STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676392	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - New Br	2468 Fm 1101 New Braunfels, TX 78130

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 3 of 7 (Resident #11, #32, and #92) residents reviewed for respiratory care. 1. The facility failed to ensure Resident #11's oxygen was administered at the correct setting of 5 liters per minute on 05/20/2026 as ordered by the physician. 2. The facility failed to ensure Resident #32's oxygen concentrator had a clean filter on 5/17/2026. 3. The facility failed to ensure Resident #92's oxygen concentrator had a clean filter on 5/17/2026. These deficient practices could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care. The findings included: 1. Record review of Resident #11's face sheet, dated 05/20/2026, revealed the resident was a 63-years-old male, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnosis of respiratory failure (a serious condition that makes it difficult to breathe on your own), chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems), and bronchitis (an inflammation on the lining of the bronchial tubes in the lung). Record review of Resident #11's quarterly MDS assessment, dated 05/11/2026 revealed the resident's BIMS score was 13 out of 15 which indicated the resident's cognitive was intact, and he had oxygen therapy in the facility in the Section O (Special Treatment, Procedures, and Program). Record review of Resident #11's comprehensive care plan, dated 11/13/2025, revealed the resident had the care plans of [Resident #11] has COPD (Chronic Obstructive Pulmonary Disease), respiratory failure with hypoxia (low oxygen level in the body) and oxygen therapy. For the intervention - Oxygen per physician orders. Record review of Resident #11's physician order, dated 03/27/2026, revealed the resident had the order of OXYGEN at 5 liter per minute VIA nasal cannula CONTINUOUS for chronic obstructive pulmonary disease, every shift. Observation on 05/20/2026 at 9:00 a.m. revealed Resident #11 was on the bed in his room and wearing a nasal cannula connected to the oxygen concentrator located at the bedside, and it was set up to 4.5 liters per minute. Interview on 05/20/2026 at 9:11 a.m., LVN-A said Resident #11's oxygen concentrator was set up to 4.5 liters per minute, but the resident's physician order indicated oxygen at 5 liters per minute. The LVN-A stated she did not know what reason Resident #11 was receiving oxygen 4.5 liters per minute, instead of 5 liters per minute, but the resident should have received 5 liters per minute as ordered, (continued on next page)

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

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	676392	A. Building B. Wing	05/20/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and the nurse should have checked the oxygen every shift to make sure the resident was receiving oxygen correctly as ordered. The LVN-A said she did not check the oxygen rate on 05/20/2026 because she was very busy, but she checked the resident's oxygen saturation, and it was 97%, and he did not have any sign or symptoms regarding hypoxia. The LVN-A said if the resident did not receive correct oxygen rate as ordered, he might have hypoxia. Interview on 05.20/2026 at 11:43 a.m., the DON said Resident #11 should have received oxygen5 liters per minute via nasal cannula as ordered, instead of 4.5 liters per minute, and the facility nurse should have checked it every shift. The DON stated if the resident did not receive correct oxygen rate as ordered, he might have hypoxia. 2. Record review of Resident #32's face sheet dated 5/20/2026 revealed a [AGE] year-old female was admitted to the facility on [DATE] with diagnoses that included: COPD (an incurable lung disease that restricts airflow and makes it difficult to breath), pleural effusion (water on the lungs), and tachycardia (elevated heart rate). Record review of Resident #32's quarterly MDS dated [DATE] revealed the resident had a BIMS score of 15, cognitively intact. Further review revealed she was independent of all ADLs. Record review of Resident #32's Care Plan dated 5/14/2026 revealed the resident was care planned for oxygen therapy as needed, dementia, and for risk of falls. Record review of Resident #32's physician orders dated 4/30/2026 revealed the resident had an order for oxygen at 3 liters per minute with a nasal canula as needed. Record review of Resident #92's face sheet dated 5/19/2026 revealed an [AGE] year-old female was admitted to the facility on [DATE] with diagnoses that included: COPD, pneumonia, legal blindness, and heart failure. Record review of Resident #92's quarterly MDS dated [DATE] revealed the resident had a BIMS score of 15, cognitively intact. Further review revealed she required minimal assistance with ADLs and mechanical lift for transfers. Record review of Resident #92's Care Plan dated 3/6/2026 revealed the resident was care planned for oxygen therapy, DNR (Do Not Resuscitate) code status, hard of hearing, and falls. Record review of Resident #92's physician orders dated 4/7/2026 revealed the resident had orders for oxygen at 3 1/2 liters per minute, continuously. Observation and interview on 5/17/2026 at 11:34 AM revealed, Resident #32 was sitting in bed with her knees to her chest, oxygen with a nasal canula in place, and she said things were fine. Resident #32 allowed the surveyor to check the concentrator that supplied the oxygen. The setting was on 3 liters and the filter that was in a tray in the back of the concentrator was dirty. The resident saw the filter and stated, Oh wow, that's dirty. She said she could not notice anything different with her oxygen coming through the nasal canula, but she did not want it to become a problem for her one day. During an observation and interview on 5/17/2026 at 11:40AM revealed Resident #92 was asleep in bed with the oxygen per nasal canula in place set at 3 1/2 liters per minute. The filter on the back of the concentrator behind a door of the unit. The door of the unit was opened and revealed the filter (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	remained dirty. During an interview on 5/19/2026 at 11:12AM, Resident #92 was asleep in bed with oxygen in place. The surveyor checked the filter in the back of the concentrator revealed it remained dirty. During an interview and observation on 5/19/2026 at 11:14AM, Resident #32 was sitting on the side of her bed. The resident allowed the surveyor to look at the filter on the concentrator and when the drawer was opened, the filter was still dirty. Resident #32 said she did not believe anyone checked or cleaned the filter. RN E was shown the dirty filters of Resident #32 and Resident #92. RN E said it was the responsibility of the night shift to clean the filters daily and all the nurses that had residents that used oxygen were supposed to check the filters to make sure they were clean. RN E said it was important to ensure that the filters on the concentrators were clean to ensure that the residents did not acquire respiratory illness or not have adequate oxygen delivered through the nasal canula. During an interview on 5/19/2026 at 11:30AM, the DON said it was the night shift's responsibility to check and clean the filters every day. The DON said it was important to clean the filters to prevent inhalation of dirty air that could cause respiratory infections and possibly respiratory distress for the resident. Record review of the facility policy, titled Oxygen Administration, undated, revealed It is the policy of this facility that oxygen therapy is administered by licensed nurses as ordered by the physician or as a nursing measure and an emergency measure until the order can be obtained. 6. Oxygen concentrators will be maintained in room with clean filters and cannula or mask.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 (Resident #123) of 4 residents reviewed for baseline care plans. The facility failed to include Resident #123's ileostomy care, oxygen care, and wound care in his baseline care plan. This failure could result in residents not receiving needed care and treatment. Findings Included:Record review of Resident #123's face sheet, dated 05/20/2026, revealed the resident was a 71-years-old male and admitted to the facility on [DATE] with diagnosis of respiratory failure (a serious condition that makes it difficult to breathe on your own), malignant neoplasm of colon (cancer to colon or rectum), and ileostomy status (an opening on the abdomen that connects the last part of the small intestine to the outside of the body). Record review of Resident #123's admission MDS assessment revealed that the MDS assessment was in progress on 05/20/2026 because the resident was admitted to the facility on [DATE]. Record review of Resident #123's physician orders, dated 05/15/2026, revealed the resident had the orders of monitor ileostomy and provide ileostomy care every shift, oxygen at 3 liters per minutes via nasal cannular continues for chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems), and Right Groin: Cleanse with wound cleanser and pat dry - Place plurogel (unique burn and wound dressing to protect the wound and soften wound debris) to wound bed and cover with calcium alginate and secure with bordered foam dressing twice weekly on Tuesday and Friday. Record review of Resident #123's baseline care plan, dated 05/17/2026, revealed that the baseline care plan did not include the resident's care plans regarding ileostomy, oxygen, and wound. Observation on 05/17/2026 at 10:45 a.m. revealed Resident #123 was sleeping on the bed and had oxygen at 3 liters per minute via a nasal cannular, ileostomy bag on the abdomen area, and dressing dated 05/19/2026 to the right groin area. Interview on 05/20/2026 at 9:31 a.m., the MDS nurse said Resident #123 was admitted to the facility on [DATE] with ileostomy, oxygen and wound, and the facility provided ileostomy care, oxygen care, and wound care as ordered, but there were no baseline care plans regarding the resident's ileostomy, oxygen and wound. The MDS nurse stated making baseline care plans was the Registered Nurse's responsibility, including DON, and she did not know the reason the Registered Nurses did not develop the care plans. Interview on 05/20/2026 at 9:51 a.m., the DON said she should have developed Resident #123's baseline care plans regarding his ileostomy, oxygen and wound because the resident was admitted to the facility with them. She said the resident received care as ordered and did not have any adverse effect. She said the team might not have full knowledge regarding the resident's ileostomy, oxygen and wound status, and it could result in inappropriate care to the resident. Record review of the facility policy, titled Comprehensive Person-Centered Care Planning, undated, revealed 1. The facility will develop and implement a baseline care plan that includes instructions needed to provide effective and person-centered care.

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	676392	A. Building B. Wing	05/20/2026

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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 observations, interviews, 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 6 medication carts (200/300-hall medication aide cart) reviewed for pharmacy services. The facility failed to ensure one bottle of medication (Simethicone 125 mg for gas relief) that expired on 03/2026 was not on 200 and 300-hall medication aide cart on 05/18/2026. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. The findings included: Observation on 05/18/2026 at 2:44 p.m. revealed one bottle of Simethicone 125 mg for gas relief was found inside the 200 and 300-hall medication aide cart, and it expired 03/2026. Interview on 05/18/2026 at 2:45 p.m., LVN-B stated one bottle of Simethicone for gas relief was found inside the 200 and 300-hall medication aide cart, and it expired 03/2026. The LVN-B said she did not know the reason expired medication was inside the medication aide cart used for 200 and 300-hall. She said nurses and medication aides should discard all expired medications from the carts as per the facility policy. She said the potential harm was if nurses or medication aide used the expired medication, the expired medication might not have therapeutic effects. Interview on 05/20/2026 at 11:43 a.m. with the DON said facility nurses or medication aides should discard all expired medications from the medication carts. Nurses or medication aides had responsibility to make sure all expired medications should have been removed from carts, and if nurses or medication aide might use the expired medication, residents who took the medication might not have gas relief. Record review of the facility policy, titled Medication Access and Storage, undated, revealed . 11. 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 exist.

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	676392	A. Building B. Wing	05/20/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 (200 /300-hall Nurse Cart) of 6 medication carts and 1 (Resident #123) of 28 residents reviewed for storage and medication carts. 1. The narcotic box inside 200 and 300-hall nursing cart was totally taken out from the cart without affixing permanently to the cart. 2. There were two bottles of Curad Plain Packing Strip for wound care (it used for boils, abscess, or other draining wounds) on the resident's nightstand unattended. This failure could place residents at risk of misappropriation of medications and using packing strip for wound care to different purpose, such as eating it. The findings were:1. Observation on 05/18/2026 at 2:30 p.m. revealed one narcotic box inside 200 /300-hall Nursing Cart, that was not permanently affixed to the cart. The narcotic box was taken out of the cart by the surveyor. Further observation revealed there were 13 narcotic blister packs inside the box. Interview on 05/18/2026 at 2:31 p.m. with LVN-B stated the narcotic box inside the 200/300-hall Nursing Cart should have been affixed to the cart permanently. She said the box was not secured and somebody might be able to take the box from the cart. She said it could cause drug diversion because the box had a total of 13 narcotic blister packs inside it. Interview on 05/18/2026 at 11:43 a.m., the DON said all narcotic boxes should have been affixed to the carts permanently to prevent possible drug diversion. 2. Record review of Resident #123's face sheet, dated 05/20/2026, revealed the resident was a 71-years-old male and admitted to the facility on [DATE] with diagnosis of respiratory failure (a serious condition that makes it difficult to breathe on your own), malignant neoplasm of colon (cancer to colon or rectum), and ileostomy status (an opening on the abdomen that connects the last part of the small intestine to the outside of the body). Record review of Resident #123's admission MDS assessment revealed that the MDS assessment was in progress on 05/20/2026 because the resident was admitted to the facility on [DATE]. Observation on 05/17/2026 at 10:45 a.m. revealed Resident #123 was sleeping on the bed, and there were two bottles of Curad Plain Packing Strip for wound care (it used for boils, abscess, or other draining wounds) on the resident's nightstand unattended. Interview on 05/17/2026 at 10:47 a.m. Resident #123 refused to interview the surveyor and kept sleeping on the bed. Interview on 05/17/2026 at 11:22 a.m. with RN-C stated she saw two bottles of Curad Plain Packing Strip for wound care on Resident #123's nightstand unattended. The RN-C said she did not know the reason they were on the resident's nightstand unattended, and all medications should have been stored inside medication carts for safety because the resident might use it incorrectly. Interview on 05/20/2026 at 11:43 a.m. with the DON said all medications including Curad Plain Packing Strip for wound care should have been stored inside medication carts for safety because some confused residents might use it incorrectly. Record review of the facility policy, titled Medication Access and Storage, undated, revealed . 2. Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medication (e.g., medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. 7. Scheduled III and IV controlled medications are stored separately from the other medications in a locked drawer or compartment designated for that purpose. Alternatively, Schedule III-V medications may be stored in the trays with the other medications. Schedule II medications are stored in a separated area under double lock. Reconciliation of controlled medication are done at least every shift by the incoming and outgoing licensed nurses at change of shifts.

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	676392	A. Building B. Wing	05/20/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 in accordance with professional standards for food service safety for 1 of 1 kitchen observed.The facility failed to ensure that 4 bags of gravy mix located in the dry storage room were labeled and dated when they were received. This failure could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: During an observation on 5/17/2026 at 9:30AM the dry storage room had 3 bags of chicken gravy mix not labeled with a date and 1 bag of pork gravy mix not labeled with a date when the packaged gravy mixes were received. During an interview on 5/17/2026 at 9:35AM, the CDM stated, Oh my God, those should have been labeled with a date, and she removed the bags to show them from the shelf. The CDM said all packaging should be labeled with the date the packages were received. During an interview on 5/20/2026 at 11:34AM, the CDM said it was important to label and date food to prevent expired foods from being served, which could cause foodborne illness to the residents. Record review of the facility's policy did not reveal information on how dry foods should be stored. Record review of Texas Health and Human Services titled, Kitchen Sanitation and Food Safety dated10/2024 stated under, Food Storage: Key Elements that, Dry food storage is clean, covered/sealed, labeled, and dated.

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	676392	A. Building B. Wing	05/20/2026

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, for 2 (Resident #11 and #43) of 28 residents reviewed, in that: 1. Resident #11's personal refrigerator located in his room was observed on 05/17/2026, and there were one piece of cake, sandwich, and one cup of milk inside the refrigerator, but no date on the food. 2. Resident #43's personal refrigerator located in her room was observed on 05/17/2026, and there was melting ice cream inside the refrigerator, instead of freezer area, but no date on it. This deficient practice could place residents at risk of foodborne illness due to consuming foods which might be spoiled. The findings included: 1. Record review of Resident #11's face sheet, dated 05/20/2026, revealed the resident was a 63-years-old male, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnosis of respiratory failure (a serious condition that makes it difficult to breathe on your own), chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems), and bronchitis (an inflammation on the lining of the bronchial tubes in the lung). Record review of Resident #11's quarterly MDS assessment, dated 05/11/2026 revealed the resident's BIMS score was 13 out of 15 which indicated the resident's cognitive was intact, and he required Setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) to eating. Record review of Resident #11's comprehensive care plan, dated 12/10/2025, revealed the resident had the care plans of [Resident #11] is at risk for malnutrition related to diabetes. For intervention - Diet as ordered by the physician. REGULAR diet, REGULAR texture, THIN LIQUIDS consistency. Observation on 05/17/2026 at 11:02 a.m. revealed Resident #11 was sleeping on the bed, and there was small refrigerator in his room, and one piece of cake, one sandwich, and one cup of milk were inside the refrigerator, but no date on the food. Interview on 05/17/2026 at 11:13 a.m. with Resident #11 refused interviewing by saying he did not want to speak. Interview on 05/17/2026 at 11:14 a.m., LVN-D stated he saw one piece of cake, one sandwich, and one cup of milk inside Resident #11's refrigerator in the resident's room. He said there were no dates on the food, so he did not know how long the foods had been inside the refrigerator. LVN-D said the facility nurse should have checked the food when they checked the resident's refrigerator's temperature and should have written a label and date on the food to prevent possible food illness. 2. Record review of Resident #43's face sheet, dated 05/20/2026, revealed the resident was a 73-years-old female and admitted to the facility on [DATE] with diagnosis of fracture of upper end of left humerus (fracture to left shoulder), conversion disorder (psychiatric condition in which the body's emotional and psychological stressors are converted to physical symptoms that cannot be explained by a neurological or medical condition), and hypertension (high blood pressures). Record review of Resident #43's admission MDS assessment, dated 4/30/2026, revealed the resident's BIMS score was 14 out of 15 which indicated the resident's cognitive was intact, and she required Setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) to eating. Record review of Resident #43's comprehensive care plan, dated 05/03/2026, revealed [Resident #43] has potential for a nutritional problem related to weakness. For intervention - Diet as ordered by the physician. REGULAR diet, REGULAR texture, THIN LIQUIDS consistency and Provide, serve diet as ordered. Monitor intake and record every meal. Observation on 05/17/2026 at 10:24 a.m. revealed there was a small refrigerator inside Resident #43's room, and ice cream was melting inside the refrigerator, instead of freezer area, and no date on the ice cream. Interview on 05/17/2026 at 10:25 a.m., Resident #43 said she did not know when and how the ice cream was on the refrigerator. Interview on 05/17/2026 at 11:28 a.m. with RN-C stated she saw the ice cream melting inside the refrigerator, instead of freezer area inside Resident #43's refrigerator in the resident's room. but no (continued on next page)

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	676392	A. Building B. Wing	05/20/2026

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	date on the ice cream, so the nurse did not know how long the ice cream was inside the refrigerator. The RN-C said the facility nurse should have checked food when they checked the resident's refrigerator's temperature and should have written labels and date on the food to prevent possible food illness. Interview on 05/20/2026 at 11:43 a.m. with the DON said the facility nurse should have checked foods and written labels and dates on the foods to prevent possible food illness per the facility policy. Record review of the facility policy, titled Resident Personal Food Storage, review date 04/2025, revealed Food or beverage in from outside sources for storage in facility pantries, refrigeration units, or personal/resident room refrigeration units will be monitored by designated facility staff for food safety.5. Resident and individuals bring food in from outside sources will be educated on safe food handling and storage techniques by designated facility staff as needed.

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	676392	A. Building B. Wing	05/20/2026

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. The facility failed to ensure that the garbage and refuse containers were in good condition (no leaks) and is waste properly contained in dumpsters or compactors with lids or otherwise covered and that the garbage storage area was well maintained in a sanitary condition to prevent the harborage and feeding of pests for 1 of 1 garbage disposal area reviewed. The facility failed to keep the area around the outdoor garbage receptacle clear of debris when a bag of trash and broken-down boxes were observed outside the garbage receptacle and on the ground. The facility failed to keep the lids closed on the outdoor garbage receptacle during observation of the garbage receptacles. These failures could cause unpleasant odors and attract pest and rodents to the facility. During an observation and interview on 5/17/2026 at 9:55AM revealed, the dumpster outside was in an enclosed area. The DM opened the doors and there was a bag of garbage on the ground, boxes were broken down on the ground, and the door on the dumpster was opened. The CDM stated, It was the nursing side that left the bag of garbage and the boxes on the ground, but unfortunately, it was dietary's responsibility to make sure no garbage was on the ground and the door of the dumpster was closed. During an interview on 5/20/2026 at 11:34AM, the CDM said it was important to keep trash off the ground, and the dumpster door closed to prevent infestation of pests and rodents that could cause food contamination and food borne illness of the residents if they entered the building. Record review of the facility's policy titled, Garbage Disposal and Dumpster Sanitation not dated, under policy stated: To ensure proper containment, handling, and disposal of garbage preventing odors, pest infestation, and infection control risks. Under procedure, stated: 4. Be kept closed when not actively in use. 5. Be free from overflow, excess buildup, or exposed waste. 6. Staff must close lids immediately after depositing trash.