

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/05/2025
NAME OF PROVIDER OR SUPPLIER  Legend Oaks Healthcare and Rehabilitation Garland		STREET ADDRESS, CITY, STATE, ZIP CODE 2625 Belt Line Road Garland, TX 75044	

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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, 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 residents' goals and preferences for one of three residents (Resident #1) reviewed for respiratory care. The facility failed to ensure Resident #1's sleep apnea mask was properly stored in a bag when not in use on 09/30/25. The facility failed to ensure Resident #1's nebulizer mask was properly stored in a bag when not in use on 09/30/25. The facility failed to ensure Resident #1's nasal canula attached to the oxygen tank on his wheelchair was properly stored in a bag when not in use on 09/30/25. These failures could place the resident at risk for respiratory infection and not having his respiratory needs met. Findings include: Record review of Resident #1's Face Sheet, dated 09/30/25, reflected she was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included chronic respiratory failure (severe lack of oxygen). Record review of Resident #1's Quarterly MDS assessment, dated 8/18/25, reflected he had a BIMS score of 13 (intact cognitive response). The resident had an active diagnosis of chronic respiratory failure. Record review of Resident #1's Comprehensive Care Plan, dated 8/11/25, reflected a plan of care for oxygen therapy. Record Review of Resident #1's physician orders, dated 9/30/25, reflected O2 at 4l/Min continuous per NC, Albuterol Sulfate Nebulization Solution 3 ml inhale orally via nebulizer every 6 hours as needed for shortness of breath, and BiPAP/CPAP nightly In an observation on 09/30/25 at 8:27 AM, Resident #1 had a sleep apnea mask unbagged, a nebulizer mask unbagged, and a nasal canula attached to the oxygen tank connected to his wheelchair unbagged. In an observation and interview on 09/30/25 at 8:35 AM, the DON and RN G were shown Resident #1's sleep apnea mask unbagged, his nebulizer mask unbagged, and his nasal canula attached to the oxygen tank connected to his wheelchair unbagged. They stated all the breathing devices should have been bagged when not in use to avoid infection. The DON stated the nurses should be re-bagging equipment when they make their rounds. She stated they were completing in-services on re-bagging nasal cannulas and mask when not in use. Review of the facility's policy Oxygen Administration (Mask, Canula, Catheter), 05/2007, reflected It is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency until the order was obtained. The purpose of the oxygen therapy is to provide sufficient oxygen to the blood stream and tissues.</p>

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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