STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676489	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Legacy Midtown Park	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided with such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 3 residents (Resident #6) reviewed for respiratory care. The facility failed on 09/23/2025 to ensure Resident #6's oxygen was administered at the correct setting of 4 liters per minute per physician's orders when Resident's oxygen was set at 1 LPM.This failure could place residents at risk of developing respiratory complications. Findings included:Record review of Resident #6's admission record, dated 09/23/2025, revealed an [AGE] year-old male who admitted to the facility on [DATE] with a primary diagnosis of Pneumonia (infection in one or both lungs). Other diagnoses included Acute and chronic respiratory failure with hypoxia (condition when there is not enough oxygen in the tissues in the body), and Chronic Obstructive Pulmonary Disease (a lung disease that blocks airflow and makes it difficult to breathe). Record review of Resident #6's admission MDS, dated [DATE], revealed a BIMS of 11, indicating moderate cognitive impairment. Record review of Resident #6's care plan, dated 09/01/2025, revealed the following: -The Resident has COPD with intervention of Head of bed elevated while in bed to tolerable/preferred level or out of bed upright in a chair during episodes of difficulty breathing.-The Resident Has altered respiratory status/difficulty breathing r/t COPD, Acute respiratory failure. On Oxygen via nasal cannula with interventions of Monitor for s/sx of respiratory distress and report to MD PRN. and O2 via nasal cannula per physician orders.Record review of Resident #6's Active physician's order summary revealed, O2 at 4 L/min via NC every day and night shift with start date of 09/01/2025.Observation and interview on 09/23/2025 at 3:13 PM revealed Resident #6 lying in bed with nasal cannula on. The oxygen concentrator was on and set at 1 LPM. Resident #6 stated they [staff] had been running it at 4 [LPM]. Resident #6 did not appear to be in respiratory distress. Interview on 09/23/2025 at 4:03 PM, CNA B stated that Resident 6's oxygen was supposed to be set at 2 LPM. She stated she had not checked with the nurse, but when they had another resident on oxygen, the nurse told her to put it on 2 LPM. CNA B stated if oxygen was not at the right setting the resident could have breathing problems. She stated she had not seen Resident #6 have any problems breathing. Observation and interview on 09/23/2025 at 4:23 PM, in Resident #6's room, LVN A stated Resident #6's concentrator was set at 1 LPM. LVN A went to verify the order on the computer and brought the vital sign monitor with her back to the room. Resident #6's oxygen saturation level read 95%. She stated she would check with Therapy about the setting and maybe the knob on the concentrator was bumped. LVN A stated if the setting was incorrect, the risk was the resident could go hypoxic. She said the nurse and everybody else involved in care was responsible for ensuring the setting was correct. She stated the nurses were responsible to monitor and follow the physician order.In a follow up interview on 09/23/2025 at 4:58 PM, CNA B stated she had not changed the setting on the concentrator. She stated when she switched the O2 from the concentrator and turned on the e-tank (portable oxygen cylinder) she would set it for 2 LPM. She stated she was supposed to verify the setting with the nurse. Interview on 09/25/2025 at 4:00 PM, the DON stated her expectation for staff was the setting should be per the physician orders. She stated the licensed nurse was responsible and CNAs were to verify with the licensed nurse what the flow rate should be. The DON said if not followed, the patient could not have adequate oxygen delivery or more. She said it was monitored by the nurse; the order pops up and the licensed nurse observed the correct flow rate.Interview on 09/25/2025 at 4:59 PM, the Administrator stated the nurse was responsible based on the order and to communicate that to the CNA. She said if not followed the resident could desat and have an emergent episode. Record review of the facility policy titled Oxygen Administration undated, revealed: The purpose of this procedure is to provide guidelines for safe oxygen administration.Preparation1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.Steps in the Procedure.8. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute.