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	04/17/2026

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 0689 Level of Harm - Actual harm Residents Affected - Some	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 observation, interview, and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #1) reviewed for accidents.The facility failed to address the root cause of Resident #1's multiple falls, failed to implement therapy recommendations, and failed to implement interventions to prevent the resident from falling from his wheelchair from November 2025 to February 2026. On 12/02/25, Resident #1 fell from his wheelchair and sustained a laceration to the top of his left eyebrow and required four sutures on 02/07/26 when Resident #1 again fell from wheelchair and sustained an abrasion to the forehead and a hematoma of the scalp and during a scan Resident #1 was also found to have a subacute (condition that falls between sudden and long term/persistent) to chronic appearing nonunion fracture (broken bone that fails to heal) of the posterior left 11th rib. This failure could place residents at risk for serious injury or harm, decline in health, and decreased quality of life. Findings included:Review of Resident #1 quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Alzheimer's disease, non-Alzheimer's dementia, seizure disorder, anxiety disorder, difficulty walking, cognitive communication deficit, , and muscle weakness. The MDS reflected Resident #1 had unclear speech and usually understood others and had a BIMS of 0 which indicated his cognition was severely impaired. The MDS also reflected that the resident was in a manual wheelchair and was dependent for all ADLs. The MDS further reflected Resident #1 had 2 or more falls since admission. Review of Resident #1's care plan revised on 02/16/26 reflected the resident had actual falls related to poor balance and unsteady gait. 11/09/25 - Actual fall no injury11/14/25 - Actual fall no injury 12/02/25 - Actual fall with laceration to top of left eye12/06/25 - Actual fall with no injury 12/31/25 - Actual fall with laceration to left upper eyebrow01/24/26 - No injury01/25/26 - No injury02/07/26 - No injury 02/14/26 - No injuryInterventions included:- Staff to provide resident with activities - Staff to assist resident back to bed after breakfast- Staff to proper reposition resident in wheelchair at the table during lunch- Staff to provide resident with fidget blanket while sitting up in wheelchair in dining room - Staff to assist resident back to bed after lunch- Bed in lowest position - Floor mat- Staff to ensure resident is properly positioned in bed during rounds- Therapy consult for strength and mobilityReview of Resident #1's Fall Risk Evaluation dated 10/23/25 reflected the resident was high fall risk. Review of Resident #1's incident reports from November 2025 to February 2026 reflected:*11/09/25 documented by RN A - Resident fell down from the chair in the dining room.This nurse did head to toe assessment and no injuries were noted and was put back safely in bed. *11/14/25 documented the Previous DON - Resident had a fall in the dining room, was assessed and no injuries noted.*12/02/25 - documented by LVN B - nurse observed the resident on the floor in prone position, wheelchair behind him, his head on the table. Head to toe assessment done and skin laceration to top of the left eye noted. The resident was sent to the ER for further evaluation. The resident was unable to give description. *12/06/25 - documented by LVN C - called into the front lobby and the resident was observed in a sitting position on the floor in front of the wheelchair. Staff observed him slide out of the wheelchair (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
	676426	A. Building B. Wing	04/17/2026

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 0689 Level of Harm - Actual harm Residents Affected - Some	during an activity. Assessed for injury and was able to move all extremities. The resident was assisted back into bed. *12/31/25 - documented by LVN D - Resident was seen sliding out of his wheelchair to the floor of the dining room. Resident was laying on the floor on his left side when the nurse assessed him. The resident was unable to give description and head-to-toe assessment was completed and no injuries were noted. Resident rested comfortably in the wheelchair at that time. *01/24/26 - documented by LVN E - Upon entering the dining room the resident was observed laying on the floor in front of his wheelchair. The nurse assessed the resident for injuries and was transferred back to the wheelchair. The resident was unable to give description. *01/25/26 - documented by RN A - Resident had an unwitnessed fall in the dining room and was found on the floor. The resident was assisted back to the wheelchair and head to toe assessment was done and there were no injuries noted. Encouraged the resident not to get up without assistance and press call light when needed. *02/07/26 - documented by LVN F - Resident was found on the floor lying on his right side with a cut noted to the right side of his head. The resident was sent out to the hospital for evaluation and treatment. *02/14/26 - documented by LVN G - The patient was found lying on the left side near the head of the bed. No injuries were noted. Review of Resident #1's hospital dated 12/02/25 reflected the following: .pt fell forward out of wheelchair and hit head onto tile floor.Laceration noted to L eyebrow.Number of sutures: 4. Review of Resident #1's hospital records dated 02/07/26 reflected the following: .Abrasion to forehead.Fall from wheelchair.Hematoma of scalp.Subacute to chronic appearing nonunion fracture of the posterior left 11th rib.Review of Resident #1's progress notes dated 02/19/26 documented by the Social Worker revealed hospice delivered a wheelchair that was not appropriate for the resident. Observation on 04/16/26 at 9:43 AM revealed Resident #1 was in the activity room in a padded reclining wheelchair with one of his legs over the right side of the chair and the chair was next to the Activity Director. Resident #1 appeared to try to lean forward and touch his shoe, but body stayed in an upright position and there were no concerns of a fall. Observation and interview on 04/16/26 at 12:03 PM revealed Resident #1 was in the dining room sitting in his padded high back reclining wheelchair being fed by his family. Resident #1's family said they were very happy about the resident's current reclining chair and felt the resident would be safer in it. The resident's family said she had been told by the MDS Nurse that the reclining chair that was provided by hospice was a restraint, but the family said they were worried about the resident's safety more than the wheelchair being a restraint. Resident #1 was spoken to, but he did not make long eye contact and when he tried to speak, his words were not coherent. Interview on 04/16/26 at 12:54 PM with CNA H revealed she worked with Resident #1, and she was told the resident had a history of frequent falls out of his manual wheelchair. The resident fell in the dining room a couple times when she worked but did not recall the dates but said Resident #1 had not sustained any injuries. CNA H said she was told Resident # should be put to bed after every meal and other interventions included to keep an eye on him and reposition the resident in his wheelchair. CNA H further stated the resident had recently been put in a new reclining wheelchair from hospice and Resident #1 was doing much better and had not had recent falls. Interview on 04/15/26 at 1:16 PM with RN A revealed she worked with Resident #1 when he had a few of his falls but did not recall the dates. RN A said the resident was in a regular wheelchair that he would slide out of and/or fall forward from because Resident #1 was not able to hold himself for more than 5 to 10 minutes. RN A said they would try to reposition the resident in his wheelchair but there were no other interventions put in place until the resident recently got his new reclining wheelchair from hospice. RN A further stated the new chair was much better for Resident #1 because it kept him from leaning forward and he had not had recent falls.Interview on 04/16/26 at 2:23 PM with the OT revealed Resident #1 was put on therapy caseload on 10/14/25 and per the PT notes, the resident's goals were to reduce his falls from reaching forward and to improve trunk control. The OT said Resident #1 was not aware or capable of alertness processing due to his cognition. The OT said that because of his lack of awareness and poor trunk control staff were to frequently reposition the resident in his wheelchair to (continued on next page)

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	04/17/2026

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 0689 Level of Harm - Actual harm Residents Affected - Some	try to prevent falls. The OT further stated she did not recall any other intervention put in place other than repositioning Resident #1 to prevent falls. Interview on 04/16/26 at 3:35 PM with the MDS Nurse revealed Resident #1 has frequent falls and his mattress was changed and he was put in a low bed. The MDS Nurse stated she was under the impression that a reclining Broda chair was a restraint and due to her years of experience in the field, management at the time trusted her opinion of a reclining wheelchair. The MDS Nurse said Resident #1's family brought the idea of a reclining wheelchair to her attention, but the MDS Nurse had told the family the same thing about it being a restraint. The MDS Nurse further stated the hospice company had brought the resident a new padded reclining wheelchair and he appeared to be doing well in it although there were times the resident would try to swing his legs over it therefore required increased supervision. The MDS Nurse said, moving forward, they would take a resident's condition and cognition during a safety assessment for the need of a reclining wheelchair.Interview on 04/17/26 at 10:19 PM with the Director of Rehab revealed they worked with Resident #1 on balance with the resident because he could not be educated on safety awareness or take verbal cues due to his impaired cognition. The Director of Rehab said the resident was able to sit up for 5 minutes at a time, but that length decreased as time went by due to his lack of trunk control. The Director of Rehab was aware of Resident #1's frequent falls and normally they would attempt a different type of cushion or drop the seat of the wheelchair, but she was told that would be a restraint for the resident because that would prevent him from attempting to get up. The Director of Rehab said she reviewed Resident #1's records and there were no other inventions put in place to try and prevent his falls. The Director of Rehab said moving forward they would take a resident's condition and cognition during a safety assessment for the need of a reclining wheelchair.Interview on 04/17/26 at 1:36 PM with LVN B revealed Resident #1 had a couple falls during her shift in the dining room but she did not recall the dates. LVN B said the resident would be in his wheelchair one minute and the next he was on the floor. LVN B said the resident's falls were because of his condition had declined and he always tried to lean his head forward or on the dining room table. Resident #1 had to be frequently watched and reposition to try to avoid falls but since hospice had brought the new reclining wheelchair, the resident had not had any falls. Interview on 04/17/26 at 1:49 PM with CNA I revealed Resident #1 appeared to have some drastic body movements due to his cognition. CNA I said that no matter how much or often the resident was repositioned in the wheelchair he would lean to the side or forward. CNA I said the only interventions they were told to help reduce his falls were to try to lay him down after meals and continue to reposition and monitor as often as they could. CNA I further stated Resident #1 continued to have frequent falls until hospice brought in the padded reclining wheelchair because the resident was no longer able to move forward. Interview on 04/17/26 at 2:19 PM with the Previous DON revealed she no longer worked at the facility therefore did not recall all the interventions that were put in place for Resident #1's falls. The Previous DON recalled Resident #1 was put to bed after meals because most of the falls had occurred in the dining room and when the resident was admitted to hospice, he was given a high back reclining wheelchair. The Previous DON further stated staff were to reposition the resident in his chair to try and prevent falls. Interview on 04/17/26 at 3:39 PM with the Current DON revealed she began working at the facility on 03/23/26. The Current DON said they would implement a root cause to each resident and add appropriate interventions to each incident report and update the resident care plans to try and prevent resident falls. Review of other residents who were a high fall risk were in an appropriate wheelchair conducive to their needs and the rooms were equipped with low beds, scoop mattresses, and fall mats in place.Review of the facility's policy titled Fall Management System revised on 12/2003 reflected the following: Policy It is the policy of this facility to provide an environment that remains as free of accident hazards as possible. It is also 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.7. The QAA Committee will analyze trends related to falls and will determine if further intervention is needed.