

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/19/2025
NAME OF PROVIDER OR SUPPLIER  The Legacy Midtown Park		STREET ADDRESS, CITY, STATE, ZIP CODE  8280 Manderville Lane Dallas, TX 75231	

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 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.  (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

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury to the administrator of the facility and to other officials to include the State Survey Agency, in accordance with State law through established procedures for 2 of 10 residents (Resident #1 and Resident #2) reviewed for abuse/neglect. 1. The facility failed to report Resident #1's fall with injury to the State Survey Agency, where Resident #1 sustained a fractured hip and blood loss. The incident occurred on 09/21/25 at 9:00 pm and was not reported.2. The facility failed to report Resident #2's fall with injury to the State Survey Agency, where Resident #2 sustained a fractured hip. The incident occurred on 10/05/2025 at 04:08 am and was not reported.These failures could place residents at risk for potential abuse/neglect.The findings include:1. Record review of Resident #1's admission record revealed an [AGE] year-old male who was admitted to the facility on [DATE] and was his own responsible party. Resident #1 had diagnoses which included Unspecified Fracture of Shaft of Right Tibia (break in the main part of the shin bone in the right leg), Unspecified Fall, Pain in Right Knee, Muscle Weakness (Generalized), Other Lack of Coordination, Cognitive Communication Deficit (communication challenge caused by impaired thinking abilities, such as memory, thinking, or problem solving, rather than a language or speech impairment), Muscle Wasting and Atrophy (loss of muscle mass and strength), Acute Kidney Failure (sudden and significant decline in kidney function that leads to inability to remove waste products and excess fluid from the body), Hereditary and Idiopathic Neuropathy (inherited disorders that effect nerves outside the brain and spinal cord), Gout (form of inflammatory arthritis caused by accumulation of uric acid crystals in the joints), and Polyneuropathy (damage or disease nerves in roughly the same areas on both sides of the body, featuring weakness, numbness, and burning pain). Record review of Resident #1's Fall Risk Evaluation, dated 6/19/2025, revealed the resident had 1-2 falls in the past three months, had an ambulation/elimination status of bedbound/incontinent, had gait/balance needs of required use if assistive devices (i.e. cane, wheelchair, walker, furniture), and took 1-2 medications (or medication classes) currently or within the last 7 days of anesthetics, antihistamines, antihypertensives, antiseizures, benzodiazepines, cathartics, diuretics, hypoglycemics, narcotics, psychotropics, sedatives/hypnotics. The Focus revealed Resident #1 was a risk for falls. Interventions were Assist Resident with ambulation and transfers, utilizing therapy recommendations; Determine resident's ability to transfer; Evaluate fall risk on admission and PRN; If fall occurs, alert provider; if fall occurs, initiate frequent neuro and bleeding evaluation per facility protocol; If Resident is a fall risk, initiate fall risk precautions. Record review of Resident #1's Fall Risk Evaluation, dated 9/19/2025, revealed no falls in the past 3 months, ambulation/elimination status was chairbound/continent, no change in condition in last 14 days, gait/balance required the use of assistive devices (i.e. cane, walker, wheelchair, furniture), and took 1-2 medications (or medication classes) currently or within the last 7 days of anesthetics, antihistamines, antihypertensives, antiseizures, benzodiazepines, cathartics, diuretics, hypoglycemics, narcotics, psychotropics, sedatives/hypnotics with a medication change in the last 14 days. The focus revealed Resident #1 was at risk for falls. Interventions were Assist resident with ambulation and transfers, utilizing therapy recommendations; Determine resident's ability to transfer; Evaluate fall risk on admission and PRN; If fall occurs, alert provider; If fall occurs, initiate frequent neuro and bleedingevaluation per facility protocol; If Resident is a fall risk, initiate fall risk precautions.Record review of Resident #1's BIMS, on 9/21/2025, revealed a score of 08, which indicated Moderate Cognitive Impairment. Record review of Resident #1's Progress notes revealed an incident note that was struck through, dated 9/21/2025 at 11:55 PM, by RN A, that stated Note Text : 2100 [9:00 PM]:Heard Resident screaming for Help, Nurse went to pt room, Pt found laying on his on the floor, Assess pt, Pt transferred in bed with Hoyer lift x 3 Assist, ask Pt what Happen Pt stated am trying to Shut the door, Pt A&amp;O x 1, unable to move Right Lower extremity c/o pain PRN Tylenol, administered. Neuro checked initiated, VS Checked WNL, 1050: Nurse went back into Pt room to check on Pt, blood noted in Foley bag, and also from Pt Penis, Dr On call called no answer,2327 [11:27 PM]: Called 911, paramedics In, Pt transported to [local hospital], Family called and Notified, DON Notified. Strike Out Reason: Incorrect Documentation. A Health Status Note entered on 9/21/2025 at 11:55 stated Note Text : 2100 [9:00 PM]: Nurse went into Pt room. Pt observed laying Sunine</p>		