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	06/16/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the keys for 1 resident (Resident #1) of 5 residents reviewed for pharmacy services. The facility failed to ensure Resident #1's Albuterol (a fast-acting prescription inhaler used as a rescue medication that quickly opens the airways in the lungs to make breathing easier when someone is wheezing, short of breath, or having an asthma attack) was secured in the medication cart. These failures could place residents at risk for compromised unsafe administration, and increased harm to residents.Findings included: Record review of Resident #1's Comprehensive MDS Assessment, dated 05/29/26, reflected she was an [AGE] year-old female, admitted to the facility on [DATE]. She had a BIMS score of 14, which indicated she was cognitively intact. She had diagnoses that included: acute diastolic (congestive) heart failure (the heart can't pump blood as well as it should, causing fatigue, swelling, and shortness of breath.), chronic obstructive pulmonary disease (also referred to as COPD, a long-term lung disease that makes it hard to breathe, often from smoking or long-term exposure to irritants.), and acute respiratory failure (also referred to as ARF, when the lungs are not able to get enough oxygen into the blood). The MDS Assessment reflected Resident #1 was not receiving any respiratory treatments or respiratory therapy. Record review of Resident #1's Care Plan dated 5/28/2026, reflected Resident #1's HOB was to be elevated due to her diagnoses of COPD and ARF. As an intervention, the plan stated to give Resident #1 aerosol (a medicine turned into a fine mist that a person breathes in through a mask or mouthpiece so it goes straight to the lungs) or bronchodilators (a medication that relaxes and opens up the airway in the lungs) medication as ordered and to monitor for any side effects and effectiveness. Record review of Resident #1's active Physician's Orders, dated 06/16/2026, reflected Resident #1 did not have an active order for Albuterol, aerosols, bronchodilators, or to self-administer medications. Record review of Resident #1's EHR on 06/16/2026, reflected that she did not have an assessment completed to determine her ability to self-administer medications. Record review of Resident #1's hospital discharge orders dated 05/27/2026, reflected that she did not have an active order for Albuterol. Record review of Resident #1's hospital Discharge summary dated [DATE], reflected Resident #1 received Albuterol nebulizer treatment twice a day in the hospital. The summary reflected she did not have a prior to hospital admission order for albuterol. During an observation and interview with Resident #1 on 06/16/2026 at 11:40 AM, 2 albuterol inhalers were observed on her nightstand next to her bed. Resident #1 reported she always kept one inhaler at her bedside and the other one with her whenever she would leave the room to go eat or go to physical therapy. She stated she received the inhalers from her doctor but could not recall which doctor. She reported she used the inhalers as needed for shortness of breath or wheezing. Resident #1 could not recall had long she had the inhalers. During an interview with LVN on 06/16/2026 at 11:48 AM, he visually confirmed 2 albuterol inhalers on Resident #1's nightstand. He told Resident #1 the medications would be taken and kept at the nursing station and collected the (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications. He reported he did not know how long she had the medications. He reported he completed wound care on Resident #1 earlier in the morning and did not see the medications in her room at that time. He denied ever seeing the medications in her room. He reported he did not know where the medications came from or how Resident #1 obtained them. He stated the medications should not be there. He reported a resident having medications without supervision could lead to risk of overdose, increased heart rate and increased blood pressure. During an interview with the DON on 06/16/2026 at 2:00 PM, she reported she was unaware Resident #1 had the albuterol inhalers in her room. The DON reviewed Resident #1's EHR and stated the Resident had diagnoses that would indicate appropriate for albuterol use. She reported she did not know where the medications came from or how long the resident had them in her room. She reported Resident #1 had not yet had a self-administer assessment to determine her ability to self-administer medications. She reported Resident #1 was not authorized to have medications in her room. She reported the facility policy was that a resident would need to have a physician order as well to self-administer their own medications. The DON reported Resident #1 was admitted to the nursing facility from the hospital. She reported a facility nurse would go over the Resident's hospital discharge summary to review their active medications. The nurse would then contact the facility physician who would input the orders. She stated if a resident was cognitively impaired, self-administering medications would pose multiple risks to the resident. During a subsequent interview with the DON on 06/16/2026 at 2:30 PM, she reported she spoke to LVN about Resident #1's albuterol inhalers. She reported they contacted Resident's physician who gave an order for PRN albuterol inhaler to use in the evening if needed. Record review of the facility's policy for Medication Labeling and Storage, dated 2001, reflected the following: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys.