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	04/30/2026

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 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, in accordance with State and Federal laws, to ensure medications and biologicals were stored in a safe and secure manner and were not accessible to residents #17 & #21. 1. The facility failed to ensure Resident #17 did not have access to an open tube of Clear Moisture Barrier Ointment observed on the bedside table in plain view on 4/28/26. 2. The facility failed to ensure Resident #21 did not have access to an unopened packet of Essentials Prevent Ointment observed on the bedside table in plain view on 4/28/26. These failures could place residents at risk for accidental misuse or ingestion of topical medications. Findings include: 1. Record review of Resident #17's admission record dated 4/28/26 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included other cirrhosis of liver (chronic liver damage that may impair healing), thrombocytopenia (low platelet count that may increase risk for bruising and impaired skin integrity), type 2 diabetes mellitus (condition that may impair wound healing), protein-calorie malnutrition (condition that may contribute to impaired skin integrity), cellulitis (bacterial skin infection), irritant contact dermatitis due to fecal or urinary incontinence (skin irritation related to incontinence), neuromuscular dysfunction of bladder, and cognitive communication deficit. Record review of Resident #17's comprehensive Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 15 indicating cognitively intact status. Record review of Resident #17's care plan dated 3/28/26 revealed staff were instructed to Observe peri-area during cares for redness or excoriation; notify nurse or physician if present. Record review of Resident #17's active physician's orders dated 4/30/26 revealed no physician's order for self-administration of medications. 2. Record review of Resident #21's face sheet dated 4/29/26 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included unspecified dementia (progressive cognitive impairment affecting judgment and decision-making), cerebral infarction (stroke resulting in neurological impairment), chronic kidney disease stage 4, anemia, peripheral vascular disease with history of vascular intervention (condition affecting circulation and skin integrity), blindness, and immobility placing the resident at risk for skin breakdown. Record review of Resident #21's comprehensive Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 14 indicating cognitively intact status. Record review of Resident #21's care plan dated 3/16/26 revealed staff were instructed to Monitor, document, and report signs and symptoms of immobility including contractures, signs of blood clots, skin breakdown, and fall-related injury to the physician as needed. Observation of Resident #17's room on 4/28/26 at 9:05 AM revealed a barrier cream sitting on the bedside table. Interview with Resident #17 at the time of observation revealed the resident stated the cream was brought from the hospital and had been provided during hospitalization. When questioned why it was sitting out and why the resident had possession of it, the resident did not respond. Observation of Resident #21's room on 4/28/26 at 9:13 AM revealed an unopened package of Essentials Prevent ointment in the resident's room. Resident #21 was not present in the room during the observation. Interview with CNA H on 4/30/26 at 9:49 AM (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 - Some	regarding medication storage revealed CNA H had worked at the facility a little over one year. When questioned regarding the barrier cream in Resident #21's room, CNA H stated awareness that the resident had a barrier cream but was unsure what it was used for. CNA H stated nurses applied creams and treatments and residents did not administer them independently. CNA H stated creams and topical treatments are disposed of after use and should not remain in resident rooms. CNA H confirmed routine medication storage audits were conducted by nursing leadership. Interview with LVN I on 4/30/26 at 9:55 AM revealed LVN I had worked at the facility since July 2024. LVN, I stated the resident's skin condition was pretty good. When questioned regarding the ointment observed in the room, LVN I stated no awareness of the cream being in the resident's room. LVN, I stated no residents on the unit were supposed to keep medications at bedside. LVN, I stated medications, including over-the-counter medications, should be stored in the medication cart or designated storage area. LVN, I stated staff were never instructed to leave creams or treatments in resident rooms. LVN I further stated if medication was found in a resident room, staff were expected to report it to the Director of Nursing. Interview with the RN on 4/30/26 at 10:06 AM regarding Residents #17 revealed the RN stated Resident #21 was incontinent, alert with some confusion, and able to make needs known. The RN stated Resident #17 had made progress since admission, remained more active, used oxygen, and had wound care orders in place. When questioned regarding the cream observed in Resident #17's room, the RN stated no prior observation of the cream in the room and stated the cream shown was not what the facility normally used for Resident #17. The RN stated medications should remain on the medication cart and never be left in resident rooms. The RN stated staff normally took only what was needed for application and discarded the remainder after use. The RN further stated if medications were found in resident rooms, staff were expected to remove the medication and report it to the Director of Nursing. Observation on 4/30/26 at 10:15 AM revealed Resident #21 was not present in the room. No visible medications were observed in the room at that time. Interview with the Social Worker on 4/30/26 at 10:26 AM revealed no awareness of medications being left in resident rooms and no personal observations of medications left in rooms. The Social Worker stated if medications were observed in resident rooms, the concern would be reported to nursing staff and the facility administrator. The Social Worker indicated medications should not be left in resident rooms. Interview with the Director of Nursing on 4/30/26 at 10:45 AM revealed medications and treatments should not be left in resident rooms. The Director of Nursing stated no residents currently had assessments or authorizations in place for bedside medication storage or self-administration of medications. The DON stated facility policy required an assessment prior to allowing residents to self-administer medications. The DON stated medications or treatments found in resident rooms were expected to be removed immediately for resident safety and either properly stored or discarded. The DON stated residents on the skilled nursing hall frequently returned from the hospital with medications or treatments, which continued to be an ongoing issue. The DON stated the facility had postings notifying residents not to keep medications in their rooms and staff were expected to remain watchful for such items. The DON further stated responsible parties would be notified to remove medications from the facility when appropriate, or the facility would obtain physician orders and properly store medications per policy. Record review of the facility's undated nursing policy regarding medication storage revealed it was the policy of the facility to store all drugs and biologicals in locked compartments under proper temperature controls. The policy further reflected that medications were accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The policy indicated medications intended for internal use were to be stored in a medication cart or other designated area and medication carts and supplies were to remain locked or attended by authorized personnel.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for two of twenty residents (Resident #93 and Resident #95) reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #93 and Resident #95's rooms were in a position that was accessible to the residents on 04/28/2026.This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included: Resident #93Record review of Resident #93's Face Sheet, dated 04/29/2026, reflected a [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) and anxiety (intense or excessive fear or worry).Record review of Resident #93's Quarterly MDS Assessment (assessment used to determine functional capabilities and health needs), dated 02/24/2026, reflected the resident had a memory problem. The Quarterly MDS Assessment indicated the resident was dependent on staff for eating, hygiene, showers, dressing, and bed mobility.Record review of Resident #93's Comprehensive Care Plan, dated 03/13/2026, reflected the resident was at risk for falls related to weakness and one of the interventions was to be sure the resident's call light was within reach.During an observation and interview on 04/28/2026 at 9:13 a.m., revealed Resident #93 was in her bed, awake. It was observed that the resident's call light was on the floor. When asked where her call light was, the resident did not reply.During an observation and interview on 04/28/2026 at 9:20 a.m., the MDS Nurse said call lights should be with the residents at all times in case they needed to call the staff for any assistance. She went to the resident's bedside and took the call light from the floor and placed it where the resident could reach it.Resident #95 Record review of Resident #95's Face Sheet, dated 04/29/2026, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with acquired absence of left leg below knee.Record review of Resident #95's Quarterly MDS Assessment, dated 03/20/2026, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS score of 14. The Quarterly MDS Assessment indicated the resident needed assistance for hygiene, shower, dressing, bed mobility, and transfer.Record review of Resident #95's Comprehensive Care Plan, dated 02/03/2026, reflected the resident was at risk for fall and one of the interventions was for the call light to be in reach.During an observation and interview on 04/28/2026 at 9:04 a.m. revealed Resident #95 was in her bed, awake. It was observed that the resident's call light was on the floor. It was also observed that the resident's bed was soaking wet. The resident said she spilled her coffee and that was why she and her bed were wet. She said she did not have her call light and she had no way to call the staff.During an observation and interview on 04/28/2026 at 9:19 a.m., CNA E said call lights were important for the residents because they used them to call for help or assistance. She said they might get mad if they needed the staff and there was no way to call them. She went inside Resident #95's room and saw the call light on the floor. She picked it up and placed it where the resident could reach it. She also saw that the resident's bedding was wet. She said she would change also the resident.During an interview on 04/30/2026 at 7:09 a.m., ADON A said call lights should always be with the residents or within the reach of the residents in cases they needed the staff for anything. She said the residents would call if they needed to be changed, a pain pill, or if they were not feeling well. She said the staff should make sure that the call lights were with the residents before they left the room. She said the call lights had clips on them and the staff could use them to prevent the call lights from falling if the residents moved. She said the call lights were for all residents, regardless of whether they were dependent or independent. She said everybody was responsible for making sure the call lights were with the residents. She said the expectation was for the staff to make sure that all the call lights were within reach of the residents. She said they already started an in-service about call lights. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/2026 at 7:35 a.m., the DON said call lights were used by the residents to communicate with the staff if they needed something or needed assistance. She said the expectation was for the staff to make sure the call lights were within reach of the residents before they left the room. She said she already started an in-service about call light placement. During an interview on 04/30/2026 at 8:08 a.m., the Administrator said the expectation was for staff to check if the call lights were within the reach of the residents at all times. He said sometimes the residents would knock them off so another expectation would be for the staff to pick up the call lights and put them where the residents could reach them. He said the DON already started an in-service about call lights.Record review of facility's policy Call Light Policy Procedure - Nursing Clinical revised May 2023 reflected POLICY: It is the policy of this facility to provide the resident a means of communication with nursing staff . PROCEDURES . 4. Leave the resident comfortable. Place the call device within resident's reach before leaving room.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for one of three residents (Residents #17) reviewed for quality of care.The facility failed to ensure that Resident #17's open wounds to her left and right buttocks were covered with dressings on 04/28/2026. This failure could place the residents with open wounds at risk for infection.Findings included: Record review of Resident #17's Face Sheet, dated 04/29/2026, reflected an [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with irritant contact dermatitis due to fecal, urinary or dual incontinence (unable to control).Record review of Resident #17's Comprehensive MDS Assessment, dated 04/02/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated that the resident had moisture associated skin damage.Record review of Resident #17's Comprehensive Care Plan, dated 04/08/2026, reflected that the resident had an actual impairment to the skin integrity related to shear (downward pressure and friction causing skin damage)/MASD (moisture associated skin damage: inflammation or erosion of the skin caused by prolonged exposure moisture from bodily fluids)) to right and left buttocks and one of the interventions was to administer treatments as ordered.Record review of Resident #17's Physician's Order, dated 03/30/2026, reflected Cleanse: wound to left buttock with NS, pat dry, apply Triad paste, cover with foam dressing and prn for dislodgement/soiling. every day shift every Mon, Wed, Fri for Shear/MASD AND as needed.Record review of Resident #17's Physician's Order, dated 03/30/2026, reflected Cleanse: wound to right buttock with NS, pat dry, apply Triad paste, cover with foam dressing and prn for dislodgement/soiling. every day shift every Mon, Wed, Fri for Shear/MASDAND as needed.During an observation on 04/28/2026 at 11:23 a.m. revealed CNA F and CNA G were about to transfer Resident #17 to her wheelchair. Before transferring the resident, they provided incontinent. After cleaning the perineal (area between the legs) area, they rolled the resident to her side and lowered her brief. It was observed that the resident had loose, unformed stools, scattered on her left and right buttocks. It was also observed that the resident had open wounds on her right and left buttocks that had no dressings and had feces on them. It was also observed that there were no dressings on the resident's brief that was taken off from the resident's bottom. CNA F finished cleaning Resident #17's bottom and then went out of the room to call the nurse.During an interview on 04/28/2026 at 11: 36 a.m., CNA G said she was not sure why Resident #17's wounds did not have dressings.During an interview on 04/28/2026 at 11:40 a.m., CNA F said he went out of the room to call LVN H to see if she needed to put some cream or dressings on Resident #17's wounds before he put on the resident's brief. He said the Treatment Nurse heard what he was telling LVN H and said she would do the resident's wound care. He said he was not sure why the resident's wounds did not have any dressings on them. He said because the wounds had no dressing, they were contaminated with feces that could lead to infection.During an observation on 04/28/2026 at 11:45 a.m., revealed ADON B cleaned Resident #17's wounds and placed some dressings on them.During an interview on 04/28/2026 at 12:01 p.m., ADON B said she was also the Treatment Nurse. She said already cleaned Resident #17's wounds. She said the order for the resident's wound care was M-W-F and PRN if the dressings were soiled or dislodged. She said she had no idea why the resident's wounds did not have dressings on them. She said whoever changed the resident or saw that the wounds did not have any dressings on them should have informed the nurse so that the nurse could have placed some dressings. ADON B said the dressings were needed to keep the wound from having contact with any contaminants such as feces and urine. She said the wounds should be covered to prevent cross contamination and infection. She said she would start an in-service about the matter. She said she had no idea that the resident's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wounds were not covered and how long they were uncovered.During an interview on 04/28/2026 at 12:13 p.m., LVN H said nobody notified her earlier that the Resident #17's wound dressings were soiled or dislodged or that the resident's wounds did not have any dressings on them. She said if somebody informed her that the wounds were not covered, then she could have put some dressings on the wounds to keep them clean. She said since the resident was going more often, then the more they need to monitor the dressings of the wounds to prevent infections. She said, even without the feces, the wounds could not have contact with the brief because the brief might be soaking with urine. During an interview on 04/28/2026 at 1:46 p.m., CNA G said was assigned to Resident #17 but she had not changed the resident prior to the incontinent care done at around 11:30 a.m She said if she saw that the wounds did not have dressings, she would notify the nurses so they could do wound care.During an interview on 04/30/2026 at 7:35 a.m., the DON said the CNAs did the right process during incontinent care because they called the nurse when they saw that the wounds did not have any dressings on them and the possible risk would be infection. She said she did not know why the wounds had no dressings on them but already started an in-service that if any dressing was soiled or dislodged, to call the nurse so they could perform wound care. During an interview on 04/30/2026 at 8:08 a.m., the Administrator said he was not a clinician and would let the DON take the lead about the wounds having no dressings.Record review of the facility's policy Skin and Wound Monitoring and Management Quality of Care revised December 2023 reflected Policy: It is the policy of this facility that . 2. A resident having pressure injury(s) receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing . Purpose: The purpose of this policy is that the facility provides care and services to . 3. Prevent the development of additional, avoidable pressure injury . Procedure . g. Ongoing Skin and Wound Assessments . 7) Identifying any possible complications or signs/symptoms consistent with the possibility of Infection . j. Treatments per physician order . 3. Prevention: In order to prevent the development of skin breakdown or prevent existing pressure injuries . f. If the resident is incontinent, make sure that his/her skin remains clean and dry with regular pericareand toileting when appropriate.from worsening . CNAs will review electronic Kardex to view care plan interventions . f. If the resident is incontinent, make sure that his/her skin remains clean and dry with regular pericare and toileting when appropriate.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the resident's environment remained free of hazards as was possible for one of six residents (Resident #24) reviewed for accident hazards. The facility failed to ensure Resident #24 had physician orders for a scoop mattress to ensure it was not a hazard for the resident. This failure could prevent the residents from having an environment that was free from accidents, and potential injury. Findings included:Record review of Resident #24's Face Sheet, dated 04/29/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #24 had a diagnosis of reduced mobility.Record review of Resident #24's Initial MDS Assessment, dated 03/19/26, reflected the resident had a BIMS score of 5 (severe cognitive impairment). The MDS assessment reflected the resident had an active diagnosis of reduced mobility.During an observation on 04/14/26 at 11:35 a.m., revealed Resident #24 was lying in bed on a scoop mattress (a scoop mattress features raised sides and a concave center). Record review of Resident #24's Comprehensive Care Plan, dated 03/20/26, reflected the resident being a fall risk, but there was no intervention including the use of a scoop mattress. Record review of Resident #24's Physician's Order, dated 04/29/26, reflected no physician's orders for a scoop mattress. During an interview and observation on 04/29/26 at 1:30 a.m., ADON A stated Resident #24 was a fall risk. She observed the scoop mattress on the resident's bed and she stated she did not know if the resident had orders for the mattress. She stated the resident needed a physician's order for the mattress because it was part of her care. She did not know the risk of the resident having the mattress without physician orders.During an interview and observation on 04/29/26 at 1:40 a.m., the DON and Clinical Resource Nurse were informed of Resident #24 having a scoop mattress and no physician's order. The DON stated the resident had orders for use of a wedge and assumed that was for the scoop mattress. The DON stated it was used for fall prevention. They stated they would work on getting the resident a physician's order for the scoop mattress. They stated it was the nursing staff's responsibility to ensure the resident had physician orders for the use of the equipment. Record review of the facility's policy, Fall Management System, dated 02/2023, reflected This facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible. Each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision, assistive devices and functional programs as appropriate to prevent accidents.POLICY:It is the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding for one of three residents (Resident #29) reviewed for feeding tube management.The facility failed to ensure LVN D flushed Resident #29's g-tube before and after medication administration as ordered on 04/29/2026.This failure could place residents with g-tubes at risk for clogging.Findings included:Record review of Resident #29's Face Sheet, dated 04/29/2026, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with dysphagia (difficulty in swallowing) and gastrostomy status (having done a surgical procedure that creates artificial opening into the stomach to provide nutritional support).Record review of Resident #29's Comprehensive MDS Assessment, dated 04/17/2026, reflected the resident had a memory problem. The Comprehensive MDS Assessment indicated the resident had a feeding tube (a way of providing nutrition directly to the stomach).Record review of Resident #29's Quarterly Care Plan, dated 04/22/2026, reflected the resident required tube feeding (delivery of nutrition through a tube inserted in the stomach) and one of the interventions was to see MD orders for current feeding orders.Record review of Resident #29's Physician's Order, dated 08/18/2025, reflected Enteral Feed (delivery of food through feeding tube) Order every shift FLUSH G-TUBE (gastrostomy tube: a tube inserted through the abdomen that delivers nutrition directly to the stomach) WITH 30-50 ML OF WATER BEFORE AND AFTER MEDICATION ADMINISTRATION.During an observation on 04/29/2026 at 6:41 a.m. revealed LVN D was about to administer Resident #29's medications via g-tube. He sanitized his hands, put the medications in small plastic cups, crushed them, returned the crushed medications to the small plastic cups, and dissolved them with 10 ml of water. He placed the cups of crushed medications on the resident's overbed table that was sanitized prior to medication preparation. He also put some small cups of water with 15 ml each on the overbed table. He then went inside the resident's room, took a 60 ml piston syringe from the resident's bedside table, and placed it on the overbed table. He put on a gown and a pair of gloves, raised the bed, elevated the head of the bed, turned off the g-tube pump, and disconnected the g-tube from the formula. After disconnecting the g-tube, he took the syringe, pulled the plunger halfway, connected it to the gtube, and checked the placement of the g-tube by pushing air into g-tube while listening using a stethoscope (device used to listen to the sounds inside the body). After checking the placement, he pulled the plunger of the syringe and checked for the gastric residual (food, liquid, and secretions remaining in the stomach). After checking the placement and the residuals, he disconnected the syringe, pulled the plunger of the syringe, and connected the barrel of the syringe to the g-tube. After connecting the barrel of the syringe, he started to pour the first medication without flushing the g-tube. After he was done administering the medications, he flushed the g-tube with 15 ml of water.During an observation and interview on 04/29/2026 at 7:36 a.m. LVN D said the g-tube should be flushed in order to make sure that the g-tube was not clogged and patent. He said he prepared the water he needed for flushing in between medications but did not prepare for the water needed to flush before administering the medications. He checked Resident #29's orders and said there was an order to flush the g-tube before and after medication administration with 30 to 50 ml of water. He said he did flush the g-tube after but not with what was ordered.During an interview on 04/30/2026 at 7:09 a.m., ADON A said the g-tube should be flushed before medication administration to prevent clogging that could lead to replacing the g-tube. She said flushing the g-tube was done to make sure the medications would go through without any issues and there was no residues, like medications, that could interact to the medications that would be administered. She said if the order said to flush 30 to 50 cc before and after medication then the staff should have flushed it with 30 to 50 cc before and after medication administration. She said a specific amount of water was ordered to ensure hydration (continued on next page)

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	04/30/2026

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.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and that the medication was delivered safely. She said they already started an in-service about flushing before medications administration.During an interview on 04/30/2026 at 7:35 a.m., the DON said the g-tube should be flushed before administration of medications to clear the tube and to make sure the tube was patent. She said the expectation was for the staff to understand and follow the procedure. She said they already started an in-service about flushing the g-tube.During an interview on 04/30/2026 at 8:08 a.m., the Administrator said he was not a clinician and would let the DON take the lead on the issue about the g-tube.Record review of the facility's policy Gastrostomy Tube Care and Management revised July 2024 reflected Policy: It is the policy of this facility to provide proper care and maintenance of gastrostomy tubes . Procedure . 5. Flush the feeding tube and adapter, if applicable per Physician's order before and after every feeding, and before and after giving any medication by tube .9. Flushing the Tube . a. To reduce the risk of tube clogs . Before and after each administration of medication . b. The amount of water used for tube flushing depends on the individual physician orders.

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	676413	A. Building B. Wing	04/30/2026

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review the facility failed to establish and 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 diseases and infections for two of twelve residents (Resident #73, and Resident ##81) reviewed for infection control.1. The facility failed to ensure LVN D placed a cap on Resident #73's IV port after disconnecting the resident's IV on 04/28/2026.2. The facility failed to ensure on 04/28/2026 CNA E wore a gown while performing Resident #81's incontinent care, who had a permacath and was undergoing dialysis, and was on enhanced barrier precautions. Findings included:1. Record review of Resident #73's Face Sheet, dated 04/29/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with overactive bladder (a bladder control problem which leads to a sudden urge to urinate). Record review of Resident #73's Quarterly MDS Assessment, dated 03/26/2026, reflected that the resident was cognitively intact with a BIMS score of 13. The Quarterly MDS Assessment indicated that the resident was incontinent of bowel and bladder. Record review of Resident #73's Comprehensive Care Plan, dated 02/12/2026, reflected that the resident had bowel and bladder incontinence and one of the interventions was monitor for signs and symptoms of UTI (infection involving the organs producing urine).Record review of Resident #73's Physician's Order, dated 04/27/2026, reflected Midline (a long and thin tube inserted into a large vein in the upper arm used for medication administration) placement one time only for UTI for 1 Day.During an observation and interview on 04/28/2026 at 10:34 a.m. revealed Resident #73 was in her bed, awake. It was observed that there was an IV pole inside the resident's room. The resident said there was an IV pole inside her room because she was receiving antibiotics for her UTI. She pulled her hand from under her blanket to show her midline. It was observed that the midline port was not covered. She said she was not sure if the nurses were putting a cover on her IV port.During an observation and interview on 04/28/2026 at 11:09 a.m., LVN D said Resident #73 was receiving antibiotics because she had a UTI. He said he administered the antibiotics and was also the one who disconnected it. He said he was not sure if he covered the resident's midline port after disconnecting the IV. He went inside the resident's room and saw the midline port did not have a cover. He said he would get a green cap for the resident's IV. He said the risk of not covering the midline port could be infection.2. Record review of Resident #81's Face Sheet, dated 04/29/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with end stage renal failure (kidneys no longer effectively filter waste and toxins from the blood).Record review of Resident #81's Quarterly MDS Assessment, dated 04/24/2026, reflected that the resident was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated that the resident was undergoing dialysis (a medical treatment that removes waste products from the blood).Record review of Resident #81's Comprehensive Care Plan, dated 03/26/2026, reflected that the resident needed hemodialysis related to hemodialysis (medical treatment that filters waste and excess fluids from the blood when the kidney can no longer function) and one of the interventions was to use enhanced barrier precautions due to central venous catheter to right upper chest (permacath).Record review of Resident #81's Physician's Order, dated 04/27/2026, reflected ENHANCED BARRIER PRECAUTIONS: PPE required for high resident contact care activities. Indication: permacath (flexible tube used for long term dialysis often inserted into the blood vessels of the neck or upper chest) every shift.Record review of Resident #81's Physician's Order, dated 03/30/2026, reflected RESIDENT HAS CENTRAL VENOUS CATHETER (flexible tube inserted into a large vein, used for hemodialysis) TO RIGHT UPPER CHEST .MONITOR SITE Q SHIFT FOR BLEEDING, PAIN, REDNESS, TENDERNESS, SWELLING, & DISLODGEMENT. DOCUMENT (-) ABSENT OR (+) IF PRESENT. NOTIFY MD & DIALYSIS CENTER every shift.During an observations and interview on 04/28/2026 at 9:13 a.m. revealed Resident #81 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was in her bed, awake. The resident said she was waiting for the staff to get her up for her dialysis. She then pulled her permacath from her shirt and said it was what they used during her dialysis. The permacath was observed on the resident's right upper chest.During an observation on 04/28/2026 at 9:18 a.m. revealed CNA E went inside the room and started to do Resident #81's incontinent care. She washed her hands before putting on a pair of gloves and started with incontinent care. She did not wear a gown while performing incontinent care. During an interview on 04/28/2026 at 10:38 a.m., CNA E said it was an oversight on her part because she forgot to wear a gown knowing that Resident #81 had a tube on her upper chest that was used for dialysis. She said a gown was required for residents on EBP to prevent transfer of microorganisms to other residents.During an interview on 04/30/2026 at 7:09 a.m., ADON A said the IV port should be covered after disconnecting the IV bags to prevent any microorganism from going inside the midline. She said the facility had green caps, which was an alcohol-containing cap used to disinfect the IV ports. She said the staff must wear a gown when PPE was required. She said if there was a sign outside a resident's door that the resident was on EBP, then gowns should be worn, in addition to the gloves, for an extra layer of protection from splashes of blood or bodily liquids that could be infected and then could be transferred to other residents. She said the staff might also bring home any infection that adhered to their clothing. She said deviation from the said procedure could result in cross contamination and spread of infection, if there was any. She said the expectation was for the staff to be mindful and compliant with the policy of infection control. She said they would re-educate the staff about EBP and infection control.During an interview on 04/30/2026 at 7:35 a.m., the DON said that when a resident was on EBP, staff should wear a gown and a pair of gloves when handling the resident to prevent any transfer of MDROs (Multi-Drug Resistant Organisms: refers to microorganisms that are resistant to one or more antibiotics). She said these organisms might transfer to the scrub suits and then might be transferred to other residents. She also said that there were signs outside the doors of the residents that were on EBP to remind the staff to wear PPE. She said all the residents with indwelling medical devices, like feeding tube, urinary catheter, and dialysis port, were on EBP. She said the IV port should also be capped to prevent cross contamination. She said the expectation was for the staff to be mindful with what they were doing to protect the residents from all kinds of infections. She said she already initiated an in-service about EBP and infection control and would closely monitor the staff's adherence to the policy.During an interview on 04/30/2026 at 8:08 a.m., the Administrator said he was not a clinician and he would let the DON handle the issue about the IV port and not wearing a gown.Record review of the facility's policy, IPCP Standard and Transmission-Based Precautions Infection Control revised October 2022 reflected Policy: It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions . 3. Enhanced Barrier Protection (EBP}: expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROsto staff hands and clothing then indirectly transferred to residents or from resident-to-resident . c. Examples of high-contact resident care activities requiring gown and glove . vi. Changing briefs or assisting with toileting . vii. Device care or use: central vascular line (including hemodialysis catheters).A policy for capping the IV port was requested verbally on 04/30/2026 at 10:02 a.m. to the Administrator. The Administrator said the facility did not have a policy specific to capping the IV port.