STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676426	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation - Fort W	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)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to ensure residents received care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable for 1 of 5 residents (Resident #1) reviewed for pressure ulcers. The facility failed to ensure Resident #1 did not develop a pressure wound to his left heel. This failure could place residents at risk of infection or a deterioration of their health.Findings included:Record review of Resident #1's admission MDS assessment , dated 02/06/26, reflected he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included fracture of left upper arm, stroke affecting his left side, muscle weakness, and history of falls. He was discharged home on [DATE]. Resident #1's BIMS score was 14, indicating he was cognitively intact. His Functional Abilities assessment indicated he walked with the assistance of a walker, had impairment of the left arm, and required some assistance with his ADLs. Record review of Resident #1's care plan, dated 02/03/26, reflected he was admitted with a wound to his left elbow, and then developed a pressure ulcer to his left heel . He also had impaired physical mobility, and at risk of decreased tissue circulation. Record review of Resident #1's Braden Scale for predicting pressure ulcer risk evaluation date 02/03/26 reflected a score of 14 which made him a Moderate Risk. Record review of Resident #1's admission Assessment, completed 02/03/26 by RN-A, reflected he had a skin issue to his right inner forearm that was present on admission. RN-A documented in her admission note Skin/wound assessment: Fracture in humerus to the left hand, wear a sling. Record review of Resident #1's physician orders reflected the following orders: 02/11/26 - Cleanse left heel with wound cleanser, pat dry with 4x4 gauze, apply dry dressing every day shift every Mon, Wed, Fri02/25/26 - keep left heel on bunny boot at all times, to prevent heel from rubbing against surface and promote healing. every shift for wound Record review of Resident #1's Therapy notes reflected that the resident was seen in the gym by Physical, Occupational, and Speech therapies daily from 02/03/26 to 02/26/26 for several hours a day, except on the weekends. Record review of Resident #1's skin note on 02/06/26 by the Wound Care Nurse documented a bruise to the right inner forearm and a traumatic wound to the left elbow. Record review of Resident #1's skin note on 02/10/26 by RN-B documented new wound on Resident #1's left heel, which was described as an open blister that was acquired in-house. The note reflected that the skin on the left heel was partially intact and degloved (skin torn away from the body, resembling a glove being stripped off). No other notes describing the blister were found.Record review of Resident #1's hospital records for admission on [DATE] revealed he had suffered a fall at home resulting in a fracture to his left upper arm and a wound to his left elbow. No issues noted with the right arm. Record review of Resident #1's hospital records from admission on [DATE] revealed the resident had been brought to the hospital from home by his family. He was diagnosed with a stage III pressure ulcer to his left heel measuring 6cm x 6cm (pg. 23) In an interview on 03/25/26 at 2:05 PM, Resident #1's family member stated the resident was admitted to the facility after suffering a fall at home and injuring his left arm. The family member stated therapy staff were the only ones who would get the resident out of bed, and he spent the rest of his time in bed. The Family Member stated she visited (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #1 daily, and he was always in his bed. The Family Member stated staff told her the resident was too unsteady to be out of bed, and it was safer for him to be in bed or in a wheelchair. The Family Member stated Resident #1 had been living independently previously and would not use a wheelchair, preferring to keep using his walker. The family member stated the facility did not put any offloading or other preventative measures in place until after the wound to his heel developed. The resident was at another facility and doing better with therapy. In an interview on 03/26/26 at 11:00 AM, the Wound Care Nurse stated Resident #1 was admitted with the injury to his left elbow but the wound to his left heel was acquired in the facility. She stated the most likely cause was his lack of mobility and friction from the bed and sheets. She stated she was alerted to the wound on 02/11/26, and after assessing it she contacted the Wound Care Physician for treatment orders. She stated when the resident was admitted they did not start off-loading practices because he was reported to be ambulatory and able to move about. After the wound on the resident's heel developed, she placed the foam boot for padding and protection of the heel. She stated the wound measured 5.5 cm X 5 cm on her first assessment. In an interview on 03/26/26 at 12:30 PM, the Director of Rehabilitation stated Resident #1 had made minimal progress in his mobility after working with Physical Therapy. The resident remained unsteady and continued using his walker when out of bed. In an interview on 03/26/26 at 1:27 PM, LVN-C stated Resident #1 was confused at times, he would get out of bed without assistance to go to the bathroom. The resident was unsteady when using his walker, and he was encouraged to remain in bed so he would not fall. The resident did not want to participate in activities, and he spent most of his time in bed except when he was working with therapy. LVN-C stated she could not recall when the preventative measures were put in place but did know it was not until after he had the wound on his heel. She stated since he was able to turn himself, and he was getting out of bed, they would not have necessarily implemented any precautionary measures. She did not know what his Braden score was without being able to review his chart, but she did not think he was very high risk.In an interview on 03/26/26 at 2:00 PM, the Physician stated Resident #1 had a history of vascular issues and other medical problems that would have made him prone to pressure ulcers, but she could not say what caused the wound to develop. In an interview on 03/26/26 at 3:30 PM following the exit conference, the Administrator and the DON returned with the Physician on the phone. The Physician stated Resident #1's pressure ulcer was unavoidable due to his vascular issues and his medical condition. The DON stated with the resident being ambulatory, staff would not have placed heel protection boots on him. The DON was unable to state if the resident's Braden Scale, scoring him as a moderate risk for pressure ulcers was accurate without reviewing it .