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 03/06/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for two of seven residents (Resident #1, Resident #2) reviewed for abuse, neglect, and exploitation. The facility failed to ensure Resident #1 was free from abuse by Resident #2, who threw an empty plastic bowl at Resident #1. This failure could place residents at risk for abuse or neglect that could lead to serious harm. Findings included: Record review of Resident #1's face sheet, dated 03/06/26, reflected an 85-year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnosis which included: dementia (decline in memory), osteoarthritis (cartilage breakdown causing bones to rub together), type 2 diabetes mellitus (high blood sugar), hypertension (force of blood pushing against artery walls), hypothyroidism (thyroid gland does not make enough thyroid (regulates metabolism) hormones), gastro-esophageal reflux disease with esophagitis (stomach acid flows back to esophagus), hyperlipidemia (excessive fat level in the blood), reduced mobility (reduction in the ability to move, walk, or transfer independently), mood affective disorder (disruptions in emotions), generalized anxiety disorder (persistent, excessive and uncontrollable worry), hemorrhoids (swollen veins in the anus caused by straining), myopathy (muscle fibers causing primary muscle weakness), chronic pain syndrome (pain last for more than 3 to 6 months), synovial cyst of popliteal (fluid-filled lump behind the knee) and cognitive communication deficit (impairment in communication). Record review of Resident #1's MDS assessment, dated 12/1/25, reflected Resident #1 was unable to complete the interview; therefore, there was no BIMS score documented. The MDS assessment under Section GG-Functional Abilities, reflected Resident #1 needed set up to complete assistance with all ADLs, used a wheelchair and was dependent on all her mobility tasks. The MDS assessment under Section E-Behaviors, reflected Resident #1 did not have any physical or verbal behaviors. Record review of Resident #1's care plan, revised 12/03/25, reflected Resident #1 was at risk for cognitive function/dementia or impaired thought process. Interventions included: administering medications as ordered, identifying self at each interaction by facing her when speaking and making eye contact, reducing distractions, giving step by step instructions one at a time as needed, keeping routine consistent by trying to provide consistent care givers as much as possible in order to decrease confusion, monitoring/documenting/reporting any changes in cognitive function to MD and reporting to the nurse any changes in cognitive function.Record review of Resident #1's progress note, dated 03/03/26 at 09:50 AM, reflected the following: Resident to resident incident occurred during dining this morning. [Resident #1] was reportedly struck by a cup that was thrown by [Resident #2] seated nearby. Both residents were separated from one another and monitored. No injuries observed by nurse during assessment. No distress noted, resident reported she was fine. Denied pain. [Resident #'1's] family member notified via VM. Record review of Resident #2's face sheet, dated 03/06/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnosis which included: nontraumatic intercerebral hemorrhage (severe stroke involving bleeding in the brain), hypertension (blood pushing too hard against artery walls), type 2 diabetes mellitus (body resist (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	insulin or fails to produce enough), morbid obesity (chronic, complex disease with body mass index of 40 or higher), hemiplegia and hemiparesis following cerebral infarction (one-sided motor deficits occurring after a stroke), hyperlipidemia (excessive fat levels in the blood), schizoaffective disorder (combination of schizophrenia symptoms (hallucinations, delusions, disorganized thinking) and mood disorder (mania or depression), lack of coordination (clumsy, unsteady, and uncoordinated muscle movements), muscle weakness (a reduction in physical strength), dysphagia (pain, choking, or food feeling stuck in the throat), age-related nuclear cataract (lens clouding), hypertensive retinopathy (damage to the retinal blood vessels), retinal ischemia (blood flow to the retina is inadequate), bipolar disorder (chronic mental condition characterized by extreme mood swings), generalized anxiety disorder (mental health condition characterized by persistent, excessive and uncontrollable worry), clonic hemifacial spasm (neurological disorder causing involuntary, intermittent twitching of muscles on one side of the face), cerebral infarction (blood flow to the brain blocked), bilateral primary osteoarthritis (wear-and-tear diseased affecting cartilage in the joints) and facial weakness (loss of muscle control on one or both sides of the face). Record review of Resident #2's MDS assessment, dated 02/26/26, reflected BIMS score of 12, which indicated moderate cognitive impairment. The MDS assessment under Section GG-Functional Abilities, reflected Resident #2 needed setup to dependent or complete assistance with all ADLs, used a wheelchair and needed substantial assistance with all her mobility tasks. The MDS assessment under Section E-Behaviors, reflected Resident #2 did not have any physical or verbal behaviors. Record review of Resident #2's care plan, revised 12/02/25, reflected Resident #2 at risk for impaired cognitive function/dementia or impaired thought processes related to history of CVAM schizophrenia and bipolar disorder. Interventions included: communication: identifying self at each interaction, facing her when speaking and make eye contact, reducing distractions, using simple, directive sentences. Interventions also included: reporting to nurse any changes in cognitive function, attending group activities and for social services to provide psychosocial support as needed. Further review of Resident #2's care plan, reflected Resident #2 had a potential for mood problem related to schizophrenia and bipolar disorder. Interventions included: behavioral health consults as needed, encouraging her to express feelings, monitoring/recording/reporting to MD, and prn acute episode feelings of sadness, loss of pleasure and interests in activities, feelings of worthlessness or guilt, change in appetite or eating habits, change in sleep patterns, diminished ability to concentrate and change in psychomotor skills. Record review of Resident #2's progress note, dated 03/03/26 at 10:32 AM by SW, reflected the following: SW notified [Resident #2] threw cup at another [Resident #1]. SW completed BIMs and PHQ9 assessment with [Resident #2]. BIMs was a 12 (moderate impairment) and PHQ9 was a 0 (none-minimal depression). SW asked [Resident #2] if she was feeling okay. Resident stated yes. SW asked [Resident #2] of situation this morning during breakfast. [Resident 2] reported she understood [that] what she did was wrong and became upset. When [Resident #1] was reaching for her food. SW educated resident on calling staff for help. [Resident #2] voiced understanding. During interview [Resident #2] has good [effect] and did not appear to be in any signs of distress. Follow-ups with [Resident #2] would continue. SW notified psychiatrist of [Resident #2] behavior. SW would continue follow-ups with [Resident #2].In an interview on 03/06/26 at 11:53 AM, CNA A stated she worked Mondays-Fridays from 6:00 AM-2:00 PM on the 200 hall. She stated she worked with Resident #1 and Resident #2 on 03/03/26. She stated she was not a witness to the incident. She stated she went to clear the dining after lunch and a resident pointed out the empty cup on the floor. She stated Resident #2 said she threw the cup at Resident #1 because she had tried to take food off her tray. CNA A stated she immediately separated Resident #1 and Resident #2, then cleared the dining room. She stated she spoke with Resident #2 and informed her that it was not right to throw anything at anyone else. She stated she assessed Resident #1 but there were no marks or bruises. She stated Resident #1 told her that she was okay. She stated after getting the residents separated and assessed, she informed the nurse on the floor. CNA A stated that neither resident had any behavior issues. In an (continued on next page)

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	676413	A. Building B. Wing	03/06/2026

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 03/06/26 at 12:21 PM, LVN B stated she worked Mondays, Wednesdays and Fridays from 6:00 AM- 2:00 PM as the charge nurse on halls 200, 300 and partial 400. She stated she worked on 03/03/26 with both Resident #1 and Resident #2. She stated on another hall during the incident but was informed when she got back to 200 hall. She stated CNA A informed her that Resident #1 reached for Resident #2's food items on her tray. She stated CNA A told her Resident #2 apparently told Resident #1 no, but Resident #1 kept reaching to grab her food. LVN B stated Resident #2 tossed a cup at Resident #1 which hit Resident #1's upper body. LVN B revealed staff had separated the residents and monitored them throughout the day. LVN B stated she assessed Resident #1's skin and noted no marks or bruises. She stated she asked Resident #1 about pain, and she did not have any pain. She also revealed Resident #1 and Resident #2 were roommates, so Resident #1 was moved to a new room. LVN B stated she informed management of the incident. In an interview on 03/06/26 at 12:33 PM, the SW stated she was informed that Resident #1 was reaching for something on Resident #2's plated. The SW stated Resident #2 grabbed an empty cup and threw it at Resident #1. The SW stated the residents were separated to deescalate. She stated that was all she knew of the incident. She stated she spoke with both Resident #1 and Resident #2 after the incident. The SW stated Resident #2 told her Resident #1 was reaching for her food. The SW stated Resident #2 told her she did not want Resident #1 to touch her food, so she grabbed her cup and tossed it. The SW stated when she spoke with Resident #1 she was confused and did not remember the incident. Attempted interview on 03/06/26 at 2:17 PM with Resident #1 was unsuccessful. Resident #1 had no recollection of the incident. Resident #1 revealed she did not remember anything. In an interview on 03/06/26 at 3:58 PM, Resident #2 stated she [NAME] an empty salad bowl at Resident #1. Resident #2 stated Resident #1 kept coughing over her food and grabbed her food. She stated she told Resident #1 to stop but she did not. Resident #2 stated when Resident #1 did not stop, she picked up an empty plastic bowl and threw it at her. Resident #2 stated the bowl hit Resident #1 on her shoulder. Resident #2 stated the staff separated them and told her she could not throw anything. Resident #2 stated she apologized to Resident #1. She also stated Resident #1 was moved out of her room. Record review of the facility's policy titled Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, revised October 2022, reflected in part the following: Policy: It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, resident representative, families, friends, or other individuals.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide care and services, based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable for one of seven residents (Resident # 3) reviewed for activities of daily living. The facility failed to ensure Resident #3 was provided with incontinent care in a timely manner. This failure could place residents at risk for poor self-esteem, infection, and diminished quality of life.Findings included: Record review of Resident #3's face sheet, dated 03/06/26, reflected a [AGE] year-old female who was originally admitted to the facility on [DATE]. Resident #3 had diagnoses that included: chronic obstructive pulmonary disease (inflammatory lung disease), dementia with mood disturbance (emotional shifts such as depression, anxiety, agitation, apathy, or rapid swings), type 2 diabetes mellitus (body resist insulin or fails to produce enough), morbid obesity (chronic, complex disease with body mass index of 40 or higher), urinary tract infection (bacterial infection of the bladder), acute kidney failure anemia in chronic kidney disease (damaged kidneys produce less erythropoietin, a hormone necessary for red blood cell production), acute pyelonephritis (serious bacterial infections of the kidney and renal pelvis), obstructive and reflux uropathy (urine flow is blocked), chronic kidney disease (loss of kidney function), overactive bladder (sudden, uncontrollable urge to urinate), tremor (involuntary, rhythmic muscle contraction causing shaking in hands, head, voice, or legs), obstructive sleep apnea (throat muscles relax excessively during sleep), gastroesophageal reflux disease with esophagitis (inflammation, irradiation, or erosion of the esophageal lining), hyperlipidemia (excessive fat level in the blood), anxiety disorder (persistent, excessive fear or worry), osteoarthritis (wear-and-tear diseased affecting cartilage in the joints) and absence of left leg below knee. Record review of Resident #3's MDS assessment, dated 02/19/26, reflected BIMS score which indicated moderate cognitive impairment. The MDS, under Section GG-Functional Abilities, reflected Resident #3 needed substantial assistance on most of her ADLs, used a wheelchair and was dependent on all mobility tasks. Further review of the MDS assessment section H-Bowel and Bladder reflected Resident #3 had urinary and bowel incontinence. Record review of Resident #3's care plan, no date, reflected Resident #3 had bowel/bladder incontinence related to decreased mobility, deconditioning, activity intolerance, weakness, unsteady gait, and impaired cognition. Interventions included: brief use: using disposable briefs, incontinent: checking as required for incontinence. Washing, rinsing, and drying perineum. Changing clothing as needed after incontinence episodes, monitoring/documenting for signs and symptoms of UTI, monitoring/documenting/reporting to MD possible medical causes of incontinence and observing peri-area during cares for redness or excoriation and notify nurse/MD if present. In an interview on 03/06/26 at 10:52 AM, Resident #3's RP stated she received a call on 03/04/26 at 11:30 AM from Resident #3 crying because she had waited since 8:00 AM for her soiled brief to be changed. Resident #3's RP stated she called the facility at 11:38 AM but no answer. Resident #3's RP stated she called Resident #3 at 11:58 AM to inform her that she was trying to reach someone to change her. Resident #3's RP stated when she spoke with the resident, she still had not been changed. Resident #3's RP stated she called the facility again at 12:00 PM and was put in contact with a nurse on 400 that transferred her to 500 hall, but no answer. Resident #3 stated she called several family members to find out if someone could go to the facility, but no one was able. Resident #3 RP stated she called Resident #3 back at 12:27 PM and she was informed that staff still had not changed her. She stated Resident #3 told her she had fallen asleep while waiting to be changed. Resident #3's RP stated when Resident #3 called and told her, she attempted to contact the facility but to no avail. She stated when staff returned, they told Resident #3 she was not changed because she was asleep when they (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	returned. Resident #3's RP stated Resident #3 told the staff she did not know why they did not wake here as they do for everything else. Resident #3's RP stated when Resident #3 called her with issues with toileting, she would usually go to the facility to take care of Resident #3 herself. In an interview on 03/06/26 at 12:54 PM, Resident #3 stated she used her call light for assistance with changing her clothes and soiled brief. She stated CNA C came into her room and asked what she needed. Resident #3 stated when she informed CNA C that she needed changing, CNA C told her Not now because she was passing trays but would change her afterwards. Resident #3 stated she waited for over an hour and fell asleep. Resident #3 stated it was on 03/04/26 around 1:00 PM when CNA C returned to change her. Resident #3 stated she was upset because it had taken hours and asked what happened. She stated CNA C told her she returned to change her, but she was asleep and did not want to wake her. Resident #3 stated she told CNA C she wanted her to wake her, so her soiled brief was changed. Resident #3 also stated she was confused because staff constantly woke her for everything else. Resident #3 stated she wanted to be woken to be changed, and staff did not do that. Resident #3 stated staff left her in a urine soiled brief for hours. In an interview on 03/06/26 at 4:41 PM, CNA C stated she worked a double shift on 03/04/26. She stated she worked 6:00 AM-10:00 PM. CNA C stated she worked with Resident #3 on 03/04/26. CNA C stated Resident #3's call light was on and when she answered, Resident #3 told her she wanted her brief changed. CNA C stated when she looked in Resident #3's closet, she noticed Resident #3 only had smaller briefs and not the XXXL that she liked. She stated she informed Resident #3 that she would go to the storage to get the size briefs needed. CNA C stated the storage was on the 500 hall. She stated when she got back to Resident #3's room to change her, she was asleep. CNA C stated she did not wake the resident and at that time did not change Resident #3's brief. CNA C stated he did not want to wake Resident #3 because she had previously done so, and the resident got upset with her. She stated she did not want the resident to get upset with her again. CNA C revealed she made the decision to not change the resident. She stated when Resident #3 woke, she was upset that she did not wake to change her. CNA C stated if she had known Resident #3 would have been upset for not waking her, she would have woken her from her sleep. CNA C stated she was unaware of how long it took to return to Resident #'3 room with the briefs to change her. CNA C stated the expectation was to wake the resident to change, if requested. CNA C stated the risks of leaving Resident #3 in a soiled a brief was the resident could have developed a sore, infection or a rash. In an interview on 03/06/26 at 5:20 PM, the Administrator and DON stated they were made aware of the situation with Resident #3 being soiled on 03/05/26. The DON stated it was the resident's right to decide if he or she wanted to be changed. The DON stated it was the residents' right to be changed, and staff were expected to change the residents. The DON stated if the resident was asleep, then depending on the resident's choice, staff may or may not wake the resident. Both the Administrator and DON stated they did not know about this issue with the resident. The DON stated the risk was a rash or infection if a resident was not changed in a timely manner. Record review of the facility's policy titled Quality of Care, revised July 2015, reflected in part of the following: Policy:It is the policy of this facility that residents are given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. Procedures:If a resident is unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, toileting and personal oral hygiene will be provided by qualified staff. Residents will be involved in decision making and given choices related to ADL activities as much as possible. Showers and bed baths will be provided to residents in accordance with the residents shower schedule.Residents will be involved in decision making and given choices related to ADL activities as much as possible. Record review of the facility's policy titled Resident Rights, revised October 2015, reflected in part of the following: Policy: It is the policy of this facility that all residents be treated with kindness, dignity and respect. Procedures: 3. Resident will be appropriately dressed in clean clothes arranged comfortably on their persons and be well groomed.