STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676413	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Garland	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)
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. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for one (Residents #1) of ten residents and for one (Crash Cart) of three carts reviewed for medication storage. The facility failed to ensure the crash cart (cart stocked with medical equipment, supplies, and medications used during medical emergencies) was locked on 12/30/2025. The facility failed to ensure a tube of pain relieving topical (application of medication through the skin) analgesic (painkiller) cream was not inside Resident #1's room on 12/30/2025. These failures could place the residents at risk of accessing/opening the cart, accidental overdose, adverse reactions, misuse of medications.Findings included: 1. An observation on 12/30/2025 at 8:22 AM revealed a crash cart was parked outside the nurse's station unlocked. The cart and its drawers were facing the hallway, the drawers contained emergency supplies and equipment like nasal cannula, syringes, and suction device, and several types of tubing. It was observed that the first drawer had scissors in it and the third drawer had a first aid kit. It was observed that several residents were passing by the crash cart and there was no staff in the nurse's station. An observation on 12/30/2025 at 8:24 AM, a staff called ADON A and ADON A locked the crash cart. In an interview on 12/30/2025 at 10:39 AM, LVN B stated the crash cart should be locked when not in use for the safety of the residents. She said a resident might open it and grab something that would be detrimental for the residents. She said the crash cart had tubings and scissors in it that the resident could use to harm themselves if they were able to get hold of them. She said crash carts also have medications used for emergencies that when accidentally consumed could result to allergic reactions, overdose, nausea, and stomach upset. She said they were all responsible for locking the crash carts. In an interview on 12/30/2025 at 11:06 AM, LVN C stated all the carts should be kept locked when not in use or was left unattended, including the crash cart. She said the things inside the crash cart should not be assessable to the residents because the resident might use them inappropriate like wrap the tubes around their neck or poke their eyes with the syringe. She said there were scissors inside the crash cart and the resident might accident cut themselves. She said the crash carts also have medications used for emergencies and residents, staff, and visitors might open the drawers and get some medications from the cart. 2. Record review of Resident #1's Face Sheet, dated 12/30/2025, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with dementia (a condition characterized by loss of memory and ability to reason), depression (persistent feeling of sadness or loss of interest), and low back pain. Record review of Resident #1's Comprehensive MDS Assessment, dated 11/13/2025, reflected the resident had a severe (resident required significant assistance and support in daily life) impairment with a BIMS score of 02. The Comprehensive MDS Assessment indicated the resident had dementia, depression, and low back pain. Record review of Resident #1's Comprehensive Care Plan, dated 11/20/2025, reflected the resident had potential for injury related to family bringing medications and one of the goals was the resident would have no injuries related to family bringing medications and for the staff to scan the room for any medications. Record review of Resident #1's Physician Orders on 12/30/2025, reflected the resident did not have an order for the analgesic cream. Record review of Resident #1's Assessment Notes on 12/30/2025, reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment the resident was competent to manage their own medications. In an observation and interview on 12/30/2025 at 8:29 AM revealed Resident #1 was in her wheelchair, awake. It was observed that there was a tube of topical analgesic cream on top of her overbed table that was beside her wheelchair. The tube of analgesic cream was in plain view. The resident nodded her head when asked if the analgesic cream was hers. The resident nodded her head when asked if the analgesic cream had always been on her table. In an interview on 12/30/2025 at 11:06 AM, LVN C stated she was not aware there was a tube of topical analgesic cream inside Resident #1. She said she did not notice it when she did her morning round. She said the resident had dementia and might use it inappropriately like applying it to her eyes or mouth. She said the resident did not even have an order for the analgesic cream. She said the analgesic cream should be inside the nurse's carts and the nurses should be the one applying it if the resident needed it. She said she would go to the resident's room and talk to the resident regarding removing the analgesic cream. She said she would re-educate the family member about letting the nurses about any medication being brought to the