger to the resident was they could not know how to use it, could have an allergy to it or use the medication incorrectly. During an interview on [DATE] at 4:32 p.m., RN H stated when they go in residents' rooms, they generally check for items residents cannot have. RN H stated residents cannot have items such as microwaves, heating pads or medications without doctor authorization beforehand. RN H stated she did not think the resident could have Mentholatum ointment at their bedside. RN H stated the risk to the resident could be Mentholatum ointment could be contraindicated, or the resident could use it inappropriately. During an interview on [DATE] at 4:55 p.m., the DON stated if residents have medication at bedside, they need to let the nurse know so they can get an order from the doctor and care plan the medication. The DON stated the risk to residents could be if they are not alert enough, they may not know what they are doing. During an interview on [DATE] at 12:50 p.m., the DON stated residents can have medication in their possession if a self-administration medication assessment is completed, the physician is called, and the medication is care planned. Record review of the facility's policy titled Care and Treatment, Labeling of Medications and Biological, dated 05/2007, stated: Policy: It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls. Record review of the facility's policy titled Care and Treatment, Medication Access and Storage, dated 05/2007, stated POLICY: It is the policy of this facility to store all drugs and biological in locked (continued on next page)		

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 13. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy, if a current order exists. 14. Medication storage areas are kept clean, well lit, and free of clutter. Record review of the facility's policy titled Care and Treatment, Labeling of Medications and Biological, dated 05/2007, stated: POLICY: It is the policy of this facility that medications and biologicals are labeled in accordance with facility requirements, state and federal laws. Only the provider pharmacy modifies or changes prescription labels. Each prescription medication label includes. Date medication is dispensed. Quantity. Expiration date. Any anti-diabetic injectables to be dated once opened.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food for 1 of 1 kitchen in accordance with professional standards for food service safety. 1.The facility failed to date food items in the kitchen pantry. 2.Dietary Aide F failed to correctly secure their hairnet in the kitchen. 3.The facility failed to date items in the nourishment refrigerator. 4.The facility failed to seal items in the kitchen freezer. This deficient practice could place residents at risk for food borne illness.The findings include: Observation on 01/26/2026 at 12:30 p.m., of the kitchen pantry revealed the following:-16 loafs of bread with no date,-1 box of clear fry oil with no date,-1 Ziploc bag of relish packets with no date,-1 Ziploc bag of salt packets with no date, and-1 Ziploc bag of individual packs of goldfish with no date. Observation on 01/26/2026 at 12:41 p.m., of the kitchen freezer revealed the following:-1 open bag of frozen sugar cookie dough and-1 open bag of French toast sticks. During an interview on 01/26/2026 at 1:15 p.m., the Dietary manager stated that anyone in the kitchen was responsible for labeling items. The dietary manager stated the risk to the residents for not dating food products could be not knowing when food items were brought in or when to use them. The dietary manager stated if food items are not correctly sealed in the freezer it could cause them to get freezer burn which they would then have to dispose of the food items. The Dietary manager stated they were not aware of any food borne illness outbreaks within the facility. Observation on 01/27/2026 at 10:20 a.m., of the nourishment room fridge revealed 1 med pass 2.0 fortified nutritional shake with no date. During an interview on 01/27/2026 at 10:21 a.m., the Dietary manager stated the kitchen was responsible for the nourishment room and that if there was no date or label on items in the nourishment fridge then they discard the item. The dietary manager stated the risk to residents could be them not receiving the item. Observation on 01/27/2026 at 12:25 p.m., of lunch service revealed Dietary Aide F serving lunch with their hairnet halfway up the back of their hair. During an interview on 01/27/2026 at 12:27 p.m., the Dietary manager stated the expectation regarding hair nets is that they are covering all the kitchen staff's hair. The dietary manager stated the risk to the residents could be getting hair in their food. During an interview on 01/27/2026 at 1:30 p.m., Dietary aide F stated they have had training on how to properly wear hairnets, and the expectation is that the hair net covers all their hair. Dietary Aide F stated the risk to residents could be hair getting in their food. During an interview on 01/29/2026 at 11:56 a.m., the DON stated they were not aware of any food borne illness outbreaks in 2025. Record review of the facilities policy, untitled and undated, reflected: 228.43 Hair Restraints. food employees shall wear hair restraints such as hats, hair coverings or nets. worn to effectively keep their hair from contacting exposed food. Record review of the facilities policy, Infection Control Policy/Procedure: Dietary Services, revised in 2027, reflected: Policy: It is the policy of the facility to prevent contamination of food products and therefore prevent foodborne illness. Director of Food Service ResponsibilitiesF. Provide for the proper receipt and storage of all food supplies.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 3 of 4 residents (Resident #96, #14, and #108) reviewed for infection control:1. a. The facility failed to ensure Resident #96's indwelling urinary catheter bag was not on the floor and CNA A wore the proper PPE while handling Resident #96's indwelling urinary catheter bag who was on EBP.b. The facility failed to ensure CNA C used appropriate hand hygiene between glove changes and when moving from a soiled area to a clean area when providing catheter/incontinent care to Resident #96.2. The facility failed to ensure CNA A used appropriate hand hygiene when moving from a soiled area to a clean area when providing catheter/incontinent care to Resident #14.3. The facility failed to ensure Resident #108's indwelling urinary catheter bag was not on the floor. These failures could place residents at-risk for infection due to improper care practices. The findings included:1. Record review of Resident #96's face sheet dated 1/28/26 reflected an [AGE] year old male admitted to the facility on [DATE], and re-admitted on [DATE] and 12/27/23 with diagnoses that included diabetes (a chronic medical condition in which the body has trouble regulating blood sugar), respiratory failure, mild cognitive impairment, heart failure, and benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland that commonly occurs as men age and can narrow the urethra) with lower urinary tract symptoms. Record review of Resident #96's most recent quarterly MDS assessment dated [DATE] reflected the resident was cognitively intact for daily decision-making skills, had an indwelling urinary catheter, and was always incontinent of bowel. Record review of Resident #96's Order Summary Report dated 1/28/26 reflected the following:- Catheter care every shift with order date 9/16/25 and no end date- Change catheter and bag as needed for tears or leaks with order date 4/2/25 and no end date- Position privacy bag and tubing below the level of the bladder with order date 9/16/25 and no end date Record review of Resident #96's comprehensive care plan with revision date 12/29/25 reflected the resident had an indwelling urinary catheter related to obstructive uropathy (condition in which normal flow of urine is blocked) with interventions that included providing urinary catheter care, incontinence care as needed and use enhanced barrier precautions.a. During an observation and interview on 1/26/26 at 1:10 a.m. revealed Resident #96's bedroom entry revealed a sign which indicated the resident was on Enhanced Barrier Precautions. Resident #96 was observed sitting up in bed and the indwelling urinary catheter tubing was draining urine into the urine bag on the right side of the bed. Resident #96's indwelling urinary catheter bag was touching the floor. Resident #96 stated he was not aware of being treated for an infection. Observation on 1/27/26 at 9:27 a.m. revealed Resident #96 in bed and the indwelling urinary catheter tubing was draining urine into the urine bag on the right side of the bed. Resident #96's indwelling urinary catheter bag was touching the floor. During an observation and interview on 1/28/26 at 8:48 a.m. Resident #96 was seen in bed and the indwelling urinary catheter tubing was draining urine into the urine bag on the right side of the bed. Resident #96's indwelling urinary catheter bag was touching the floor. Resident #96 stated he had received incontinent care early this morning. During an observation and interview on 1/28/26 at 8:58 a.m., CNA A stated she was assigned to care for Resident #96 as part of her assignment. CNA A stated Resident #96 had an indwelling urinary catheter and observed the resident's urinary catheter bag touching the floor. CNA A stated she was responsible for caring for Resident #96's indwelling urinary catheter, which included providing incontinent and catheter care, measuring urinary output, ensuring the catheter had a leg strap, and making sure the urinary catheter bag was not touching the floor. CNA A stated the indwelling urinary catheter bag should not be touching the floor because it was cross contamination and an infection control issue. CNA A stated the indwelling urinary catheter bag touching the floor could result in the resident developing an infection, or the catheter bag could (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accidentally get stepped on possibly causing it to dislodge and injure the resident. CNA A stated she would fix the indwelling urinary catheter bag so that it would not be touching the floor. CNA A washed her hands and put on a pair of gloves. CNA A returned to Resident #96's bedside and picked up the indwelling urinary catheter bag and strapped it to the resident's bed. CNA A did not wear a gown. CNA A stated she should have been wearing a gown when handling Resident #96's indwelling urinary catheter bag and not doing so could result in the resident developing an infection, or urine could accidentally get on her clothing. CNA A stated, it is to protect the resident. b. Observation on 1/28/26 at 10:44 a.m. during incontinent/catheter care revealed CNA C used disposable incontinent wipes to clean Resident #96's anal area which had copious amounts of stool. CNA C was observed with stool on her glove and during care accidentally dropped a disposable incontinent wipe with stool on the resident's leg. CNA A who was assisting stated, it (the incontinent wipe) stuck to your glove. CNA C took the soiled wipe and threw it in the trash and obtained a clean wipe to clean Resident #96's leg. CNA C continued to clean the resident's anal area with the same gloves soiled with stool. CNA C was asked if her gloves had stool on them and CNA C stated, yes. CNA C then removed her gloves, did not wash her hands with soap and water, sanitized her hands and put on a new pair of gloves. After cleaning Resident #96's anal area, CNA C rolled up the bed pad that had stool on it, and with the same gloves placed a clean incontinent brief on the resident's bed and placed it on the resident. During a joint interview on 1/28/26 at 11:07 a.m., CNA C and CNA A stated, once the gloves had stool on them, the gloves should have been removed and changed out. CNA C stated, since the gloves were dirty with stool, she should have washed her hands with soap and water instead of using hand sanitizer. CNA C stated if by chance stool had gotten onto her bare hand, the use of hand sanitizer would have just smeared the stool whereas the soap and water would have washed it off. CNA C and CNA A stated removing the soiled bed pad and then touching the clean incontinent brief with the same pair of gloves was considered cross contamination. Both CNA C and CNA A stated a break in infection control was cross contamination and could result in the resident getting an infection.2. Record review of Resident #14's face sheet dated 1/28/26 reflected an [AGE] year old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included obstructive uropathy (condition in which normal flow of urine is blocked), diabetes (a chronic medical condition in which the body has trouble regulating blood sugar), and benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland that commonly occurs as men age and can narrow the urethra) with lower urinary tract symptoms. Record review of Resident #14's most recent quarterly MDS assessment dated [DATE] reflected the resident was severely cognitively impaired for daily decision-making skills, had an indwelling urinary catheter, and was always incontinent of bowel. Record review of Resident #14's Order Summary Report dated 1/28/26 reflected the following:- Catheter care every shift with order date 9/16/25 and no end date- Change catheter and bag as needed for tears or leaks with order date 4/2/25 and no end date- Position privacy bag and tubing below the level of the bladder with order date 9/16/25 and no end date Record review of Resident #14's comprehensive care plan with revision date 12/29/25 reflected that the resident had an indwelling urinary catheter related to obstructive uropathy with interventions that included to change the catheter bag as needed for malfunction and provide catheter care per facility protocol. During an observation of catheter/incontinent care on 1/28/26 at 1:58 p.m., CNA A completed cleaning Resident #14's buttocks and anal area, removed her gloves, sanitized her hands and put on a new pair of gloves. CNA A then retrieved a clean incontinent brief from CNA B and placed it on Resident #14's bed while the resident was positioned onto his left side. CNA A then realized she did not remove the soiled bed pad the resident was lying on and handed the clean incontinent brief back to CNA B. CNA A then removed the soiled bed pad and with the same gloves retrieved the clean incontinent brief from CNA B and placed it on Resident #14. During an interview on 1/28/26 at 2:14 p.m., CNA A stated she should have changed her gloves after touching Resident #14's soiled bed pad and before touching the clean incontinent brief because it was considered cross contamination.3. Record review of Resident #108's face sheet dated 1/29/26 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation - West S		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reflected a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included diabetes (a chronic medical condition in which the body has trouble regulating blood sugar), changes in skin texture, obstructive and reflux uropathy (a condition in which the normal flow of urine is blocked somewhere along the urinary tract; reflux uropathy occurs when urine flows backward from the bladder into the ureters and sometimes the kidneys, instead of moving out of the body), muscle wasting, and chronic kidney disease. Record review of Resident #108's most recent quarterly MDS assessment dated [DATE] reflected the resident reflected the resident was severely cognitively impaired for daily decision-making skills, had an indwelling urinary catheter, and was always incontinent of bowel. Record review of Resident #108's Order Summary Report dated 1/29/26 reflected the following:- Catheter care every shift with order date 12/23/25 and no end date- Change catheter drainage bag monthly on 15th day of each month and as needed with order date 12/23/25 and no end date- Position privacy bag and tubing below the level of the bladder with order date 12/23/25 and no end date Record review of Resident #108's comprehensive care plan with revision date 12/23/25 reflected the resident had an indwelling catheter with interventions that included positioning the catheter bag and tubing below the bladder and away from entrance room door, change catheter bag and tubing and leg strap as ordered, and use Enhanced Barrier Precautions. During an observation on 1/29/26 at 8:58 a.m., CNA B, after assisting with wound care, used the bed remote and lowered Resident #108's bed and the indwelling urinary catheter bag strapped to the resident's left side of the bed was touching the floor. During an interview on 1/29/26 at 9:14 a.m., CNA B stated she had tied the straps on Resident #108's indwelling catheter bag to keep it off the floor, but since the resident's bed had to be in the low position it was hard to keep it off the floor. CNA B stated the indwelling urinary catheter bag should not be touching the floor because it was cross contamination and considered an infection control issue and could result in the resident getting an infection such as a UTI. CNA B stated the indwelling urinary catheter bag could also get stepped on or dislodge. During an interview on 1/28/26 at 5:08 p.m., the DON stated, it was her expectation that staff should discard their gloves when they become visibly soiled and hand hygiene should be performed using soap and water. The DON stated, using hand sanitizer was not part of the procedure to clean hands. The DON stated, when providing care, glove changes are required when moving from one dirty area to a clean area because it was considered cross contamination. The DON stated cross contamination was a potential for spreading infection. During a follow up interview on 1/29/26 at 8:17 a.m., the DON stated, indwelling urinary catheter bags touching the floor was considered an infection control issue. The DON stated that the catheter bags touching the floor could also result in the resident possibly getting an infection and the bag could be accidentally stepped on or dislodge. During a follow up interview on 1/29/26 at 12:47 a.m., the DON stated staff were not supposed to be handling indwelling urinary catheter bags without the proper PPE because there could be a chance of passing an infection. Record review of CNA A's Competency Checklist document dated 8/5/25 reflected that she had satisfied the requirements for implementing proper infection control procedures including hand hygiene and proper use of PPE. Record review of CNA B's Competency Checklist document dated 8/6/25 reflected that she had satisfied the requirements for implementing proper infection control procedures. Record review of CNA C's Competency Checklist document dated 8/5/25 reflected that she had satisfied the requirements for implementing proper infection control procedures. Record review of the facility document titled Infection Prevention and Control Program with revision date 10/2022 reflected in part, .The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards. Goals. Decrease the risk of infection to residents and personnel. Recognize infection control practices while providing care. Facility personnel will wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that the transfer or discharge is documented in the resident's medical record, for 1 of 1 residents (Resident #123), in the facility reviewed for discharges. The facility failed to complete a discharge MDS for Resident #123. This failure could place residents at risk for inaccuracy of their health record. The findings include: Record review of Resident #123's admission sheet dated 09/25/2025 with an original admission date of 08/26/2025 documented an [AGE] year-old male resident with a primary diagnosis of chronic obstructive pulmonary disease (progressive lung disease making it harder to breathe). Record review of Resident #123's order summary included an admit to the facility with a verbal order which was discontinued with no end date and no discharge order. Record review of Resident #123's progress notes revealed a noted dated 09/30/2025 at 11:04 stating resident discharged home at approx. 1100am, picked up via a local transport company in wheelchair. Was on respite care from 9/25-9/30. Record review of Resident #123's MDS record on the electronic medical record (EMR) revealed an entry MDS completed on 09/25/2025, upon admission, but no discharge MDS upon Resident #123's discharge on [DATE]. During an interview on 01/29/2026 at 10:33 a.m., the MDS nurse stated MDS's should be completed on admission, quarterly, for a significant change, and upon discharge. The MDS nurse stated the discharge MDS should be completed by the 14th day after a resident had been discharged with a purpose of showing the residents status when they leave the facility and can be used in comparison from when the resident admitted to the facility. The MDS nurse confirmed Resident #123 did not have a discharge MDS when they should have but that there was no risk to Resident #123 due to it not being completed. During an interview on 01/29/2026 at 11:56 a.m., the DON stated Resident #123 should have had a discharge MDS. The DON stated the discharge MDS shows the whole picture of the resident and could be needed if the resident is submitted to another facility for accuracy. Review of the facilities policy, Resident Assessment and Associated Processes, revision date 2025, revealed: 8. The facility will electronically transmit encoded, accurate, and complete MDS data to the CMS system (QIES ASAP). Transmission of MDS data will include the following documents in addition to those mentioned above; resident's transfer, entry, reentry, discharge, & death.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 7 medication carts (300 hall nurse medication cart) reviewed for medications and pharmacy services, in that: The facility failed to ensure the controlled drugs-count record was not signed prior to the shift change. This failure could place residents at risk for not receiving therapeutic effects. The findings included: During an observation and record review on 1/29/26 at 8:46 a.m., LVN D was observed to have pre-signed the controlled drugs-count record for the 3:00 p.m. to 11:00 p.m. shift. The controlled drugs-count record, dated January 2026, contained LVN D's signature in the section designated for the off going nurse for the 3:00 p.m. to 11:00 p.m. shift. The narcotic count had not yet occurred with the oncoming nurse at shift change at the time the signature was observed. During an interview on 1/29/26 at 8:49 a.m., LVN D stated the controlled drugs-count record was used to know who counted the narcotics at the end or beginning of their shift. LVN D stated he should not have signed the document until the end of his shift on 1/29/25 when he counted all the narcotics with the oncoming nurse. During an interview on 1/29/26 at 11:48 a.m. the DON stated staff was expected to sign the controlled drugs-count record when a nurse came in to relieve them, they needed to count to make sure all the narcotic medications were accounted for and none were missing. Record review of the facility's policy titled Controlled Medications-Storage and Reconciliation, dated 05/2007, revised last 12/2023, stated Policy, It is the policy of this facility to safeguard access and storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse using separately locked, permanently affixed compartments. This facility will maintain a process for monitoring, administration, documentation, reconciliation and destruction of controlled substances. 8. A reconciliation or physical inventory of all controlled medications is conducted by two licensed nurses and is documented on an audit record at each shift change. Alternatively, the shift change audit may be recorded on the accountability record if there is a designated column for the audit. The reconciliation at shift change includes controlled medications stored under refrigeration and those stored in emergency kits (which may include verification of a secured and intact lock number). Secured automated dispensing/vending systems are not included in the shift reconciliation as electronic meta-data provides ongoing inventory and records of personnel accessing controlled substances.		