

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676426	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation - Fort W		STREET ADDRESS, CITY, STATE, ZIP CODE 4240 Golden Triangle Boulevard Keller, TX 76244	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible and each resident received adequate supervision and assistive devices to prevent accidents for 1 of 4 residents (Resident #1) reviewed for supervision. The facility failed to ensure Resident #1, who was a high risk for elopement for which he wore a WanderGuard device, was provided with adequate supervision to prevent him from exiting the building on 07/28/25. Despite the WanderGuard alarm sounding, RN A turned the alarm off without immediately going outside to determine if there was a resident elopement. The resident was found approximately nine hours after he went missing. He was found two miles away from the facility by the local police department following an extensive search. The noncompliance was identified as past non-compliance. The Immediate Jeopardy (IJ) began on 07/28/25 and ended on 07/29/25. The facility had corrected the noncompliance before the survey began. This failure placed residents at risk of harm and/or serious injury. Findings included: Record review of Resident #1's admission MDS assessment, dated 07/03/25, reflected the resident was an [AGE] year-old male, who was admitted to the facility on [DATE]. The resident's diagnoses included Alzheimer's Disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline), cerebral ischemia (inadequate blood supply to the brain), hypertension (high blood pressure), muscle weakness (a condition where your muscles cannot work with the expected amount of force). The MDS reflected Resident #1 had severe cognitive impairment with a BIMS score of 00. Resident #1 did not exhibit wandering behaviors. The MDS further reflected Resident #1 had Wander/elopement alarm (bracelet detected near a sensor, the system triggers an alert). Record review of Resident #1's care plan, dated 06/24/25, reflected Focus: Elopement risk/wanderer r/t Impaired safety awareness. Goal: Will not leave facility unattended through the review date. Interventions: Document wandering behavior and attempted diversional interventions. Monitor placement and function of Wander Guard Q Shift Wander Guard to Right ankle expiration date 02/24/26. Record review of Resident #1's Elopement Risk Evaluation, dated 06/29/25, reflected Resident #1 was a high risk for elopement. The evaluation indicated Resident #1 had a diagnosis of dementia and Alzheimer's disease. Ambulation: Ambulates independently or with supervision. Mental status: Disoriented. History of elopement in the last 6 months: Two or more Episodes. Does the wandering place the resident at significant risk of getting to a potentially dangerous place (stairs, outside the facility): 2. Yes, wandering is aimless w/potential to go outside, active exit seeking behavior. Record review of Resident #1's physician orders dated 07/01/25, reflected Wander guard to right ankle every day shift every 90 day(s) for wanderguard. Record review of Resident #1's progress notes dated 07/29/25 at 2:02 AM by RN A reflected: Resident active walking on the hallway upon arrival at 1800 [6:00 PM] appeared happy had a smile on his face and very talkative in Spanish. Tolerated his HS meds. Resident started following this nurse while passing the medicine. Approximate 2000 [8:00PM] this nurse did not see resident in the hallway. The nurse and CNA started looking for him in the rooms of 600 hall, we did not see him. This nurse called for code white alerted all the staff in the facility and we started looking for him in and out of the facility. Family called and left them a message to call the facility. The family called back later and told this nurse they will come over to the facility. Administrator was notified. Record review of Resident #1's progress notes dated 07/29/25 at 4:53 AM by Clinical Market Leader reflected: 4:50am police arrived to facility with resident in back seat. Resident able to stand and transfer to wheelchair and brought into facility for assessment by charge nurse. Family also arrived behind police and notified of return to facility. Police notified this writer that EMS would arrive shortly to assess him as this was their protocol. Resident alert and denies pain, water in hand, assisted to his room by nurse and family. Record review of the facility's Provider Investigation Report, completed by the Administrator on 08/05/25, reflected the following: Incident date: 07/28/25, Time of Incident: 8:00 PM Description of the Allegation: Resident missing from facility Assessment Date: 07/29/25; Time: 4:55 AM; Charge nurse completed head to toe assessment upon resident return on 7/29/25 @ apprx. 4:55 a.m - no injuries notes, resident mood was pleasant and friendly. EMS arrived at apprx. 5:10 a.m. (per PD policy). Completed assessment as well - no concerns. Vitals within normal limits. Attending physician assessed at apprx. 10:30 a.m. no injuries notes - suggested precautionary CBC - normal results - Skin assessment completed during shower by c.n.a. no issues noted. Provider Response: The facility initiated missing resident protocol. Implementing search efforts to include inside facility, outside the facility and an extensive search of</p>		