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 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - Waxaha	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately consult with the resident's physician and notify the resident's representative of the significant change in the resident's physical, mental, or psychosocial status for two residents (Resident #2 and Resident #3) of ten residents reviewed for resident rights. The facility failed to inform Resident #2's RP she was being transferred to another facility on 3/7/2026. The facility failed to ensure Resident #3's RP was notified when she fell on 3/17/2026 or 3/18/2026. The facility failed to ensure Resident #3's Physician was notified when she fell on 3/17/2026 or 3/18/2026. This failure placed residents at risk of a decreased quality of life and risk of not having their responsible party represent them in medical and care decisions or having their Physician make care decisions post fall. Findings included:Resident #2Review of Resident #2's face sheet dated 4/8/2026, reflected a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included: Alzheimer's Disease (progressive brain disorder that destroys memory and thinking skills), Hypertension (high blood pressure) and atrial fibrillation (irregular heart rhythm). Review of Resident #2's admission MDS dated [DATE], reflected no BIMS score assessment. Review of Resident #2's assessments in the EMR reflected no BIMS assessment listed. Review of Resident #2's Progress note dated 3/6/2026 at 3:57 pm reflected: The resident is newly admitted to facility and moved into a long-term care room today. She has been ambulating around pleasantly confused. Family visited today and upon leaving patient with increased emotional outburst. Patient continued to seek family towards the exit doors. Patient easily redirected to room. Wanderguard (A4525-3140) placed on right ankle. [FM] notified. Review of Resident #2's progress note dated 3/7/2026 at 2:08 pm by Nurse A, reflected; resident discharged to [another nursing facility] memory care; transported by facility transport; resident's family collected all resident's belongings During an interview on 4/8/2026 at 1:22 pm, FM of Resident #2 stated the facility called them the morning of 3/7/2026 and said they were moving Resident #2 to another facility, and they needed to come and get her stuff. FM stated the NF called them an hour or two before they moved her and the family was given no choice where she was being moved. FM stated they did not have time to do anything but go up to the facility and get her belongings. FM stated this was very upsetting to the entire family because they did not get any notice she was being moved and did not have any time to prepare. During an interview on 4/8/2026 at 2:16 pm, admission Director stated she spoke to Resident #2's FM when Resident was leaving on 3/7/2026. She stated she had not called the RP and had not notified them that resident was being moved, she thought another staff had already done that. During an interview on 4/8/2026 at 2:33 pm, Nurse A stated she completed the progress note when Resident #2 left the facility. She stated Resident #2 was transferred over to the hall where she was working on 3/6/2026, late in the afternoon. She stated she had come in the next morning on 3/7/2026 and a staff member said they were discharging her and transferring her to another facility due to her wandering. Nurse A stated she could not remember who told her about the transfer. She stated she had not called the RP about the transfer because she thought it had already been done. She stated in her mind the family was aware of the transfer because later in the day they were in the building getting Resident #2's belongings. (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

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 04/15/2026

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an Interview on 4/8/2026 at 2:48 pm, CNA B stated she had been working as a social worker assistant and did not find out about Resident #2 discharging until she came back to work on 3/9/2026. She stated typically she would contact the RP about a transfer or discharge. She stated she would let them know other facilities that are available for transfer and once the RP chose a facility, they will send the clinical information over to see if the resident will be accepted. She stated she did not speak to the RP for Resident #2 about her being discharged and had not sent any clinical information over to other facilities. She stated she came in on Monday, 3/9/2026 and Resident #2 was gone. During an interview on 4/8/2026 at 3:49 pm, ADM stated his expectations were that staff would have communicated with Resident #2's RP prior to a transfer or discharge. He stated he thought staff had spoken to the family on Friday 3/6/2026, but acknowledged there was no documentation in the EMR. He stated Resident #2 was having exit seeking behaviors and needed a facility with a secure unit, so they transferred Resident #2 to their sister facility. He stated that typically they will notify the RP of the facility options and wait for the RP to make a decision, then they will send the clinical information and follow up to complete the transfer. He stated he was unaware this had not been done for Resident #2. Resident #3 Review of Resident #3's face sheet dated 4/1/2026, reflected a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included: acute respiratory failure with hypoxia (condition where the body tissues do not received enough oxygen), type 2 diabetes (blood sugar regulation disorder), cognitive communication deficit, hypertension (high blood pressure) and muscle weakness. Review of Resident #3's BIMS assessment dated [DATE], reflected a score of 1 suggesting severe cognitive impairment. Review of Resident #3's care plan with a closed date of 4/6/2026 reflected: Focus - At risk for falls r/t DEMENTIA, WEAKNESS, FOOT ULCER WITH UNSTEADY GAIT/TRANSFERDate Initiated: 03/14/2026. Goal: Will minimize risk of injury. Review of Resident #3's progress notes from 3/17/2026 to 3/26/2026 when resident discharged reflected no entries from any facility staff about resident's fall. Review of Resident #3's progress notes dated 3/23/2026 at 6:15 am by Nurse F reflected: This nurse did body assessment last night and noticed a bruise on the resident right upper arm and the resident had pain with movement. When asked what happened resident did not know. Writer notified NP and received N/O for x-ray 2V right shoulder, humerus, and elbow to rule out fracture. RP [FM] notified. ADON was in building and notified. Review of Resident #3's progress notes for from 3/17/2026 until 3/27/2026, reflected no notes regarding RP notification of Fall. Review of Resident #3's radiology report dated 3/23/2026 reflected: Impression: The bones are osteoporotic. The acute right humeral head fracture is present (osteoporotic - metabolic disease causing weak, brittle bones, humeral head fracture - broken or cracked upper arm bone) During an interview on 4/1/2026 at 1:27 pm FM of Resident #3 stated they received a call on 3/22/2026 notifying them of the bruising and injury to Resident #3's right arm and that an x-ray had been ordered. FM stated they were unaware that the resident had fallen the previous week until this investigator informed them on this day. They stated if the facility failed to call them about this fall - they would have concerns about other events that may have happened and they were not notified. During an interview on 4/15/2026 at 11:10 am, Nurse F stated she completed a weekly skin assessment on Resident #3 and noticed an injury with bruising. She called the provider and received an order for an x-ray and then called the RP to let them know about the injury and x-ray. Nurse F stated she did not inform family about the fall because she was not aware at that time that Resident #3 had sustained a fall. During an interview on 4/15/2026 at 11:40 am, CNA C stated she found Resident #3 on her floor mat in her room by her bed on either 3/17/2026 or 3/18/2026 in the evening. She stated she went to the nurses station and notified Nurse E of the fall and CNA D was standing there and came down to the room to help. She stated that when a resident falls, she is supposed to report it to her charge nurse and then the charge nurse is responsible from there. CNA C stated CNAs do not notify RPs of falls; they tell the charge nurse, and the charge nurse calls the family. She stated she came back to work several days later and heard about Resident #3's injury so she went to DON and told them about (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her fall and that is when she found out the fall had not been reported by Nurse E. During an interview on 4/15/2026 at 1:07 pm, Nurse E stated he did not call Resident #3's MD, RP or FM about her fall on 3/17/2026 or 3/18/2026 because the resident never fell and he did not recall CNA C reporting a fall to him for Resident #3. Nurse E stated if a resident fell, the nurse was responsible for notifying the family and medical providers, completing an assessment and doing an incident report. Nurse E reiterated he was unaware that Resident #3 had fallen. During an interview on 4/15/2026 at 1:55 pm, DON stated they found out about Resident #3's fall from CNA C. DON stated she interviewed Nurse E and he initially denied it several times that Resident #3 had a fall and then he said she was found on her fall mat on the floor but he did not count it as a fall, so he did not report it or make any notifications. She stated Nurse E was termed on 3/26/2026. She stated her expectation is that all falls will be reported and that nursing staff will complete incident reports and make appropriate notifications. During an interview on 4/15/2026 at 1:59 pm, CNA D stated she was with CNA C on 3/17/2026 or 3/18/2026 in Resident #3's room and observed resident on the floor. She stated she was in the room when Nurse E came in and saw Resident #3 on her fall mat by her bed. She stated CNA C reported the fall to Nurse E and when a resident has a fall, CNAs are supposed to report it to their charge nurse and that is what she witnessed that night. During an interview on 4/15/2026 at 2:11 pm, NP stated she was never informed Resident #3 had a fall. She stated she had been notified of Resident #3's arm bruising and injury and had ordered x-rays which were completed in the facility. She stated she was notified of the x-ray results and reviewed the results. She stated her expectations on resident falls was that staff would report it and notify them so that if there is any need for imaging, labs, or injuries to be treated, she can provide orders for care. She stated if falls were not reported, potential injuries could not be discovered or treated. She stated that depending on how the injury occurred, injuries that are not treated could result in long term issues. During an interview on 4/15/2026 at 2:54 pm, MD stated he was informed about Resident #3's fall after the fact when nursing staff discovered a fall had occurred the week prior. He stated his expectations were that staff would notify providers of the fall details and any trauma, bruising, pain, or injury discovered during their assessment. He stated his potential concerns around falls not being reported would be delays in care, lack of documentation and not being able to appropriately treat a resident. Record Review of facility policy Resident Rights dated July 13, 2017, reflected: Information and Communication. You have the right to: be immediately informed when there is: a decision to transfer or discharge you from the facility. Record Review of facility policy Fall Management System dated 4.2025, reflected:3. When a resident sustains a fall, a physical assessment will be completed by a licensed nurse, with results documented in the medical record.a. The attending Physician and Resident Representative shall be notified of the fall and the resident status.

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NAME OF PROVIDER OR SUPPLIER: Legend Oaks Healthcare and Rehabilitation - Waxaha		STREET ADDRESS, CITY, STATE, ZIP CODE: 151 Country Meadows Boulevard Waxahachie, TX 75165	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for one 1 (Resident #1) of ten residents reviewed for quality of care. The facility failed to remove Resident #1's PICC line before he discharged on 3/12/2026. Nurse E failed to report a fall for Resident #3 on or about 3/17/2026 or 3/18/2026. Nurse E failed to assess Resident #3 for injuries after a fall on or about 3/17/2026 or 3/18/2026 These failures placed Resident at risk of injury, infection, not receiving adequate care and services, and decreased quality of life.Findings include: Review of Resident #1's face sheet dated 4/8/2026, reflected a [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included: cellulitis of right lower limb (bacterial skin infection) , cellulitis of left lower limb, muscle weakness, hypertension (high blood pressure), atrial fibrillation (heart rhythm disorder), chronic heart failure (chronic heart condition where the heart cannot pump enough blood) and chronic kidney disease. (long term condition where kidneys are damaged and don't work effectively). Review of Resident #1's admission MDS assessment dated [DATE], reflected a BIMS score of 13 suggesting no cognitive impairment. Review of Resident #1's discharge summary progress note dated 3/12/2026 at 3:42 pm by Nurse G reflected: Patient completed IV antibiotics r/t cellulitis. Reason for discharge: The Resident's health has improved sufficiently, resident no longer needs the services of the facility. Review of Resident #1's discharge assessment dated [DATE] at 3:54 pm by Nurse G reflected Patient completed IV antibiotics r/t cellulitis. The assessment indicated there were no skin issues and no special instructions. There was no mention of the PICC line in the assessment. Review of Resident #1's orders on 4/8/2026 reflected there was no order to have the PICC line removed. Review of Resident #1's care plan with a closed date of 3/16/2026 reflected resident was receiving IV antibiotics for cellulitis. During an interview on 4/8/2026 at 11:25 am, MD stated he was not aware that Resident #1 was discharged with the PICC still inserted until later. He stated the resident had completed his antibiotic therapy and it is standard of care to remove PICC lines prior to discharge unless there is a rare circumstance. He stated Resident #1 should have had his PICC line removed prior to discharge. MD stated the PICC was removed by nursing staff the next morning and there were no bad outcomes. He stated a potential concern could be infection and possibly cellulitis if it was left in too long but Resident #1's was only left in overnight. He stated it was an unfortunate situation and they tried to correct it as soon as they found out. MD reiterated he had no immediate concerns since the PICC line was removed the next day. During an interview on 4/8/2026 at 11:58 am, DON 2 stated she was aware that Resident #1 was discharged on 3/12/2026 with his PICC still inserted. She stated she received a telephone order from NP on 3/13/2026 in the morning to remove Resident #1's PICC line. She stated she and another nurse went to Resident #1's house on 3/13/2026 in the morning and she removed his PICC line. She stated she assessed the site and there were no skin issues noted and the PICC was removed completely. She stated a concern for leaving a PICC line in after discharge could be injury at the site, infection or the resident could have pulled it out and started bleeding. She stated she was not able to document any of this in the EMR because resident had already been discharged . During an interview on 4/8/2026 at 12:23 pm, Resident #1's FM stated they noticed that evening the PICC line was still in his arm. They stated they called up to the facility the evening on 3/12/2026 and told the staff, then the next day two nurses came out in the morning and removed the PICC line. FM stated they checked Resident #1 over and he was fine and there were no issues. During an interview on 4/8/2026 at 12:25 pm, Resident #1 stated he discharged on 3/12/2026 and forgot he still had the PICC line in his arm. He stated he was in his bedroom later that evening and then saw it still in his arm. He stated he notified his FM who called the facility and let them know. He stated it did not cause any problem and denied any issues with the site or bleeding. During an interview on 4/8/2026 at 3:49 pm, ADM stated he was aware that Resident #1 was discharged with the PICC line (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER: Legend Oaks Healthcare and Rehabilitation - Waxaha		STREET ADDRESS, CITY, STATE, ZIP CODE: 151 Country Meadows Boulevard Waxahachie, TX 75165	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	still inserted. He stated his expectation is that PICC lines will be removed prior to discharge unless there is an order to keep it in. He stated staff should have gotten an order to remove Resident #1's PICC line especially since he was done with his antibiotic therapy and discharged shortly after. During an interview on 4/8/2026 at 5:20 pm with Nurse G, she stated she completed the discharge assessment on Resident #1 and did not realize or remember that he had a PICC line. She stated she knew he had been on IV antibiotics, but when she discharged him that morning, she did not see a PICC line. She stated she did not think to look for a PICC line because he had completed his antibiotics. She stated she was not aware he had been discharged with the PICC line and not aware nursing staff had gone to his house to remove the PICC. She staed if a resident has a PICC at discharge they are supposed to notify the RN on duty as only RNs can remove PICC lines. She stated she did not notify the RN because she did not know he still had his PICC line. She stated a potential concern with a resident still having a PICC line in at discharge could be infection or possibly pulling the line out accidentally. Resident #3 Review of Resident #3's face sheet dated 4/1/2026, reflected a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included: acute respiratory failure with hypoxia (condition where the body tissues do not received enough oxygen), type 2 diabetes (blood sugar regulation disorder), cognitive communication deficit, hypertension (high blood pressure) and muscle weakness. Review of Resident #3's BIMS assessment dated [DATE], reflected a score of 1 suggesting severe cognitive impairment. Review of Resident #3's care plan with a closed date of 4/6/2026 reflected: Focus - At risk for falls r/t DEMENTIA, WEAKNESS, FOOT ULCER WITH UNSTEADY GAIT/TRANSFERDate Initiated: 03/14/2026. Goal: Will minimize risk of injury. Review of Resident #3's progress notes from 3/17/2026 to 3/26/2026 when resident discharged reflected no entries from any facility staff about resident's fall or post fall assessment. Review of Resident #3's progress notes dated 3/23/2026 at 6:15 am by Nurse F reflected: This nurse did body assessment last night and noticed a bruise on the resident right upper arm and the resident had pain with movement. When asked what happened resident did not know. Writer notified NP and received N/O for x-ray 2V right shoulder, humerus, and elbow to rule out fracture. RP [FM] notified. ADON was in building and notified. Review of Resident #3's skin assessment dated [DATE] by Nurse F reflected resident had bruising on her right upper arm and decreased range of motion. Review of Resident #3's radiology report dated 3/23/2026 reflected: Impression: The bones are osteoporotic. The acute right humeral head fracture is present (osteoporotic - metabolic disease causing weak, brittle bones, humeral head fracture - broken or cracked upper arm bone) During an interview on 4/15/2026 at 11:10 am, Nurse F stated she completed a weekly skin assessment on Resident #3 and noticed an injury with bruising. She called the provider and received an order for an x-ray and then called the RP to let them know about the injury and x-ray. Nurse F stated she was not aware at that time that Resident #3 had sustained a fall. During an interview on 4/15/2026 at 11:40 am, CNA C stated she found Resident #3 on her floor mat in her room by her bed on either 3/17/2026 or 3/18/2026 in the evening. She stated she was in another resident's room and as she was coming out of the room, she heard a thud. She walked into Resident #3's room and she was on the floor mat on the floor. She stated she went to the nurses' station and notified Nurse E of the fall and CNA D was standing there and came down to the room to help. She stated Nurse E came in the room, scooped up the resident under both arms and put her in her wheelchair. Then she and CNA D wheeled Resident #3 down to the nurse's station. She stated she did not see any visible injuries or bleeding, and the resident did no cry our in pain or make any facial expressions of pain. She stated she did not see Nurse E assess resident, did not take vitals signs, and did not check her pupils.She stated that when a resident falls, she is supposed to report it to her charge nurse and then the charge nurse is responsible from there. She stated she came back to work several days later and heard about Resident #3's injury so she went to DON and told them about her fall and that is when she found out the fall had not been reported by Nurse E. During an interview on 4/15/2026 at 1:07 pm, Nurse E stated he did not call Resident #3's MD, RP or FM about her fall on 3/17/2026 or 3/18/2026 because the resident never fell and he did not recall CNA C reporting a fall to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	him for Resident #3. Nurse E stated if a resident fell, the nurse was responsible for notifying the family and medical providers, completing an assessment and doing an incident report. Nurse E reiterated he was unaware that Resident #3 had fallen, so he did not complete an assessment of the resident because there was no fall. During an interview on 4/15/2026 at 1:55 pm, DON stated they found out about Resident #3's fall from CNA C. DON stated she interviewed Nurse E and he initially denied it several times that Resident #3 had a fall and then he said she was found on her fall mat on the floor but he did not count it as a fall, so he did not report it or make any notifications. She stated Nurse E was termed on 3/26/2026. She stated her expectation is that all falls will be reported and that nursing staff will complete incident reports and make appropriate notifications. During an interview on 4/15/2026 at 1:59 pm, CNA D stated she was with CNA C on 3/17/2026 or 3/18/2026 in Resident #3's room and observed resident on the floor. She stated she was in the room when Nurse E came in and saw Resident #3 on her fall mat by her bed. She stated CNA C reported the fall to Nurse E and when a resident has a fall, CNAs are supposed to report it to their charge nurse and that is what she witnessed that night. She stated she observed Nurse E came in the room and immediately picked up Resident #3 under her arms and put her in the wheelchair. She stated her and CNA C pushed Resident #3 in her wheelchair down to the nurses station. She stated she never saw Nurse E check the resident over or do any vital signs or check her body for any injuries. She stated she did not observe any bleeding from the resident and the resident did not cry out in pain or make any faces when she was moved by Nurse E. During an interview on 4/15/2026 at 2:11 pm, NP stated she was never informed Resident #3 had a fall. She stated she had been notified of Resident #3's arm bruising and injury and had ordered x-rays which were completed in the facility. She stated she was notified of the x-ray results and reviewed the results. She stated her expectations on resident falls was that staff would assess the resident, report it and notify them so that if there is any need for imaging, labs, or injuries to be treated, she can provide orders for care. She stated that if residents were not assessed after a fall, there could be potential injuries that were not discovered or treated. She stated that depending on how the injury occurred, injuries that are not treated could result in long term issues. During an interview on 4/15/2026 at 2:54 pm, MD stated he was informed about Resident #3's fall after the fact when nursing staff discovered a fall had occurred the week prior. MD stated it was possible that the fall contributed to Resident #3's injury, but due to the length of time between when the fall occurred and the injury was discovered he can't say one way or the other. He stated his expectations were that staff would assess the resident, notify providers of the fall details and any trauma, bruising, pain, or injury discovered during their assessment. He stated his potential concerns around residents not being assessed would be delays in care, lack of documentation and not being able to appropriately treat a resident. A facility policy on PICC line removal was requested but not provided prior to exit. Review of the undated facility procedure on PICC Line Removal provided, reflected no instructions/guidance on removal of PICC prior to discharge. A facility Policy on Quality of Care dated revised 7/2020 reflected: 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. Record Review of facility policy Fall Management System dated 4.2025, reflected:3. When a resident sustains a fall, a physical assessment will be completed by a licensed nurse, with results documented in the medical record.a. The attending Physician and Resident Representative shall be notified of the fall and the resident status.