STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035097	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Legacy Rehab & Care Center	2812 Silver Creek Road Bullhead City, AZ 86442

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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interviews, review of facility documentation, and review of facility policies and procedures the facility failed to ensure residents were free from avoidable accidents related to transportation for 1 of 18 sampled residents (resident #44). The universe was 85. The deficient practice could lead to potential avoidable injuries. Findings include: Resident #44 was re-admitted to the facility on [DATE] with diagnoses of unspecified gangrene, acute kidney failure, and acute respiratory failure. The revised care plan dated April 30, 2026 revealed a problem related to potential injuries from falls. Interventions included to assist in ambulating and transferring, and to observe, record and correct all unsafe conditions. Review of the care plan revealed a problem related to an actual fall on May 7, 2026 with interventions to ensure all safety measures are in place during transportation. Further review of the care plan revealed a problem related to the need for supplemental oxygen due to poor oxygenation. Interventions included to ensure oxygen tank is turned on and nasal cannula is in place prior to leaving the resident. An admission minimum data set (MDS) assessment dated [DATE] revealed Resident #44 had a brief interview for mental status (BIMS) score of 15, indicating the resident was cognitively intact. Further review of the MDS revealed the resident required the use of a walker for mobility and moderate staff assistance with showering and toileting. Additional review of the MDS indicated the resident was receiving continuous supplemental oxygen. An Incident Note dated May 7, 2026 at 3:00 p.m. revealed that while the resident was being transported in a van, the resident's wheelchair tipped backwards. The note documented that the resident reported hitting her head and that the driver pulled over and assisted the wheelchair back to an upright position. The resident denied pain and declined transfer to the hospital when offered, stating she wanted to go to her scheduled appointment. Upon the resident's return to the facility, a skin assessment was completed and the resident was noted to have a small bump to head without bruising and a skin tear with flap to the left upper outer arm. The note further revealed the provider was notified and new orders were received for skin treatments, monitoring the mid-back for possible bruising, monitoring the bump to the back of the head, and neuro checks. The note stated that the resident's daughter was present in the room during assessment. The incident note further revealed the resident stated she was sitting in her wheelchair and then flipped back and hit her back on the oxygen tank behind her and hit her head. The resident stated the incident frightened her but reported she was otherwise fine. A Post-Fall evaluation dated May 7, 2026 at 3:03 p.m. revealed the fall occurred unwitnessed in the transportation van with injury. The evaluation further revealed a wheelchair was involved, the resident was wearing oxygen at the time of the incident, and reported a pain level of 4/10, and the responsible parties were notified. A Skin Check note dated May 7, 2026 at 3:06 p.m. revealed Resident #44 sustained a new in-house acquired Type 1 skin tear with flap to the left upper outer arm without skin loss, pain, or signs/symptoms of infection. The note revealed the resident was also noted to have a bump to the back of the head without bruising following a fall, and monitoring for possible bruising was initiated. A physician's order dated May 7, 2026 at 4:53 p.m. included to cleanse skin tear to left upper outer arm with wound wash, re-approximate skin and apply (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Steri-Strips, and monitor every shift until the wound has resolved. A Communication with Family, Next-of-Kin, Power-of-Attorney note dated May 7, 2026 at 5:09 p.m. revealed Resident #44's son was concerned regarding his mother's fall and choice to not go to the hospital for treatment and evaluation. The note revealed the son was notified that neuro checks have been initiated and if the resident has any change of condition, increased pain, the facility would send her to hospital. Review of the Medication Administration Record and Treatment Administration Record (MAR/TAR) for May 2026 revealed clinical staff administered treatment to the skin tear on the left upper outer arm as ordered. Review of a Corrective Action form dated May 8, 2026 revealed a fact which stated the Transportation Driver (Staff #7) failed to follow policy and procedure while on transport and the Staff #7 responded to that statement by saying he should have double checked. Further review of the form revealed an impact which stated failure to follow proper policies and procedures can result in harm. Review of the form revealed the Transportation Driver received a verbal warning regarding the incident. Further review of the form revealed both the Administrator (Staff #49) and Staff #7 signed the Corrective Action form. Review of a Job Summary for Van Driver position revealed the essential job functions of the employee included to secure residents in and out of the vehicle and provide outstanding customer service in transportation of residents. Review of the Resident Transport Training revealed staff are checked-off prior to transporting a resident which included areas such as; both wheelchair brakes are locked and ratchet straps applied and properly secured. An observation was conducted on May 12, 2026 at 2:07 p.m. of Resident #44. The resident was observed to have a large white gauze bandage wrapped around her left upper arm with no dates or labels. Resident #44 could not recall the last time the bandage was applied. An interview was conducted on May 12, 2026 at 2:07 p.m. with Resident #44. Resident #44 stated she was being transported for an appointment out of the facility and the transportation staff (Staff #7) must have forgotten to lock her wheelchair in place. Resident #44 stated when the driver was taking a turn her wheelchair tipped backwards with her in it and she hit a tote box on a shelf in the vehicle and then landed on her oxygen tank. Resident #44 further stated that the transportation staff pulled over and offered to take her to the hospital to which she declined. Resident #44 stated it was the worst thing that had ever happened to her and she was so shaken up after the incident that she could hardly sleep. An interview was conducted on May 14, 2026 at 12:44 p.m. with transportation driver (Staff #7). Staff #7 stated that prior to transporting a resident in a wheelchair, staff are expected to follow scheduled departure times and ensure the resident is brought to the front for transport. Staff #7 stated he ensures the resident is positioned correctly in the wheelchair and, if the resident is able to respond, he speaks with them to confirm readiness for transport. Staff #7 stated he will check that the wheelchair is functioning properly, including the foot pegs, and verify whether the resident requires oxygen. Staff #7 stated residents are wheeled out and loaded into the van, the wheelchair is secured using clamps and a four-point tie-down system, and the resident is secured with a seatbelt. Staff #7 stated the wheelchair should not move once secured. Staff #7 stated he received training from the previous driver through side-by-side instruction and competency checklists, and annual training is completed thereafter. Staff #7 stated the goal is to ensure residents are transported safely. Staff #7 further stated an incident involving Resident #44, during which he forgot to secure the two front clamps on the wheelchair. The Staff #7 further stated the wheelchair tipped backward while the resident remained seated in the chair. Resident #44 stated he stopped the vehicle in the median, assisted in lifting the chair back upright, and offered to take her to the hospital in which the resident declined. Staff #7 stated the resident reported hitting her head and was observed rubbing her head at the time of the incident, although no visible injuries were observed. Staff #7 stated he immediately notified the administrator, completed an incident report, and then received disciplinary training and a verbal warning. An interview was conducted on May 14, 2026 at 1:21 p.m. with the facility's administrator (Staff #12) and Maintenance Director (Staff #49). Staff #49 stated he will ride along and complete a checklist with new drivers that ensures the new staff know how to properly hook up wheelchairs, restraining of the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seat, using the van lift, and how to check the vehicles fluids, tire pressure, and oil. The Staff #12 stated her and Staff #49 will occasionally do a re-check on skills if the drivers are not executing the skills correctly. Staff #49 further stated that he has never had to re-educate any of the drivers and there had never been any incidents regarding resident transportation. Staff #49 stated his number one priority is safety of the residents and the drivers. Staff #49 stated that the drivers are expected to ensure that the wheelchair foot pegs are on the wheelchair and the brakes on the wheelchair work. Staff #49 stated that drivers are expected to load the resident onto the van safely and ensure all four points of the wheelchair restraints are locked, further indicating that if only one or two straps are used the wheelchair is not properly secured. Staff #12 stated that the incident regarding Resident #44 happened because the ratchet straps must have come un-done which had never happened before. Staff #49 stated that the ratchet straps must not have been properly secured when Staff #7 drove out of the parking lot, Resident #44's wheelchair flipped backwards in which the driver pulled into the middle lane to assess Resident #44. Staff #49 stated that there were no physical injuries; however, recanted and stated Resident #44 sustained a skin tear to the left arm. Staff #12 stated Resident #44 refused to go to the hospital and a fall protocol was initiated for the resident. Staff #12 further stated the Transportation Driver did a good job and met her expectations. Review of the Safety and Supervision of Residents last revised May 6, 2026 revealed that resident safety, supervision, and assistance to prevent accidents is a facility-wide priority. Further review of the policy revealed the facility strives to make the environment as free from accident hazards as possible.