

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/24/2025
NAME OF PROVIDER OR SUPPLIER  Legend Oaks Healthcare and Rehabilitation - Waxaha		STREET ADDRESS, CITY, STATE, ZIP CODE  151 Country Meadows Boulevard Waxahachie, TX 75165	

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 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.  (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interviews, and record review, the facility failed to ensure residents were afforded rights, including the right to self-determination, for 1 of 6 residents (Resident #1) reviewed for resident rights. The facility failed to ensure Resident #1's Statutory Durable Power of Attorney (DPOA) was appropriately executed in that its elected agents and witness were facility staff, which posed a conflict of interest and the potential for impropriety, and it was implemented during a time in which the resident's capacity to consent was in question. This failure created a dual relationship between the resident and staff and a conflict of interest which could have placed the resident at risk of harm, fraud, exploitation, and/or other legal and medical complications. Findings include: Record review of Resident #1's face sheet revealed a [AGE] year-old male whose most recent admission to the facility was on [DATE], with an initial admission date of [DATE], and an original admission date of [DATE]. The other contacts listed were for a friend and next of kin. Resident #1's diagnoses include in part: Fracture of unspecified part of neck of right femur (thigh bone), onset date: [DATE], Type 2 Diabetes Mellitus (a condition that happens when the body cannot use insulin correctly and sugar builds up in the blood) with foot ulcer (open sore), onset date: [DATE], Cerebral Infarction, Unspecified (a type of stroke where the specific cause or location is not detailed), onset date: [DATE], and Cognitive Communication Deficit (difficulties in communication stemming from impairments in cognitive processes, impacting daily interactions and effective information exchange), onset date: [DATE]. Resident #1's code status was listed as DNR. Record review of Resident #1's face sheet showed that Resident #1's most recent admission was from an acute care hospital, with the hospital stay lasting from [DATE]-[DATE]. Resident #1 was listed as his own Financial Responsible Party with his niece being listed as Emergency Contact #1, Care Conference Person. Observation of Resident #1 was made on [DATE] at 1:05 PM. The resident was pointed out by staff while sitting in the dining room. The resident was observed to be dressed appropriately with good hygiene. Resident #1 sat in his wheelchair at a dining table. Interview with Resident #1 was attempted but it was apparent that his use of the English language was limited, and he only answered in yes or no phrases. The resident affirmed that he was doing okay, that staff treated him well, and he his needs were met. The resident made these affirmations by saying, Yes and nodding his head. During an interview with ADM and DON on [DATE] at 11:20 AM, ADM revealed that Resident #1 and his family/fictive kin ((individuals who are not biologically related but are considered part of one's family) were Jehovah's Witnesses. ADM stated this created a conflict with the assignment of a POA due to religious beliefs. Per ADM, the family/fictive kin did not believe in blood transfusions or other life saving measures and the resident initially designated his code status to be a full code, a medical status in which all available life-saving treatments are used. ADM stated the resident's cognitive status has fluctuated during his time in the facility and he has been in and out of the state of confusion, but the resident has been able to elect his medical care and procedures. ADM stated that the facility has consulted with their legal department, and it was felt that the appointment of a guardian was in the best interest of the resident. ADM stated that appointments are being sought through the local courts. ADM stated that this is a long process in this county and no appointment has been made yet. ADM stated the application process began in [DATE]. ADM claimed that the lack of a designated POA has not interfered with the resident's care. In an interview on [DATE] at 12:43 PM, SW A with a local hospital, indicated they were involved in the discharge planning of Resident #1 during his most recent hospital stay. SW A stated on or about [DATE], she reviewed the DPOA provided for Resident #1 and questioned its legality as it listed SSA and SSM as the Resident's agents, but Resident #1 had no designated medical decision maker. SW A stated that she spoke to the facility (possibly ADM) and highly suggested they apply for guardianship on behalf of Resident #1. The facility stated they would speak to their liaison. SW A stated Resident #1 was confused throughout his stay, unable to make his own decisions, and lacked family willing to serve as POA. SW A stated this made Resident #1 appropriate for guardianship. SW A stated the hospital was able to secure a valid out of hospital DNR on behalf of Resident #1 prior to his discharge on [DATE]. SW A stated the documentation provided by the facility did not include a valid medical POA. In an interview on [DATE] at 1:05 PM, DON stated that Resident #1 is able to understand English, but his understanding was limited. In an interview on [DATE] at 1:15PM, SSA verified she was an assistant to the facility's SW. SSA stated that she had been employed with the facility for 8.5 years, starting as a CNA then moving into the transporter role and then as an SSA. SSA stated Resident #1 was initially</p>		