| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676426 | A. Building<br>B. Wing | 06/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Legend Oaks Healthcare and Rehabilitation - Fort W | 4240 Golden Triangle Boulevard<br>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) |
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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident was free of any significant medication errors for 1 of 6 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure Resident #1, who was diagnosed with Stage 4 renal carcinoma (kidney cancer), was administered his physician ordered oral chemotherapy medication, axitinib 3 mg bid, to treat his advanced kidney cancer. On 05/27/26 a computed tomography (CT) scan showed a 2 mm increase in the mass on Resident #1's right kidney. An Immediate Jeopardy (IJ) was identified on 06/12/26 at 4:16 p.m. and an IJ Template was provided to the Administrator at 4:50 p.m. While the IJ was removed on 06/13/26, the facility remained out of compliance at a scope of pattern with the severity level of no actual harm with potential for more than minimal harm that was not an immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of not receiving therapeutic dosages of medication as ordered by the physician, which could cause serious harm, worsening of condition, or death.Findings included:Record review of Resident #1's Quarterly MDS Assessment, dated 05/11/26, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. The MDS Assessment under Section C-Cognitive Patterns reflected Resident #1 had a BIMS score of 0, which indicated severe cognitive impairment or irresponsiveness. The MDS Assessment under Section GG-Functional Abilities reflected Resident #1 did not have limited range of motion or require any mobility devices. The MDS Assessment under Section GG-Functional Abilities (mobility devices) reflected Resident #1 required a wheelchair for mobility. The MDS Assessment under Section GG-Functional Abilities (self-care) reflected Resident #1 substantial assistance with most ADLs. The MDS Assessment under Section I-Active Diagnoses reflected Resident #1's active diagnoses included: cerebral infarction (stroke), aphasia (communication disorder), delirium (sudden, severe stated of confusion), hemiplegia and hemiparesis (weakness and paralysis that affects one side of the body), and cancer. Record review of Resident #1's care plan, revised 10/20/25, reflected the resident had chemotherapy related to renal cell carcinoma (cancer). The care plan interventions included: giving medications and treatments as ordered, monitoring and documenting for side effects, activities to divert attention from effect of chemotherapy, keeping environment clean to prevent risk of infection, monitoring nutritional status and intervening as indicated, and reporting any side effects or complications to the MD. Record review of Resident #1's progress notes, dated 04/01/26-06/11/26, reflected the following: 04/21/26 at 8:34 p.m. - RN D wrote: [RN D] called to [family] regarding a refill for Axitinib Oral Tablet 1 MG 3 tablet by mouth two times a day for renal cell carcinoma, for a total of 3mg. The [family] stated she will bring the medication this morning. Further review of this document reflected there were no other notes regarding requests or deliveries for axitinib medication. Record review of Resident #1's Out on pass sign out sheets, dates April 2026-June 2026, reflected the resident spent five days with family that required medication administration outside of the facility. Record review of Resident #1's April 2026 MAR reflected axitinib was administered as follows: 04/01/26-04/02/26 - 7:00 a.m. and 7:00 p.m. doses administered; 04/03/26 - 7:00 a.m. dose administered; 04/03/26 - 7:00 p.m. dose coded as 9 which indicated resident was away from facility with medications; 04/04/26 - 7:00 a.m. and 7:00<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | p.m. doses coded as 9 which indicated resident was away from facility with medications;04/05/26 - 7:00 a.m. dose coded as 9 which indicated resident was away from facility with medications; 04/06/26-04/09/26 - 7:00 a.m. and 7:00 p.m. doses administered; 04/10/26 - 7:00 a.m. dose administered; 04/10/26 -7:00 p.m. dose coded as 9 which indicated resident was away from facility with medications; 04/11/26 - 7:00 a.m. and 7:00 p.m. doses coded as 9 which indicated resident was away from facility with medications; 04/12/26 -7:00 a.m. dose coded as 9 which indicated resident was away from facility with medications; 04/12/26 - 7:00 p.m. dose administered; 04/13/26-04/16/26 - 7:00 a.m. and 7:00 p.m. doses administered; 04/17/26- 7:00 a.m. dose administered; 04/17/26 - 7:00 p.m. dose coded as 9 which indicated resident was away from facility with medications; 04/18/26 - 7:00 a.m. dose coded as 8 which indicated resident was absent from facility; 04/18/26 - 7:00 p.m. dose coded as 9 which indicated resident was away from facility with medications; 04/19/26 - 7:00 a.m. dose coded as 9 which indicated resident was away from facility with medications; 04/19/26- 7:00 p.m. dose administered; 04/20/26-04/24/26- 7:00 a.m. and 7:00 p.m. doses administered; 04/25/26 - 7:00 a.m. dose administered; 04/25/26 - 7:00 p.m. dose coded as 9 which indicated resident was away from facility with medications; 04/26/26 - 7:00 a.m. dose coded as 9 which indicated resident was away from facility with medications; 04/26/26 - 7:00 p.m. dose administered;04/27/26 - 7:00 a.m. dose coded as 9 which indicated resident was away from facility with medications; 04/27/26 - 7:00 p.m. dose administered; and 04/28/26-04/30/26 - 7:00 a.m. and 7:00 p.m. doses administered. Record review of Resident #1's May 2026 MAR reflected axitinib was administered as follows: 05/01/26-05/07/26 - 7:00 a.m. and 7:00 p.m. doses administered; 05/08/26 - 7:00 a.m. dose administered; 05/08/26 - 7:00 p.m. dose coded as 9 which indicated resident was away from facility with medications; 05/09/26 - 7:00 a.m. and 7:00 p.m. doses coded as 9 which indicated resident was away from facility with medications; 05/10/26 - 7:00 a.m. dose coded as 9 which indicated resident was away from facility with medications; 05/10/26 - 7:00 p.m. dose administered; and 05/11/26-05/31/26 - 7:00 a.m. and 7:00 p.m. doses administered. Record review of Resident #1's MAR, dated June 2026, reflected axitinib was administered as follows: 06/01/26-06/11/26 - 7:00 a.m. and 7:00 p.m. doses administered; and 06/12/26 - 7:00 a.m. dose administered. Record review of Resident #1's order summary report, dated 06/12/26, reflected in part the following order: Axitinib oral tablet 1 mg-give 3 tablets by mouth two times a day for renal cell carcinoma, total of 3 mg. Start Date: 01/01/26 Further review of the order summary report reflected Resident #1 was not ordered any other medications or treatments for renal cell carcinoma. Record review of Resident #1's clinical chart-after visit summary, dated 5/29/26, reflected in part the following: CT chest abdomen pelvis scan with contrast collected on 5/27/26:Impression:Slight interval increase in size of the exophytic right renal mass invading the right abdominal wall.Slight interval increase in size of adjacent soft tissue metastasis.Mildly enlarged para-aortic lymph nodes.Stable pulmonary nodules likely representing metastatic disease.Assessment and Plan:Metastatic renal cell carcinoma-with renal mass and nodules.Status post 24 months of Keytruda, last October CT scan shows few mm increase (6mm to 8mm) in the mass.Per [RP], [Resident #1] might have missed several doses at the nursing home. Continue on axitinib 3 mg bid Plan to continue until progression or intolerance. Emphasized that [Resident #1] needs to get his medication regulated. In an interview on 06/12/26 at 10:02 a.m., Resident #1's Family Member AA stated Resident #1 was diagnosed with kidney cancer in 2003 that progressed over the years and was currently Stage 4. She stated Resident #1 started axitinib for treatment of his cancer about three years ago, and it was helping to slow the disease. Family Member AA stated Resident #1's tumor was stable for 3-4 months prior to his most recent oncology appointment on 05/29/26 when a CT scan showed a growth of what she initially thought was 1 mm but the lab report showed 2 mm. Family Member AA stated she had ongoing concerns that the facility was not administering Resident #1's axitinib as ordered. She stated there were multiple times the facility had medication remaining when it was time for a refill. She stated LVN A called her on 05/13/26 and informed her that Resident #1 only<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | had six pills remaining and would be completely out at the end of the day. Family Member AA stated Resident #1's most recent bottle of axitinib was delivered to her home on [DATE], and she took it to the facility on [DATE]. She stated she visited the facility about every other day, and the nurses would allow her to count the pills when she requested. Family Member AA stated she counted Resident #1's axitinib on 06/08/26, and he still had approximately 97 pills remaining in the bottle that was provided to the facility on [DATE], which indicated that some doses were missed. Family Member AA stated the facility had not notified her of any issues with the medication, and they denied missing any doses when she inquired about the extra pills remaining. Resident #1's Family Member AA stated since she recently moved, Resident #1 had not been able to spend many nights away from the facility with her, but when he did, she administered his medications as scheduled. She stated Resident #1 had not been away from the facility overnight in about a month. Family Member AA stated she noticed Resident #1 was weaker and more fatigued, but she could not completely contribute it to the missed doses of medication. In an observation on 06/12/26 at 10:15 a.m., LVN A completed a count of Resident #1's axitinib medication, and there were a total of 72 tablets remaining in the bottle. The label reflected a fill date of 05/07/26 with a quantity of 180 tablets. Further observation reflected that there was not a documented date of when the bottle was opened. With order for the resident to receive a total of 6 tablets per day, 72 tablets remaining on 06/12/26 indicated a surplus and significant medication error. In an interview on 06/12/26 at 10:26 a.m., LVN A stated she worked at the facility for a year and worked on the hall with Resident #1. LVN A stated Resident #1 received axitinib as chemotherapy treatment for his cancer, and the medication was provided to the facility by the resident's family. LVN A stated she would notify the family when Resident #1 was down to his last few doses, and the family would bring in a new, unopened bottle. LVN A stated she was the nurse who received Resident #1's current bottle of medication but she could not remember the exact date. She stated it was around the end of May 2026. LVN A stated she just remembered calling the family and informed that he only had 6 pills remaining and a new bottle was brought in the following day. LVN A stated the medication was always available and Resident #1 never missed a dose on her shift. LVN A stated Resident #1 had not complained or shown any signs of being unwell. She stated he enjoyed sitting outside in the sun and had not changed his routine. In an observation and interview on 06/12/26 at 10:40 a.m., Resident #1 was observed sitting on an enclosed patio with his sunglasses and hat. Resident #1 was unable to complete a full interview due to aphasia; however, he could understand others and gesture to answer Yes and No questions. When asked if he felt well, Resident #1 shook his head Yes and gave the surveyor a fist-bump. When asked if he had missed any medications, Resident #1 shrugged and indicated that he did not know. In an interview on 06/12/26 at 11:24 a.m. with the Administrator and Clinical Resource, the Administrator described Resident #1's family dynamic as conflicted; however, they were involved in his care. The Administrator stated the family was responsible for delivering Resident #1's chemotherapy medication (axitinib) to the facility and staff would let them know when it was time for a refill. The Administrator stated the facility did not have a process in place to track and inventory the medication as it was brought in to prevent any errors. She stated she could see how implementing a process would benefit the residents and the facility, so she would start an in-service with staff. The Administrator stated there should already be log of when Resident #1's medications left the facility when the resident was out on pass; however, the log was never provided. An attempted interview on 06/12/26 at 1:53 p.m. with Resident #1's oncologist was unsuccessful due to the doctor being unavailable. In an interview on 06/12/26 at 2:00 p.m., the MD stated she did not manage Resident #1's cancer treatment; however, it was her medical opinion that missing multiple doses of axitinib had the potential to cause progression of the tumor. The MD stated she managed Resident #1's general health and there had been no reports of the resident showing any signs or symptoms of being unwell. The MD stated she also saw Resident #1 weekly and did not have any significant concerns. In an interview on 06/13/26 at 10:00 a.m., RN D stated he worked at the facility for over a year. RN D stated he worked with Resident #1 and<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | administered the resident's medication. He stated Resident #1 received axitinib that was provided by his family. RN D stated he never received the medication from Resident #1's family and it was always available in the cart during his shift. RN D stated he received medications from the families of other residents in the past and there was no policy or procedure for the nurses to count and document the medications unless it was a narcotic. In an interview on 06/13/26 at 11:05 a.m., the Pharmacy Representative stated Resident #1's account reflected the axitinib was a last dispensed on 05/07/26 and delivered to the family's address on 05/08/26 at 1:28 p.m. The Pharmacy Representative stated Family Member AA called on 05/05/26 and reported that the nursing facility still had 7 days' worth of medication left over, so the pharmacy advised them to start the new bottle on 05/12/26. The Pharmacy Representative stated the family should have needed a new bottle by 06/12/26; however, there was a note on the account that stated the refill needed to be delayed until 06/22/26 because Family Member AA called the pharmacy again on 06/10/26 and stated the facility still had 16 days' worth of medication remaining. The Pharmacy Representative stated Resident #1's account had an adverse event due to the number of times the medication refill was put on hold as it indicated that the medication was not being administered as scheduled. The Pharmacy Representative stated a pharmacist would have to provide any additional information needed regarding the medication. In an interview on 06/13/26 at 11:20 a.m., the Pharmacist stated an adverse event was placed on Resident #1's account each time the refill was held due to a surplus of medication. The Pharmacist stated all adverse events were reported to the prescriber for them to determine course of action. The Pharmacist stated Family Member AA called the pharmacy and reported concerns that the nursing facility was not administering Resident #1's axitinib correctly, and it caused the resident's tumor to grow. The Pharmacist stated the Oncologist was made aware of the concern reported. The Pharmacist stated the original fill date for Resident #1's axitinib was on 10/30/24 and had been ongoing since then. The Pharmacist stated the refills were consistent with no documented adverse events until approximately two months ago, except for one adverse event documented in October 2025. In an interview on 06/13/26 at 11:51 a.m., Resident #1's Family Member BB stated the facility had not reported any recent issues with the resident's medications; however, she recalled about a year ago when the facility admitted they made an error by overlooking the axitinib because it was stored in a top drawer and Resident #1 missed some doses. Family Member BB stated she sometimes received Resident #1's axitinib at her home and the nurses would tell her to hold it when there was medication left over. Family Member BB stated in May 2026 the facility informed her that they still had about 2 weeks' worth of medication remaining, and they did not need the new bottle. She stated Family Member AA usually dealt with the medication, so she did not think too much of it. Family Member BB stated Family Member AA believed the axitinib was keeping Resident #1 alive, so she was very adamant about the medication being administered as ordered. Review of the facility's policy titled Medication Administration, revised May 2025, reflected in part the following: Policy: It is the policy of this facility to accurately prepare, administer and document oral medications.Further review of this document reflected it did not address managing medication inventory. On 06/12/26 at 12:06 p.m., the Administrator was asked to provide a policy regarding management of medication inventory for non-narcotic medications brought to the facility from an outside pharmacy and/or family. The Administrator revealed the facility did not have this policy. An Immediate Jeopardy (IJ) was identified on 06/12/26 at 4:16 p.m. The Administrator was notified of an Immediate Jeopardy (IJ) on 06/12/26 at 4:45 p.m., due to the above failures and the IJ template was provided at 4:50 p.m. A Plan of Removal was requested. In an interview on 06/12/26 at 6:58 p.m., the Administrator stated she had just completed her own investigation and did not agree that Resident #1 had a significant medication error. The Administrator now had documents and provided the following information: - A statement from LVN A that an unopened bottle of Resident #1's axitinib with 180 tablets was delivered to the facility on [DATE], and the nurse continued to administer the medication as ordered. - An interview with the pharmacy that revealed Resident #1's axitinib was delivered and signed for by the resident's<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | family on dates: 01/07/26, 02/16/26, 03/11/26, 04/09/26, and 05/08/26. - Statements from LVN A, LVN B, LVN C, RN D, LVN E, LVN L, and LVN M verifying that Resident #1's axitinib was available in the cart and all doses were administered as reflected on the MAR. - A progress note, dated 04/21/26, from RN D stating Resident #1's family was notified that a refill for axitinib was needed. - The 24-hour working report that reflected the axitinib was delivered to the facility by family on 04/22/26, the facility requested a refill on 05/23/26, and the family delivered another bottle of axitinib on 05/24/26. Further review of the additional information provided by the Administrator did not reflect when the bottles of axitinib were opened. There also was no documentation provided to show if the new bottles were used immediately upon delivery or if the nurses continued administering medications that remained from the previous bottle. The facility's Plan of Removal (POR) was accepted on 06/12/26 at 9:05 p.m. and included: Plan of Removal June 12, 2026 Version 2 F760 Significant Medication Errors Per the information provided in the IJ Template given on 6/12/2026, the facility allegedly failed to ensure Resident #1 was free of a significant medication error potentially resulting in worsening of the resident's condition and placed him at risk of serious harm or death. The Medical Director was notified of alleged IJ on 6/12/2026 at 5:00 p.m.An audit was completed on June 12, 2026 for residents that have medications that are provided by their family/responsible party. Medications were counted and match the eMAR administration.Education was initiated with Nurses on 6/12/2026 and will be completed for all Nurses by 6/13/26 by the DON, ADONs or Clinical Resource. The training is to include medication brought in by family/responsible parties, documenting the date of receipt and count of those medications, documentation of medication administration of the eMAR.This education may be in-person or over the phone with the DON, ADONs or Clinical Resource.This education will also be included in the new hire orientation and will be included for agency/PRN nursing staff. All education will be completed prior to the employee's start of their next shift; no staff will be allowed to work unless they have had the training.An ad hoc meeting regarding items in IJ template was completed on 6/12/2026 at 5pm. Attendees included the Administrator, DON, ADON, Medical Director and Clinical Resource. The Plan of Removal items and interventions were developed, reviewed, and agreed upon.The DON or designee will monitor to ensure medication that is provided by family/responsible parties is counted and documented when they are delivered to the nurses. These meds will be counted and verified with eMAR weekly to ensure accurate administration.The DON and ADON will verify nurse knowledge on medications brought in by family/responsible parties with 3 nurses weekly using a knowledge check form.These medications will be reviewed during the weekly clinical meeting, and the Medical Director will be consulted for any recommendations or suggestions, as necessary.9. Knowledge checks will be completed with 3 nurses weekly and will be on-going throughout the Quality Assurance process, reported weekly to the QAPI committee meeting for 4 weeks or until substantial compliance is established and then monthly for 90 days.10. Summary of IJ and corrective action to be reviewed by QAPI Committee weekly x 4 weeks or until substantial compliance is established and continue monthly for 90 days to ensure ongoing compliance. QAPI meetings content will include laboratory orders and results.11. Follow up on IJ Plan of Removal and monitoring will be verified by the DON and the Administrator by review of medication count orders, the weekly clinical meeting, review of nurse knowledge checks obtained throughout the week, and the weekly QAPI meeting.Alleged date of compliance 6/12/2026[Administrator][Nursing Facility] In an interview on 06/13/26 at 2:44 p.m. with the Clinical Resource and Administrator, the Administrator stated the expectation was for the clinical staff to follow a process that validates the amount of medication in the building to ensure it was available and administered as ordered. The Clinical Resource stated medication errors could place residents at risk of all sorts of issues including a change in condition depending on the medication and existing issues. Monitoring of the facility's implementation of the Plan of Removal on 06/13/26 from 9:45 a.m.- 4:30 p.m. revealed the following: Record review of an in-service, dated 06/12/26, reflected nurses were educated by the ADON prior to the start of the shift on the facility's updated procedures on verifying, counting and documenting all (continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | medications brought into the facility from outside pharmacies and families. Record review of Residents #1, #2, #3, #4, #5, and #6, who all received medication from outside pharmacies and/or families, MARs and medication logs reflected that all medications were verified with an accurate quantity. Record review of a document provided by the Administrator, dated 06/12/26, reflected a medication audit was completed on all residents who had medications brought in by family/RPs. Record review of a document provided by the Administrator, dated 06/12/26, reflected a QAPI meeting was held to discuss the correction plan for the facility's deficiency in pharmacy services. Interviews on 06/13/26 from 10:20 a.m.-11:00 a.m. with the RPs of Residents #1, #2, #3, #4, and #6, revealed no concerns regarding delivery and administration of medications. Resident #5's RP was unavailable for an interview. Interviews on 06/13/26 from 9:45 a.m.-3:25 p.m. conducted with the Administrator, Clinical Resource, and nurses: LVN A (day shift), LVN B ( day shift), LVN C (night shift), RN D ( night shift), LVN E ( day shift), LVN F (day shift), RN G (day shift), RN H (day shift), RN I (night shift), LVN J (night shift), LVN K (night shift), indicated they all participated in an in-service regarding the facility's updated procedures on medication reconciliation for medications brought in from outside pharmacies and/or families. All nurses were able to state medications brought into the facility from an outside pharmacy or family member would be verified against the order, counted, and documented on a log and the MAR to include date of receipt. All nurses were also able to state that all medications sent on pass with residents would be counted and documented on a log upon the resident leaving and returning to the facility to ensure that all doses were administered according to the physician's order. All nurses stated any discrepancies with the medication would be reported to the DON or Clinical Resource immediately. The Clinical Resource and Administrator understood that management was responsible for monitoring medication reconciliation and ensuring that staff remained in compliance with procedures. An Immediate Jeopardy (IJ) was identified on 06/12/26 at 4:16 p.m. and an IJ Template was provided to the Administrator at 4:50 p.m. While the Administrator was informed on 06/13/26 at 4:58 p.m. that the IJ was removed, the facility remained out of compliance at a scope of pattern with the severity level of no actual harm with potential for more than minimal harm that was not an immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. |