Printed: 05/12/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676413	A. Building B. Wing	10/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Garland	2625 Belt Line Road Garland, TX 75044

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on interview and record review, the facility failed to ensure residents had the right to be free from any physical or chemical restraints imposed for the purpose of disciplie or convenience for 1 (Resident #1) of four residents reviewed for chemical restraints. The facility failed to ensure LVN A did not sedate Resident #1 with a medication not prescribed for her. This failure could place the residents at risk of injury or death. Findings included: Record review of Resident #1's undated Admission Record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia, reduced mobility, and emphysema. Record review of Resident #1's annual MDS, dated [DATE], revealed a BIMS score of 8, which indicated she had moderate cognitive impairment. Her Functional Status indicated she required assistance with all of her ADLs. Record review of Resident #1's care plan revealed she was resistive to care, demonstrated physical behaviors of anger by hitting staff, and pulling the fire alarm, she was at risk for falls with a history of falls, and was on psychotropic medications to help with her behaviors. Interview on [DATE] at 12:32 PM with Resident #1's family member revealed she was visiting the resident on [DATE] around 4:00 PM and Resident #1 was more agitated than normal. Resident #1 was yelling at staff, going up and down the hallway yelling at residents, and causing quite a disturbance. The family member asked LVN A if she was given her sedating medication, and LVN A stated she was given it, but it was not working. The family member asked if there was anything else that could be done and LVN A stated there was. LVN A returned to the room with a syringe of liquid, asked if the resident had anything to drink because the medicine did not taste good. LVN A squirted the medication into Resident #1's mouth and gave her water to drink. The family member stated she thought LVN A had brought the resident's gel medication at first, but when he squirted it in the resident's mouth she knew something was not right. The family member stated she left for the day but contacted the DON the next morning to report what had happened. (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: 676413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2023
NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation Garland		STREET ADDRESS, CITY, STATE, ZIP CODE 2625 Belt Line Road Garland, TX 75044	

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 6:25 AM with the DON revealed he received a call from Resident #1's family member who relayed what had happened on [DATE]. The family member thought the liquid medication might have been Xanax, but the resident was no longer on Xanax. The DON stated he interviewed LVN A who stated he had given Resident #1 liquid Xanax on [DATE]. LVN A stated her Xanax from a previous order was still in the medication cart. After reviewing Resident #1's EHR the DON determined Resident #1 had liquid Xanax that was discontinued on [DATE], but was still on the cart. The DON stated LVN A stated he knew there was no order for the Xanax but gave it anyway because that is what was best for the resident. LVN A stated he had asked various hospice nurses to renew the Xanax, but they never did. The vial remained in the medication cart after it was discontinued, and LVN A admitted to giving Resident #1 Xanax twice. The DON stated LVN A was terminated immediately. Phone interview [DATE] at 1:30 PM with LVN A revealed he was aware the Xanax had been disconinued and that the vial was expired when he administered it to Resident #1 on [DATE]. He stated he had communicated with the hospice agency twice to have the medication renewed, but it never was. LVN A stated the Xanax worked for the resident in the past and that is why he gave it. LVN A stated the Xanax should have been removed when it was discontinued, but for some reason it never was. LVN A stated he had administered the Xanax twice. Review of Resident #1's physician orders revealed on [DATE] she had been prescribed Xanax 1 mg/ml, 1 ml every four hours as needed for anxiety. The order was discontinued on [DATE]. Review of the facility's policy Six Rights of Medication Administration, revised [DATE], reflected: .1. Right Resident - Resident is identified prior to medication administration 2. Right Time - Medications are administered within prescribed time frames. 3. Right Medication - Medications are checked against the order before they are given. 4. Right Dose - Medications are administered according to the dose prescribed 5. Right Route - Medications are administered according to the route prescribed 6. Right Documentation - Document administration or refusal of the medication after the administration or attempt and note any concerns .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2023
NAME OF PROVIDER OR SUPPLIER Legend Oaks Healthcare and Rehabilitation Garland		STREET ADDRESS, CITY, STATE, ZIP CODE 2625 Belt Line Road Garland, TX 75044	

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 - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43791 Based on observation and interview, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 8 of 10 sharp containers reviewed for accidents and hazards. The facility failed to ensure staff changed sharps containers prior to them becoming overfilled and becoming a hazard. This failure could place residents at risk of injury or exposure to needles contaminated with unknown biological agents. Findings included: Observation on 10/14/23 from 5:30 AM to 6:00 AM of rooms on 200, 300, and 500 Halls revealed sharps containers located inside resident rooms 211, 212, 213, 305,310, 502, 506, and 507 were over filled to the point the safety lid would not operate. Interview on 10/14/23 at 6:45 AM with LVN B revealed all nursing staff were responsible for changing out sharps containers before they were overfilled. LVN B stated overfilled sharps containers posed a risk to anyone trying to introduce another sharps into the container. Interview on 10/14/23 at 8:00 AM with the DON revealed all nursing staff were responsible for monitoring sharps containers and changing them out when they were 3/4 full as indicated by the Fill Line. Over filled containers could cause anyone trying to place another sharps in them to be poked with a dirty needle and being contaminated with unknown biological agents. The DON stated the facility did not have a policy that addressed sharps containers directly. Record review of OSHA standards on sharps, as described on their website osha.gov, accessed on 10/14/23 reflected: .1910.1030(d)(4)(iii)(A)(2) During use containers for sharps shall be: . Easily accessible to personnel . Maintained upright throughout use . Replaced routinely and not be allowed to overfill . Containers should be closed immediately to prevent spillage or protrusions of contents during handling, storage, transport, or shipping.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2023
NAME OF PROVIDER OR SUPPLIER: Legend Oaks Healthcare and Rehabilitation Garland		STREET ADDRESS, CITY, STATE, ZIP CODE: 2625 Belt Line Road Garland, TX 75044	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services which included procedures that assured the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 of 4 residents (Resident #2) reviewed for medication administration. 1. The facility failed to ensure LVN C administered Resident #2's medications as ordered. 2. The facility failed to ensure a discontinued medication, Xanax, for Resident #1 was removed from the medication cart on 05/30/23, which resulted in the resident being administered the drug without physician orders. The failures could place residents at risk of not receiving their medications as ordered and adverse drug reactions. Findings included: 1. Record review of Resident #2's undated Admission Record revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included stroke affecting his left side, difficulty swallowing related to stroke, and left sided paralysis. Record review of Resident #2's annual MDS, dated [DATE], revealed a BIMS score of 10 indicating he had moderate cognitive impairment. His Functional Status indicated he required assistance with all of his ADLs. Record review of Resident #2's care plan, dated 9/15/23, revealed he was resistive of care and medications, he had swallowing problems identified by Speech Therapy, and communication deficit related to foreign language. Observation on 10/14/23 at 7:27 AM revealed Resident #2 had a medication cup with four pills sitting on his over bed table. The cup contained a round purple pill, white oval pill, white round pill, and small white oval pill. Interview on 10/14/23 at 7:28 AM with LVN D revealed she had not administered any medications to Resident #2 that morning, and she had not been in the room yet. Interview on 10/14/23 at 7:30 AM with RN E revealed stated she had not administered any medications to Resident #2 nor had she been into his room yet. Observation and interview on 10/14/23 at 7:32 AM with RN E and the DON revealed the pills found at Resident #2's bedside were identified as Risperdol 150 mg, Lipitor 40 mg, Metformin 500 mg, and Mirtzapine 7.5 mg when compared to his MAR and his medications in the medication cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2023
NAME OF PROVIDER OR SUPPLIER: Legend Oaks Healthcare and Rehabilitation Garland		STREET ADDRESS, CITY, STATE, ZIP CODE: 2625 Belt Line Road Garland, TX 75044	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's MAR revealed LVN C had documented all four medications were administered at 9:05 PM on 10/13/23. Telephone interview on 10/14/23 at 7:38 AM with LVN C revealed he administered Resident #2's medications on the evening of 10/13/23. He stated he placed the medications in the resident's hand and watched him swallow the pills. He did not know how the pills could have still been at the bedside unless the resident had spit them out. Interview on 10/14/23 at 7:40 AM with RN E and the DON revealed they observed the pills and agreed they did not appear to have been spit out. Interview on 10/14/23 at 8:00 AM with the DON revealed he contacted LVN C who stated he was confused earlier about which resident he was asked about. He stated Resident #2 was slow to take pills, and he wanted his medications left at the bedside and he would take them when he was ready. LVN C stated it was routine practice to leave Resident #2's medications at the bedside and when he would check back later the medications would be gone. The DON stated the risk of not observing a resident take their medications included not receiving the therapeutic dosage intended, choking on the medication, especially with a resident with known swallowing difficulty. The DON stated the facility policy was to watch each resident take their medications and not leave them at the bedside. Telephone interview on 10/14/23 at 10:15 AM with the Nurse Practitioner revealed Resident #2 was prescribed Risperdol for behavior issues, missing one dose would not have an affect on the resident. Metformin was prescribed for his diabetes, missing one dose would not affect the resident as his A1C was ok when it was last checked. Lipitor was prescribed for his cholesterol and missing one dose would have no affect as his lipids were within normal range when they were checked. Mirtzapine was prescribed for an appetite stimulant and one missed dose would have no affect on the resident. The NP stated she advised the staff to monitor Resident #2 and report any issues. 2. Record review of Resident #1's, undated, Admission Record reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included dementia, reduced mobility, and emphysema. Record review of Resident #1's physician orders reflected, on 01/30/23, she was prescribed Xanax 1 mg/ml, 1 ml every four hours as needed for anxiety. The order was discontinued on 05/30/23. Record review of the Xanax count sheet reflected the pharmacy delivered a 30 ml bottle to the facility on [DATE]. One dose of 0.5 ml was administered on 07/18/23 by a person unknown to the DON. The bottle should have contained 29.5 ml. Record review of Resident #1's annual MDS, dated [DATE], reflected a BIMS score of 8, which indicated she had moderate cognitive impairment. Her Functional Status indicated she required assistance with all of her ADLs. Record review of Resident #1's care plan reflected she was resistive to care, demonstrated physical behaviors of anger by hitting staff, and pulling the fire alarm, she was at risk for falls with a history of falls, and was on psychotropic medications to help with her behaviors . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2023
NAME OF PROVIDER OR SUPPLIER: Legend Oaks Healthcare and Rehabilitation Garland		STREET ADDRESS, CITY, STATE, ZIP CODE: 2625 Belt Line Road Garland, TX 75044	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nursing progress notes reflected a note by LVN G written on 10/03/23 at 2:54 AM reflected: Resident called police around 20:00 PM [8:00 PM] and reported a need of help. Police upon arrival Nursing staff present trying to figure out. No specific help noted. Nursing get resident back to W/C as she requested. Keep Screaming, aggressive, refusing to go back to her room/Bed. Resident propelling self on hallway, screaming. call placed to Hospice requesting ABH if it can help. Hospice will send it as soon as possible and ordered one more dose of Xanax. Resident finally went to bed around 0100 AM. ADON notified. will continue to monitor. The note indicated the dose of Xanax did not affect the resident as she did not calm down until approximately 10 hours after it had been administered. Observation and interview on 10/14/23 at 6:25 AM of the bottle of Xanax, supplied by the DON, revealed it contained 21 ml. The DON concurred there were 21 ml in the bottle, which indicated there were 8.5 doses unaccounted for. Observation on 10/17/23 at 1:20 PM of the medication cart check with the DON revealed no expired medications, no un-prescribed medications, and all controlled substances were accounted for. Interview on 10/13/23 at 12:32 PM with Resident #1's family member revealed she was visiting the resident on 10/02/23 around 4:00 PM and Resident #1 was more agitated than normal. Resident #1 was yelling at staff, going up and down the hallway yelling at residents, and causing quite a disturbance. The family member asked LVN A if she had been given her sedating medication, LVN A stated she had been given it, but it was not working. The family member asked if there was anything else that could be done, and LVN A stated there was. LVN A returned to the room with a syringe of liquid, asked if the resident had anything to drink because the medicine did not taste good. LVN A squirted the medication into Resident #1's mouth and gave her water to drink. The family member stated she thought LVN A had brought the resident's gel medication at first, but when he squirted it in the resident's mouth, she knew something was not right. She left for the day but contacted the DON the next morning to report what had happened. Interview on 10/14/23 at 6:25 AM with the DON revealed he received a call from a family member of Resident #1 who relayed what had happened on 10/02/23. The family member thought the liquid medication might have been Xanax, but the resident was no longer on Xanax. The DON stated he interviewed LVN A who stated he had given Resident #1 liquid Xanax on 10/02/23. LVN A stated her Xanax from a previous order was still in the medication cart. After reviewing Resident #1's EHR the DON determined that Resident #1 had liquid Xanax that had been discontinued on 05/30/23, but was still on the cart. LVN A stated he knew there was no order for the Xanax but gave it anyway because that is what was best for the resident. LVN A stated he had asked various hospice nurses to renew the Xanax, but they never did. The vial remained in the medication cart after it was discontinued, and LVN A admitted to giving Resident #1 Xanax twice. The DON stated LVN A was terminated immediately. Telephone interview on 10/14/23 at 11:20 AM with RN F revealed she observed LVN A administer a dose of liquid Xanax on 10/02/23 to Resident #1. She stated Resident #1 eventually slept and seemed like her normal self in the morning. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Garland	2625 Belt Line Road Garland, TX 75044

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/14/23 at 1:00 PM with the DON revealed he checked on the resident after speaking to Resident #1's family member and the resident was awake and acting like her normal self. The DON stated he began his investigation right after that by checking all medication carts in the facility for any un-prescribed medications and any expired medications. He found the bottle of Xanax in question and nothing else out of place. The DON stated he did not know why staff had not removed the Xanax when it was discontinued in May because he was not working at the facility at that time. Record review of the facility's Medication Administration policy, revised December 2022, reflected: The six rights of medication administration are as follows in order to ensure safety and accuracy of administration. 1. Right Resident - Resident is identified prior to medication administration 2. Right Time - Medications are administered within prescribed time frames. 3. Right Medication - Medications are checked against the order before they are given. 4. Right Dose - Medications are administered according to the dose prescribed 5. Right Route - Medications are administered according to the route prescribed 6. Right Documentation - Document administration or refusal of the medication after the administration or attempt and note any concerns

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2023
NAME OF PROVIDER OR SUPPLIER: Legend Oaks Healthcare and Rehabilitation Garland		STREET ADDRESS, CITY, STATE, ZIP CODE: 2625 Belt Line Road Garland, TX 75044	

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors for one of four residents (Resident #1) reviewed for medications. LVN A failed to ensure Resident #1 was not administered the psychotropic drug, Xanax, on 10/02/23 that had been discontinued by the physician on 05/30/23. The failure could place residents at risk of serious adverse drug reactions. Findings included: Record review of Resident #1's, undated, Admission Record reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included dementia, reduced mobility, and emphysema. Record review of Resident #1's physician orders reflected, on 01/30/23, she was prescribed Xanax 1 mg/ml, 1 ml every four hours as needed for anxiety. The order was discontinued on 05/30/23. Record review of the Xanax count sheet reflected the pharmacy delivered a 30 ml bottle to the facility on [DATE]. One dose of 0.5 ml was administered on 07/18/23 by a person unknown to the DON. The bottle should have contained 29.5 ml. Record review of Resident #1's annual MDS, dated [DATE], reflected a BIMS score of 8, which indicated she had moderate cognitive impairment. Her Functional Status indicated she required assistance with all of her ADLs. Record review of Resident #1's care plan reflected she was resistive to care, demonstrated physical behaviors of anger by hitting staff, and pulling the fire alarm, she was at risk for falls with a history of falls, and was on psychotropic medications to help with her behaviors . Record review of Resident #1's nursing progress notes reflected a note by LVN G written on 10/03/23 at 2:54 AM reflected: Resident called police around 20:00 PM [8:00 PM] and reported a need of help. Police upon arrival Nursing staff present trying to figure out. No specific help noted. Nursing get resident back to W/C as she requested. Keep Screaming, aggressive, refusing to go back to her room/Bed. Resident propelling self on hallway, screaming. call placed to Hospice requesting ABH if it can help. Hospice will send it as soon as possible and ordered one more dose of Xanax. Resident finally went to bed around 0100 AM. ADON notified. will continue to monitor. The note indicated the dose of Xanax did not affect the resident as she did not calm down until approximately 10 hours after it had been administered. Observation and interview on 10/14/23 at 6:25 AM of the bottle of Xanax, supplied by the DON, revealed it contained 21 ml. The DON concurred there were 21 ml in the bottle, which indicated there were 8.5 doses unaccounted for. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2023
NAME OF PROVIDER OR SUPPLIER: Legend Oaks Healthcare and Rehabilitation Garland		STREET ADDRESS, CITY, STATE, ZIP CODE: 2625 Belt Line Road Garland, TX 75044	

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/17/23 at 1:20 PM of the medication cart check with the DON revealed no expired medications, no un-prescribed medications, and all controlled substances were accounted for. Interview on 10/13/23 at 12:32 PM with Resident #1's family member revealed she was visiting the resident on 10/02/23 around 4:00 PM and Resident #1 was more agitated than normal. Resident #1 was yelling at staff, going up and down the hallway yelling at residents, and causing quite a disturbance. The family member asked LVN A if she had been given her sedating medication, LVN A stated she had been given it, but it was not working. The family member asked if there was anything else that could be done, and LVN A stated there was. LVN A returned to the room with a syringe of liquid, asked if the resident had anything to drink because the medicine did not taste good. LVN A squirted the medication into Resident #1's mouth and gave her water to drink. The family member stated she thought LVN A had brought the resident's gel medication at first, but when he squirted it in the resident's mouth, she knew something was not right. She left for the day but contacted the DON the next morning to report what had happened. Interview on 10/14/23 at 6:25 AM with the DON revealed he received a call from a family member of Resident #1 who relayed what had happened on 10/02/23. The family member thought the liquid medication might have been Xanax, but the resident was no longer on Xanax. The DON stated he interviewed LVN A who stated he had given Resident #1 liquid Xanax on 10/02/23. LVN A stated her Xanax from a previous order was still in the medication cart. After reviewing Resident #1's EHR the DON determined that Resident #1 had liquid Xanax that had been discontinued on 05/30/23, but was still on the cart. LVN A stated he knew there was no order for the Xanax but gave it anyway because that is what was best for the resident. LVN A stated he had asked various hospice nurses to renew the Xanax, but they never did. The vial remained in the medication cart after it was discontinued, and LVN A admitted to giving Resident #1 Xanax twice. The DON stated LVN A was terminated immediately. Telephone interview on 10/14/23 at 11:20 AM with RN F revealed she observed LVN A administer a dose of liquid Xanax on 10/02/23 to Resident #1. She stated Resident #1 eventually slept and seemed like her normal self in the morning. Interview on 10/14/23 at 12:06 PM with Resident #1's family member revealed when she checked on the resident the morning of 10/03/23 the resident was still sleeping, was hard to wake up, and was slurring her words. That was when she notified the DON. Interview on 10/14/23 at 1:00 PM with the DON revealed he checked on the resident after speaking to Resident #1's family member and the resident was awake and acting like her normal self. The DON stated he began his investigation right after that by checking all medication carts in the facility for any un-prescribed medications and any expired medications. He found the bottle of Xanax in question and nothing else out of place. The DON stated he did not know why staff had not removed the Xanax when it was discontinued in May because he was not working at the facility at that time. Record review of the facility's Medication Administration policy, revised December 2022, reflected: The six rights of medication administration are as follows in order to ensure safety and accuracy of administration. 1. Right Resident - Resident is identified prior to medication administration (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Garland	2625 Belt Line Road Garland, TX 75044

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Right Time - Medications are administered within prescribed time frames. 3. Right Medication - Medications are checked against the order before they are given. 4. Right Dose - Medications are administered according to the dose prescribed 5. Right Route - Medications are administered according to the route prescribed 6. Right Documentation - Document administration or refusal of the medication after the administration or attempt and note any concerns. Record review of the facility's Controlled Medications policy, revised January 2022, reflected: .6. When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: Date and time of administration. Amount administered. Signature of the nurse administering the dose, completed after the medication is actually administered.