| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045267 | A. Building<br>B. Wing | 03/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Legacy Health and Rehabilitation Center | 3310 North 50th Street<br>Fort Smith, AR 72904 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>49689<br><br>According to observation, interview, and record review, the facility failed to ensure the dignity of 3 (Resident #61, #72, and #304) sampled residents by not pulling the curtain or closing the door, leaving them exposed for any visitors to see from the hallway. The findings are:<br><br>1. Resident #72 had diagnoses of Parkinson's without fluctuations and Dementia without behavioral disturbances. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/19/2024 revealed the resident received a score of 3 (0-7 indicates severe cognitive impairment) on the Brief Interview for Mental Status (BIMS), and that the resident is dependent for transfers.<br><br>A. On 03/19/2024 at 08:52 AM, the Surveyor observed the shower room door open with Resident #72 sitting fully naked in a shower chair, curtain and door not pulled. Resident #72 was fully visible from the hallway.<br><br>B. On 03/20/2024 at 09:30 AM, the Surveyor asked Certified Nursing Assistant (CNA) #4, When transferring Resident #72 yesterday to the shower, should the curtain have been pulled and the door closed? CNA #4 said, Yes it should have been. The Surveyor asked why this could be an issue. CNA #4 said, For the resident's privacy.<br><br>C. On 03/20/2024 at 09:32 AM, the Surveyor asked CNA #3, When transferring Resident #72 yesterday to the shower, should the curtain have been pulled and the door closed? CNA #3 said, Yes it should have been. The Surveyor asked why this could be an issue. CNA #4 said, Dignity.<br><br>2. Resident #304 had diagnoses of Alzheimer's disease early onset, Generalized anxiety disorder, and Depression. According to the MDS with an ARD 01/31/2024 revealed the resident scored a 4 BIMS.<br><br>3. Resident #61 had a diagnosis of Dementia with unspecified severity with agitation and a history of falling. The MDS with an ARD of 01/15/2024 revealed the resident scored a 3 BIMS and that the resident is an independent/supervision with transfers.<br><br>(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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045267 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/21/2024 |
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| NAME OF PROVIDER OR SUPPLIER Legacy Health and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 3310 North 50th Street Fort Smith, AR 72904 | |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A. On 03/19/2024 at 02:39 PM, the Surveyor observed two CNA's changing Resident #61 and Resident #304 in the resident women's bathroom for the secure unit. The Surveyor observed CNA #2 changing Resident #61 in the right stall with the door open. Surveyor observed that CNA #2 was changing Resident #61's clothes, while CNA #2 was pulling up teal-colored pants on Resident #61 the surveyor observed that you can see the resident naked and fully visible from the hall, as the main door was left opened to the resident's women bathroom as well. The Surveyor observed CNA #2 pulling a pink shirt with flowers over Resident #61's head. Surveyor observed that CNA #1 was changing Resident #304 in the left most stall with the door open as they began to walk out of the room when finished with care. CNA #1 was telling CNA #2 that Resident #304 also had a bowel movement that required clothes to be changed.<br><br>B. On 03/19/2024 at 02:45 PM, the Surveyor asked CNA #1, Should the door have been closed to the bathroom and stalls while residents were undressed? The CNA said, Well, there is not much room in there to work in but yes, I should have. The Surveyor asked CNA #1, Why is that an issue for the resident? CNA #1 said, Well like I said, there is not much room in this bathroom to work with, but yes, for privacy.<br><br>C. On 03/19/2024 at 02:48 PM, the Surveyor asked CNA #2, Should the door have been closed to the bathroom and stalls while residents were undressed? CNA #2 said, Yes, they should have been. The Surveyor asked, Why is that an issue for the resident? CNA #2 said, For their privacy.<br><br>D. On 03/21/2024 at 08:30 AM, the Surveyor asked the Director of Nursing (DON), When transferring residents or providing care should the curtain be pulled, and the door closed? The DON said, Yes it should be pulled closed. The Surveyor asked the DON why this is an issue for the residents. DON said, For their privacy and dignity.<br><br>E. On 03/20/2024 at 04:45 PM, the Administrator provided a policy titled Federal Rights of Resident/Guest(s) that states (e) Respect and dignity: The resident/guest has a right to be treated with respect and dignity. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39316<br><br>Based on observation, interview, and record review, the facility failed to ensure care plan interventions were implemented for 1 (Resident #36) of 1 sampled resident who were at risk for falls, to prevent falls and possible injury. The findings are:<br><br>A review of a Face Sheet indicated Resident #36 had a diagnosis of dementia.<br><br>The annual Minimum Data Set (MDS), dated [DATE], revealed Resident #36 had a Staff Assessment for Mental Status (SAMS) score of 1, which indicated a memory problem.<br><br>Review of Resident #36's Care Plan. reviewed 02/09/2023, revealed the resident had potential for falls. Interventions included: encourage clutter free environment and path to bathroom, initiated 12/17/2022; encourage use of handrails/appropriate assistive devices, initiated 12/17/2022; wear non-slip footwear while out of bed, initiated 12/17/2022. The resident was at risk for poor safety awareness. Interventions included: place resident in area where frequent observation is possible, initiated 03/06/2019.<br><br>On 03/18/2024 at 11:46 AM, Resident #36 observed sitting in a chair alone in the room. Resident #36 attempted to get up out of the chair by lifting bottom and scooting toward the front of the chair. Resident # 36 ' s chair is stuck on the fall mat on the side of the A bed. A fall mat was observed on the floor in front of the B bed. Resident #36 had regular socks on.<br><br>On 03/18/2024 at 01:39 PM, Resident #36 was observed alone in their room in the chair. The chair was observed on the fall mat near the bed. Resident #36 was unable to move self in the chair while on the fall mat.<br><br>On 03/18/2024 at 02:29 PM, Resident # 36 was observed in their room alone and sitting on the edge of the chair in the doorway of room. Resident #36 was unable to self-propel/ambulate in the chair. Resident #36 had regular socks on.<br><br>On 03/19/2024 at 02:48 PM, Resident # 36 was observed sitting in a chair in room alone. The chair is next to the resident ' s bed, on the fall mat, and the brake is locked on the right wheel. Resident #36 was not able to ambulate in the chair.<br><br>On 03/19/2024 at 02:51 PM, Certified Nursing Assistant (CNA) #10 was asked why Resident #17 ' s brake was locked on their chair. CNA #10 stated, We can't leave it locked. CNA #10 was asked if locking Resident #17 brake would be considered a restraint. CNA #10 stated, Yes, it's a restraint.<br><br>On 03/19/2024 at 02:52 PM, CNA #11 stated, I locked it when I changed her earlier, I forgot to unlock it. CNA #11 stated, We are short staffed every day, I was in a hurry. CNA #11 was asked how long the facility had been short staffed. CNA #11 stated, it's been going on for quite a while, night shift comes in to help day shift. CNA #10 stated, We have 21 residents on this hall, there's a lot of lifts, we don't even have time to chart. CNA #10 was asked, Do you have a shower team or do you do your own shower? CNA#10 stated, We do our own, we had 7 showers today and 5 on the other days.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER: Legacy Health and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 3310 North 50th Street, Fort Smith, AR 72904 | |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/19/2024 at 04:30 PM, Resident #36 was observed alone in room sitting in a chair going around in circles.<br><br>On 03/20/2024 at 06:25 AM, Resident #36 was observed in a chair at the nurses ' station with eyes closed.<br><br>On 03/20/2024 at 01:38 PM, Resident #36 was observed alone in room sitting up in a chair with eyes closed. The brake on the right side of Resident #36's chair is locked.<br><br>On 03/20/2024 at 01:45 PM, the Director of Nursing (DON) was asked, Is Resident #36 supposed to be left alone in the room? The DON stated, I will find out. The DON was asked, Why is the locked brake on Resident #36 ' s chair considered a restraint? The DON stated, Because she can't move. The DON stated, The resident could not move being left on the fall mat, nothing will roll on the fall mat.<br><br>On 03/21/2024 at 09:39 AM, CNA #10 was asked, What are the fall interventions for Resident # 36? CNA #10 stated, Use a gait belt to transfer, 2 person assist, fall mat, and they just told us we are to remove the fall mats off the floor when she is in the chair. CNA #10 was asked, Is Resident #36 supposed to be observed at all times? CNA #10 stated, I always left her in her room, she can't defend herself. CNA #10 was asked, Is Resident #36 supposed to wear special footwear? CNA #10 stated, No, special socks. CNA #10 was asked, Why should resident ' s care plan be followed and interventions implemented for residents at high risk for falls? CNA #10 stated, For their safety.<br><br>On 03/21/2024 at 10:04 AM, Licensed Practical Nurse (LPN) #3 was asked, What are the fall interventions for Resident #36? LPN #3 stated, Fall mat at bedside while in the bed, wheelchair brakes have to be unlocked so she can move around, non-skid socks, and out so we can observe her. LPN #3 was asked, How do you know how to take care of Resident #36? LPN stated, The care plan, any special needs pop up on the Medication Administration Record (MAR), and in report. LPN #3 was asked, Why is Resident #36 supposed to be supervised? LPN #3 stated, Because she will get hung on stuff and it prevents the chair from moving, and it scoots her closer to the edge of the chair. LPN #3 was asked, Why is Resident #36 supposed to have non-skid socks on while up in the chair? LPN #3 stated, It helps to grip the floor and helps to move. LPN #3 was asked, Why should resident ' s care plan be followed, and interventions implemented for residents at high risk for falls? LPN #3 stated, To maintain a safe environment. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>39316<br><br>Based on observations, interview, and record review, the facility failed to (1) ensure medications were readily available at all times for 1 (Resident #28) of 1 sampled resident, who was on scheduled pain medication, to prevent possible increase in pain or further decline in status, (2) ensure that staff performed hand hygiene while providing incontinence care for 1 (Resident #32) sampled resident, (3) ensure that staff utilized adjustable chairs in a manner that avoided causing a restraint for 1 (Resident #36) sampled resident, (4) ensure that privacy was maintained while providing bathing and incontinence care for 3 (Residents #61, #72, and #304) sampled residents, and (5) ensure that safety devices were utilized while lifting and transferring for 2 (Residents #87 and #304) sampled residents.<br><br>The findings are:<br><br>Resident #28 had diagnoses of Chronic pain and Dementia. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/07/2024 documented a Brief Interview for Mental Status (BIMS) score of 10 (8-12 indicates moderate cognitive impairment).<br><br>Resident #28's Physician Orders documented an order, dated 02/02/2024, for Lyrica (a medication that can treat nerve and muscle pain) 150 milligram (mg), one capsule twice daily for pain.<br><br>Resident 28's Care Plan, initiated 09/27/2022, revealed the resident will not have unrelieved pain times (x) 90 days as evidenced by (AEB) no moaning, groaning, or facial grimaces. Interventions included coordinating with physician to manage pain medication for optimum control of pain.<br><br>The Approved Emergency Medication List 2024 dated 2024, revealed no Lyrica in the emergency kit.<br><br>A nursing Progress Notes, dated 03/15/2024 at 03:44 PM, revealed scheduled for 03/15/2024 04:00 PM, needs new script (rx), doctor (name) aware per day shift nurse.<br><br>Resident #28's Medication Administration Record (MAR) dated March 2024, revealed Lyrica was administered to Resident #28 on 03/15/2024 at 08:00 AM, 03/16/2024 at 08:00 AM and at 04:00 PM, on 03/17/2024 at 08:00 AM and at 04:00 PM. Lyrica was not administered on 03/18/2024 at 08:00 AM or at 04:00 PM.<br><br>On 03/20/2024 at 10:37 AM, in the medication cart for South East and East Hall a bubble card for, Resident #28 was found that was labeled, Lyrica 150 mg give 1 tablet twice a day (BID) . The bubble card documented a 0 balance, with the last dose given 3/15/2024 at 08:00 AM. Registered Nurse (RN) #1<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | stated, We've ordered it and it didn't come in, and I called the pharmacy and they said they were waiting on a script. I asked if they had called/faxed the doctor, this was the day before yesterday I think, it might have been yesterday, they said no, they we're waiting on us to contact the doctor, I asked them if the send out request for that, for the script, and they said yes they would do that, so they were going to send it to the doctor, and I talked to the Assistant Director of Nursing (ADON) and she was going to contact the doctor too. RN #1 stated, [The resident] has not complained of pain or asked for pain meds. RN #1 was asked what do you normally do if you run out of meds for a resident? RN #1 stated, Normally call the pharmacy, normally we don't call the doctor for scripts. I would think the pharmacy would be responsible for it. RN #1 was asked, Have you been trained on ordering medications when the script runs out? RN #1 stated, I had 3 days of training, and I had to learn it on my own because they were shorthanded. RN #1 was asked, How long have you worked here? RN #1 stated, I started February 5, I left for vacation, and came back on the 25th.<br><br>On 03/20/2024 at 12:00 PM, the Director of Nursing (DON) stated, We don't have it (Lyrica) in the E-kit. The DON was asked, Is there any documentation that the nurse contacted the pharmacy or physician about being out of Resident #28 ' s Lyrica? The DON stated, I was just made aware of this, the ADON said she called the doctor yesterday. The DON was asked, What about the resident not receiving the scheduled medication? The DON said, [His/her] pain had not increased and [he/she] had PRN Norco.<br><br>On 03/20/2024 at 02:02 PM, RN #1 was asked, On 03/19/2024 did you document that you administered Lyrica to Resident #28? RN #1 stated, I accidentally checked it. RN #1 was asked, Did you take the Lyrica from the ER box? RN #1 stated, I didn't check the ER box, I gave the last dose of Lyrica on March 15th, which made it zero. RN #1 was asked, What does a check mark on the MAR mean? RN #1 stated, I assume it was given. After assessing the Narcotic book with RN #1, the nurse marked the date of 3/15/2024 at 04:00 PM instead of 03/14/2024 at 04:00 PM. RN #1 was asked, How do you ensure medication/narcotics are documented for accurate counts? RN #1 stated, Sign out in the (narcotic) book, each shift counts, oncoming and outgoing, and if there are any discrepancies, we look into it. RN #1 was asked, Why should medications/narcotic records be accurate when documenting administration of the medications? RN #1 stated, To show the resident is getting the correct medication, the right dose, follow the 5 rights, right resident, right medication, right dosage, right time, and right route. RN #1 was asked, Why should the doctor be notified if a resident runs out of medication, and they need more? RN #1 stated, So they know they are out and need more. RN #1 was asked, Who is responsible for ensuring the doctor is notified? RN #1 stated, I'm not sure, everywhere I've worked it's always been me.<br><br>(continued on next page) |

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F 0726

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 03/20/2024 at 03:12 PM, the ADON was asked to explain the situation regarding Resident #28's Lyrica 150 mg BID that ran out on March 15, 2024. The ADON stated, The night nurse showed me the empty card when I took over and did the count yesterday morning, I called the on-call for doctor (name), I never got a call from on-call, so I called doctor (name), and I had to leave a voicemail because he didn't answer. I called a second time with no answer, then I called Doctor (name he's our medical director, and he said I could go ahead and call the Lyrica to the pharmacy under him, because I'm an agent under him. The ADON was asked, Why did it take 5 days before someone said anything or ordered the meds? The ADON stated, That's the first I had heard about it, doesn't make any sense to me. The ADON was asked, Why should the nurse contact the physician when a resident runs out of medication or needs a new script? The ADON stated, So the resident doesn't run out. That tells me they weren't paying attention to what they were giving or paying attention to the MAR. The ADON was asked, How do you ensure medications/narcotics are documented for accurate counts? The ADON stated, Nurses count each shift and any discrepancies we contact unit manager. The ADON was asked, Why should medication/narcotic records be accurate when documenting administration of the medications? The ADON stated, So you know the resident got the medication and it's not diverted.

A Face Sheet indicated the facility admitted Resident #32 with diagnoses of Hemiplegia and Dementia.

The Quarterly MDS with an ARD of 03/15/2024, revealed Resident #32 had a BIMS score of 15 (13-15 indicates cognitively intact). The resident required partial/moderate assistance for toileting and was always incontinent of bowel and bladder.

Resident #32's Care Plan, reviewed 12/06/2022, revealed the resident was incontinent of bowel and bladder. Interventions included perineal care after each incontinent episode, initiated 05/15/2018; disposable brief program, initiated 05/15/2018.

A facility policy titled, Hand Hygiene, dated June 11, 2020, specified, To provide guidelines to employees for proper and appropriate hand washing techniques that will aide in the prevention of the transmission of infections. Hand washing should be performed between procedures with the resident/guest(s) based upon the principle that all blood, body fluids, secretions, excretions (except swear), non-intact skin, and mucus membranes may contain transmissible infectious agents. If hands are not visible soiled, use an alcohol-based hand sanitizer for routinely decontaminating hands in all clinical situations other than those listed under Handwashing above. Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: when hands are visibly soiled (hand washing with soap and water); before and after direct resident/guest contact (for which hand hygiene is indicated by acceptable professional practice). Before and after assisting a resident/guest with personal care (e.g. oral care, bathing). After contact with a resident/guest(s) mucous membranes and body fluids or excretions. After handling soiled or used linens, dressings, bedpans, catheters, and urinals. After handling soiled equipment or utensils. After removing gloves or aprons. Consistent us by staff of proper hygienic practices and techniques is critical to preventing the spread of infections.

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/21/2024 at 11:04 AM, Certified Nursing Assistants (CNA) #10 and #11 entered Resident #32 ' s room. CNA #10 and CNA #11 did not perform hand hygiene. Both CNAs applied gloves. CNA #11 moved Resident #32 ' s bed away from the wall and positioned him/herself between the bed and wall. CNA #11 did not perform hand hygiene and did not change gloves. CNA #10 pulled the privacy curtain with gloved hands. CNA #10 did not change gloves and did not perform hand hygiene. CNA #10 obtained two plastic bags and placed at the head of Resident #32 bed and near Resident #32 ' s head. CNA #10 obtained a package of premoistened wipes from the nightstand and placed them on Resident #32 ' s bed. CNA #10 performed incontinence care, during which they did not change gloves and did not perform hand hygiene. CNA #10 picked up the premoistened wipe package with both gloved hands, placed the package on the nightstand. CNA #11 rolled Resident #32 toward the wall. CNA #11 placed a clean brief under the dirty brief and under Resident #32, then removed the dirty brief using the same dirty gloves. CNA #10 stated, I'm in a rush, I need to slow down. Using the same dirty gloves, CNA #11 obtained the package of premoistened wipes from the nightstand, placed on the bed, and using the left hand, held the premoistened package of wipes, while removing wipes from the package using the right hand. CNA #10 continued performing incontinence care, during which they did not change dirty gloves and did not perform hand hygiene. CNA #10 placed the package of premoistened wipes in a basket on the nightstand. The CNAs rolled Resident #32 toward CNA #10, with Resident #32 ' s face near the plastic bags with the dirty brief and wipes. CNA #10 removed a package of skin protectant from the basket using the same dirty gloves used to provide incontinence care, then opened the package of skin protectant, squeezed the package with the left hand, and placed the skin protectant into the right hand. CNA #10 applied skin protectant to Resident #32 genitals and in between both legs on the front side. CNA #10 removed their used gloves and placed into the trash, then stated, I forgot to change gloves, you are supposed to change gloves when doing perineal care.<br><br>e. On 03/21/2024 at 12:03 PM, CNA #10 was asked, When should hand hygiene be performed? CNA #10 stated, Before, during, and after care. CNA #10 was asked, When should gloves be changed when doing perineal care? CNA #10 stated, Before, during, and after. CNA #10 was asked, Why should hand hygiene/gloves be changed during perineal care? CNA #10 stated, To keep from transferring germs.<br><br>f. On 03/21/2024 at 12:05 PM, the ADON was asked, When should hand hygiene be performed? The ADON stated, Anytime you enter or leave the room, before providing care, when you complete care for a resident, when gloves become soiled. You should sanitize before putting clean gloves on. The ADON was asked, When should gloves be changed when doing perineal care? The ADON stated, Change gloves before going to a different area and if they become soiled. The ADON was asked, Why should hand hygiene/glove changes be performed during perineal care? The ADON stated, To prevent infection, to prevent the staff from giving anything to a resident or transferring anything from a resident.<br><br>g. On 03/21/2024 at 12:16 PM, the DON was asked, When should hand hygiene be performed? The DON stated, Prior to entering the room, in between tasks, when visibly soiled and dirty. The DON was asked, When should gloves be changed when doing perineal care? The DON stated, When visibly soiled. The DON was asked, Why should hand hygiene/glove changes be performed during perineal care? The DON stated, To prevent infection.<br><br>3. A Face Sheet indicated Resident #36 had a diagnosis of Dementia.<br><br>a. The Annual MDS with an ARD of 01/23/2024, revealed Resident #36 had a Staff Assessment for Mental Status (SAMS) score of 1, which indicated a memory problem.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Legacy Health and Rehabilitation Center | 3310 North 50th Street<br>Fort Smith, AR 72904 |

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) |
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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | b. Resident #36's Care Plan, reviewed 02/09/2023, revealed the resident had a potential for falls. Interventions included: encourage clutter free environment and path to bathroom, initiated 12/17/2022; encourage use of handrails/appropriate assistive devices, initiated 12/17/2022; wear non-slip footwear while out of bed, initiated 12/17/2022. The resident was at risk for poor safety awareness. Interventions included: place resident in area where frequent observation is possible, initiated 03/06/2019.<br><br>c. On 03/18/2024 at 11:46 AM, Resident #36 was observed sitting in an adjustable chair alone in their room. Resident #36 attempted to get up from the chair by lifting bottom and scooting toward the front of the chair. Resident # 36 ' s chair is stuck on the fall mat on the side of the A bed. A fall mat was observed on the floor in front of the B bed. Resident #36 had regular socks on.<br><br>d. On 03/18/2024 at 01:39 PM, Resident #36 was observed alone in their room seated in an adjustable chair. The chair was sitting on the fall mat near the bed. Resident #36 was unable to move self in the chair while on the fall mat.<br><br>e. On 03/18/2024 at 02:29 PM, Resident #36 was observed alone in their room, sitting on the edge of their chair in the doorway of room. Resident #36 was unable to self-propel in the chair. Resident #36 had regular socks on.<br><br>f. On 03/19/2024 at 02:48 PM, Resident #36 was observed sitting in a chair in their room alone. The chair was next to the resident ' s bed, on the fall mat, and the brake was locked on the right wheel. Resident #36 was not able to self-propel the chair.<br><br>g. On 03/19/2024 at 02:51 PM, Certified Nursing Assistant (CNA) #10 was asked why Resident #36 ' s brake was locked on their chair. CNA #10 stated, We can't leave it locked. CNA #10 asked CNA #11 if she had locked Resident #36 brake. CNA #10 was asked if locking Resident #36 brake would be considered a restraint. CNA #10 stated, Yes, it's a restraint.<br><br>h. On 03/19/2024 at 02:52 PM, CNA #11 stated, I locked it when I changed [him/her] earlier, I forgot to unlock it. CNA #11 stated, We are short staffed every day, I was in a hurry. CNA #11 was asked how long the facility has been short staffed. CNA #11 stated, It's been going on for quite a while, night shift comes in to help day shift. CNA #10 stated, We have 21 residents on this hall, there's a lot of lifts, we don't even have time to chart. CNA #10 was asked, Do you have a shower team, or do you do your own showers? CNA#10 stated, We do our own, we had 7 showers today and 5 on the other days.<br><br>i. On 03/19/2024 at 04:30 PM, Resident #36 was observed alone in their room sitting in a chair going around in circles.<br><br>j. On 03/20/2024 at 06:25 AM, Resident #36 was observed in their chair at the nurses ' station with eyes closed.<br><br>k. On 03/20/2024 at 01:38 PM, Resident #36 was observed alone in their room sitting up in a chair with eyes closed. The brake on the right side of Resident # 36 chair is locked.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045267 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/21/2024 |
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| NAME OF PROVIDER OR SUPPLIER Legacy Health and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 3310 North 50th Street Fort Smith, AR 72904 | |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | l. On 03/20/2024 at 01:45 PM, the Director of Nursing (DON) was asked, Is Resident # 36 supposed to be left alone in the room? The DON stated, I will find out. The DON was asked, Why is the locked brake on Resident #36 chair considered a restraint? The DON stated, Because she can't move. The DON stated, The resident could not move being left on the fall mat, nothing will roll on the fall mat.<br><br>m. On 03/21/2024 at 09:39 AM, CNA #10 was asked, What are the fall interventions for Resident #36? CNA #10 stated, Use a gait belt to transfer, 2 person assist, fall mat, and they just told us we are to remove the fall mats off the floor when [he/she] is in the chair. CNA #10 was asked, Is Resident #36 supposed to be observed at all times? CNA #10 stated, I always left [the resident in their] room, [he/she] can't defend [his/herself]. CNA #10 was asked, Is Resident #36 supposed to wear special footwear? CNA #10 stated, No, special socks. CNA #10 was asked, Why should residents care plan be followed, and interventions implemented for at high risk for falls? CNA #10 stated, For their safety.<br><br>n. On 03/21/2024 at 10:04 AM, Licensed Practical Nurse (LPN) #3 was asked, What are the fall interventions for Resident #36? LPN #3 stated, Fall mat at bedside while in the bed, wheelchair brakes have to be unlocked so she can move around, non-skid socks, and out so we can observe [him/her]. LPN #3 was asked, How do you know how to take care of Resident #36? LPN stated, The care plan, any special needs pop up on the Medication Administration Record (MAR), and in report. LPN #3 was asked, Why is Resident #36 supposed to be supervised? LPN #3 stated, Because [he/she] will get hung on stuff and it prevents the chair from moving, and it scoots [him/her] closer to the edge of the chair. LPN #3 was asked, Why is Resident #36 supposed to have non-skid socks on while up in their chair? LPN #3 stated, It helps to grip the floor and helps to move. LPN #3 was asked, Why should residents care plan be followed, and interventions implemented for at high risk for falls? LPN #3 stated, To maintain safe environment.<br><br>4. Resident #72 had diagnoses of Parkinson's without fluctuations and Dementia without behavioral disturbances. The MDS with an ARD of 02/19/2024 revealed the resident received a score of 3 (0-7 indicates severe cognitive impairment) on the BIMS. The MDS with an ARD of 02/19/2024 on section GG documented that the resident is dependent for transfers.<br><br>a. On 03/19/2024 at 08:52 AM, the Surveyor observed the door open with Resident #72 sitting fully naked in a shower chair, with the curtain and door not closed. Resident #72 was fully visible from the hallway.<br><br>b. On 03/20/2024 at 09:30 AM, the Surveyor asked CNA #4, When transferring Resident #72 yesterday to the shower, should the curtain have been pulled and the door closed? CNA #4 said, Yes it should have been. The Surveyor asked why this could be an issue. CNA #4 said, For the resident's privacy.<br><br>c. On 3/20/2024 at 09:32 AM, the Surveyor asked CNA #3, When transferring Resident #72 yesterday to the shower, should the curtain have been pulled and the door closed? CNA #3 said, Yes it should have been. The Surveyor asked why this could be an issue. CNA #3 said, Dignity.<br><br>5. Resident #87 had diagnoses of Autistic disorder and Intellectual disabilities. The Significant Change MDS with an ARD of 02/16/2024 documented the resident scored 3 (3 indicates severely impairment) on a (SAMS) and was a maximal assistance dependent with two people assist for transfers.<br><br>The Care Plan documented, .Potential for falls .start date 01/31/2024 .care plan goal .I don't want to fall x 90 days .Intervention .Staff to check resident during rounds .<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/21/2024 at 09:30 AM, the resident was observed sitting on the floor at the front nurse's station by his/her wheelchair. Observed Certified Nursing Assistant (CNA) #3 and #5 place their hands in the resident arm pits on each side. They lifted the resident from the floor into the chair. The Administrator was standing at the nurse's station observing the incident.<br><br>On 03/21/2024 at 09:35 AM, the Surveyor asked RN #1, How did the staff lift the resident from the floor? RN #1 said, They picked him up. The Surveyor asked, What should the staff use when lifting a resident? RN #1 stated, We should probably use a gait belt.<br><br>On 03/21/2024 at 09:38 AM, the Surveyor asked the Administrator, Did the staff use a gait belt when lifting the resident from the floor? They replied, No.<br><br>Resident #61 had a diagnosis of dementia with unspecified severity with agitation and a history of falling. The MDS with an ARD of 01/15/2024 revealed the resident scored a 3 on the BIMS, and that the resident is an independent/supervision with transfers. Resident #304 had diagnoses of Alzheimer's disease early onset, Generalized anxiety disorder, and Depression. According to the MDS with an ARD 01/31/2024 revealed the resident scored a 4 on the BIMS.<br><br>On 03/19/2024 at 2:45 PM, the Surveyor observed CNA #1 walking with Resident #304 with no gait belt in use. Resident #304 lost their footing and fell backwards. CNA #1 caught him/her from behind, while another CNA held Resident #304 hands while CNA #1 helped stand Resident #304 up. CNA #1 then attempted to walk Resident #304 with the other CNA behind them. Resident #304 continued having trouble with footing and almost fell again. Both CNAs then helped Resident #304 to sit on their rolling walker with basket. CNA #1 took Resident #304 to their room, parked the rolling walker at the end of the bed, locking both brakes, then proceeded to wrap their arms around Resident #304's chest and asked the resident to hold on. Surveyor observed the transfer occur with no gait belt. Resident #304's legs were shaky, and their arms lifted up completely vertical during the transfer.<br><br>b. On 03/19/2024 at 02:58 PM, the Surveyor asked CNA #1, Should any safety devices be in use while transferring? CNA #1 said, Yes, because they could fall or get hurt.<br><br>c. On 03/21/2024 at 08:40 AM, the Surveyor asked the DON, Should any safety devices be in use while transferring residents? The DON said, Yes, they should be in use. The Surveyor asked why could this be an issue with the residents. The DON said, They could get injured. The Surveyor asked the DON about the level of transfer for Resident #304. The DON said that right now [Resident #304] is charted as independent but had a recent change with the resident being added on hospice, and the transfers can change from day to day.<br><br>d. On 03/19/2024 at 02:39 PM, the Surveyor observed two CNA's changing Resident #61 and Resident #304 in the resident women's bathroom for the secure unit. The Surveyor observed CNA #2 changing Resident #61 in the right stall with the door opened. Surveyor observed that CNA #2 was changing Resident #61's clothes, while CNA #2 was pulling up teal-colored pants on Resident #61 the surveyor observed that you can see the resident naked and fully visible from the hall, as the main door was left opened to the resident's women bathroom as well. The Surveyor observed CNA #2 pulling a pink shirt with flowers over Resident #61's head. Surveyor observed that CNA #1 was changing Resident #304 in the left most stall with the door open as they began to walk out of the room when finished with care. CNA #1 was telling CNA #2 that Resident #304 also had a bowel movement that required clothes to be changed.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | e. On 03/19/2024 at 02:45 PM, the Surveyor asked CNA #1, Should the door have been closed to the bathroom and stalls while residents were undressed? The CNA said, Well, there is not much room in there to work in but yes, I should have. The Surveyor asked CNA #1, Why is that an issue for the resident? CNA #1 said, Well like I said, there is not much room in this bathroom to work with, but yes, for privacy.<br><br>f. On 03/19/2024 at 02:48 PM, the Surveyor asked CNA #2, Should the door have been closed to the bathroom and stalls while residents were undressed? CNA #2 said, Yes, they should have been. The Surveyor asked, Why is that an issue for the resident? CNA #2 said, For their privacy.<br><br>g. On 03/21/2024 at 08:30 AM, the Surveyor asked the DON, When transferring residents or providing care should the curtain be pulled and the door closed? The DON said, Yes it should be pulled closed. The Surveyor asked the DON why this is an issue for the residents. The DON said, For their privacy and dignity.<br><br>h. On 03/20/2024 at 04:45 PM, the Administrator provided a policy titled Federal Rights of Resident/Guest(s) that states (e) Respect and dignity: The resident/guest has a right to be treated with respect and dignity.<br><br>49689 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>39316<br><br>Based on observation, interview, and record review, the facility failed to ensure medications were readily available at all times for 1 (Resident #28) of 1 sampled resident, who was on scheduled pain medication, to prevent possible increase in pain or further decline in status. The findings are:<br><br>A Face Sheet indicated the facility admitted Resident #28 with diagnoses of Chronic pain and Dementia.<br><br>The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/07/2024 revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment.<br><br>A review of Resident #28's Physician Orders, for the month of 03/2024, revealed an order, dated 02/02/2024, for Lyrica (a medication given for pain) 150 milligram (mg), one capsule twice daily for pain.<br><br>Review of Resident 28's Care Plan, initiated 09/27/2022, revealed the resident will not have unrelieved pain times (x) 90 days as evidenced by (AEB) no moaning, groaning, or facial grimaces. Interventions included coordinate with physician to manage pain medication for optimum control of pain, initiated 09/27/2022.<br><br>A review of the Approved Emergency Medication List 2024 dated 2024, revealed no Lyrica in the emergency kit.<br><br>A review of a nursing Progress Notes, dated 03/15/2024 at 03:44 PM, revealed scheduled for 03/15/2024 04:00 PM, needs new script (rx), doctor (name) aware per day shift nurse.<br><br>A review of Resident #28 ' s Medication Administration Record dated March 2024 revealed Lyrica was administered to Resident #28 on 03/15/2024 at 08:00 AM, 03/16/2024 at 08:00 AM and at 04:00 PM, on 03/17/2024 at 08:00 AM and at 04:00 PM. Lyrica was not administered on 03/18/2024 at 08:00 AM or at 04:00 PM.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/20/2024 at 10:37 AM, a bubble card was observed for Lyrica 150 mg give 1 tablet twice a day (BID) with a zero balance with a last dose given 3/15/2024 at 08:00 AM. It documented the card was for Resident #28. RN #1 stated, We've ordered it and it didn't come in, and I called the pharmacy and they said they were waiting on a script. I asked if they had called/faxed the doctor, this was day before yesterday I think, it might have been yesterday, they said no, they we're waiting on us to contact the doctor, I asked them if the send out request for that, for the script, and they said yes they would do that, so they were going to send it to the doctor, and I talked to the Assistant Director of Nursing (ADON) and she was going to contact the doctor too. RN #1 stated, [Resident #28] has not complained of pain or asked for pain meds. RN #1 was asked, What do you normally do if you run out of meds for a resident? RN #1 stated, Normally call the pharmacy, normally we don't call the doctor for scripts. I would think the pharmacy would be responsible for it. RN #1 was asked, Have you been trained on ordering medications when the script runs out? RN #1 stated, I had 3 days of training, and I had to learn it on my own because they were shorthanded. RN #1 was asked, How long have you worked here? RN #1 stated, I started February 5, I left for vacation, and came back on the 25th.<br><br>On 03/20/2024 at 12:00 PM, the Director of Nursing (DON) stated, We don't have it (Lyrica) in the E-kit. The DON was asked, Is there any documentation that the nurse/nurses contacted the pharmacy or physician about being out of Resident #28 ' s Lyrica? The DON stated, The ADON (Assistant Director of Nurses) said she called the doctor yesterday. The DON was asked, What about the resident not receiving the scheduled medication? The DON said, [His/her] pain had not increased and [he/she] had PRN Norco.<br><br>On 03/20/2024 at 02:02 PM, RN #1 was asked, On 03/19/2024 did you document that you administered Lyrica to Resident #28? RN #1 stated, I accidentally checked it. RN #1 was asked, Did you take the Lyrica from the ER box? RN #1 stated, I didn't check the ER box, I gave the last dose of Lyrica on March 15th, which made it zero. RN #1 was asked, What does a check mark on the MAR mean? RN #1 stated, I assume it was given. After assessing the Narcotic book with RN #1, the nurse marked the date of 03/15/2024 at 04:00 PM instead of 3/14/2024 at 04:00 PM. RN #1 was asked, How do you ensure medication/narcotics are documented for accurate counts? RN #1 stated, Sign out in the (narcotic) book, each shift counts, oncoming and outgoing, and if there are any discrepancies, we look into it. RN #1 was asked, Why should medications/narcotic records be accurate when documenting administration of the medications? RN #1 stated, To show the resident is getting the correct medication, the right dose, follow the 5 rights, right resident, right medication, right dosage, right time, and right route. RN #1 was asked why should the doctor be notified if a resident runs out of medication, and they need more? RN #1 stated, So they know they are out and need more. RN #1 was asked who is responsible for ensuring the doctor is notified. RN #1 stated, I'm not sure, everywhere I've worked it's always been me.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/20/2024 at 03:12 PM, the ADON was asked to elaborate about Resident #28's Lyrica 150 mg BID that ran out on March 15, 2024. The ADON stated, The night nurse showed me the empty card when I took over and did the count yesterday morning, I called the on-call for doctor (name), I never got a call from on-call, so I called doctor (name), and I had to leave a voicemail because he didn't answer. I called a second time with no answer, then I called Doctor (name he's our medical director, and he said I could go ahead and call the Lyrica to the pharmacy under him, because I'm an agent under him. The ADON was asked, Why did it take 5 days before someone said anything or ordered the meds. The ADON stated, That's the first I had heard about it, doesn't make any sense to me. The ADON was asked, Why should the nurse contact the physician when a resident runs out of medication or needs a new script? The ADON stated, So the resident doesn't run out. That tells me they weren't paying attention to what they were giving or paying attention to the MAR. The ADON was asked, How do you ensure medications/narcotics are documented for accurate counts? The ADON stated, Nurses count each shift and any discrepancies we contact unit manager. The ADON was asked, Why should medication/narcotic records be accurate when documenting administration of the medications? The ADON stated, So you know the resident got the medication and it's not diverted. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39316<br><br>49689<br><br>According to record review, observations, and interview the facility failed to ensure that a clean, safe, comfortable homelike environment was provided in rooms [ROOM NUMBER], the Resident Bathroom in the secure unit, the Dayroom/Dining Room in the secure unit, and for 1 (Resident #50) sampled resident. The findings are:<br><br>On 03/20/2024 at 04:05 PM, the Surveyor did environmental rounds with Maintenance. These are the findings:<br><br>In room [ROOM NUMBER] the Surveyor observed on several ceiling tiles brown areas that were round with irregular borders. On Side B where the bed was against the wall there were varying vertical stripes of stripped paint exposing cinder block. The damage ran the length of the bed. When Maintenance saw the area, he/she said that it was a rather large area that has not been reported.<br><br>In room [ROOM NUMBER] the Surveyor observed on Side A in between the bed and nightstand a horizontal rectangular area that is missing paint and two nails are exposed from chipped drywall. The area has chipped paint and raised areas throughout. Surveyor observed above the head of the bed on Side A are five screws that are out of the wall about an inch or more. On Side B next to the nightstand is a patched area with scuff marks throughout it, paint is chipped in the large area and there are raised bulbous areas. On the ceiling on side a above the window is a darker brown area that is rounded with irregular borders, the darkest area appears to be in the middle. Throughout the room several tiles have brown areas that are brown with irregular borders. Surveyor brought Maintenance in and he said that it was painted yesterday, but the room was horrible.<br><br>On the Secure Unit in the Resident Bathroom, both toilet seats sit in askew positions, the back of the right one, the tank lid is not secured correctly. On the right most stall the door does not close and the handle is pushed inwards. The door to the bathroom on the bottom has large gouges in it with chipped paint exposing splintering wood and paint peeling.<br><br>On the Secure Unit the Dayroom/Dining Room the entrance has a scuffed area with chipped paint, while the entrance area on the right-hand side has a gouged area with chipped paint exposing drywall. Above a table has a large horizontal mark that runs the length of the wall where the paint is chipped and scuffed exposing drywall. A locker in the dining area back left corner has a rust-colored brown area on the floor. The Surveyor observed the cabinet door being opened by staff; the right most upper cabinet is the bottom hinge is completely off the cabinet facing. The other cabinet doors are loose and coming from the cabinet facing.<br><br>On 03/20/24 at 4:05 PM, the Surveyor asked maintenance how they keep track of what repairs are needed. Maintenance said that they increased the number of logbooks, but that Administration would prefer if the staff would put it into the computer.<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/18/2024 at 01:00 PM, Resident #50 was observed lying in bed on a mattress with the vinyl torn and ripped with plastic hanging from underneath the mattress.<br><br>On 03/20/2024 at 07:41 PM, Review of the Equipment or Building Repair Requisition Form, dated 01/08/2024 through 03/14/2024, revealed no repair form for the above environmental concerns.<br><br>On 03/21/2024 at 08:21 AM, a review of documents titled Supplier Invoice, dated 11/21/2023, 12/20/2023, 01/23/2024, and 02/27/2024, documented a total of 10 sets of headboards and footboards had been ordered.<br><br>On 03/21/2024 at 08:25 AM, a review of Supplier Invoice dated 12/21/2023 documented a total of 4 dressers had been ordered.<br><br>On 03/21/2024 at 09:06 AM, a 4-drawer dresser observed in room [ROOM NUMBER] exposing staples approximately 1 inch in length protruding outward in each corner of the top drawer. The footboard vinyl in room [ROOM NUMBER] was observed to be hard, sharp, and peeling, protruding outward approximately 0.5 inches. The finish on a nightstand in room [ROOM NUMBER] B was observed to be worn and in need of repair.<br><br>On 03/21/2024 at 09:39 AM, Certified Nursing Assistant (CNA) #10 was asked, What do you do if something in the facility needs to be fixed? CNA #10 stated, Fill out the form at the nurses ' station for maintenance. CNA #10 was asked, Have you reported anything that needs repair on the South Hall this week? CNA #10 stated, No. CNA #10 was asked to describe the 4-drawer dresser, footboard, and the nightstand in room [ROOM NUMBER]. CNA #10 stated, There are nails sticking out on the dresser that are sharp and dangerous, if people would report this stuff when it happens, it wouldn't be so bad. I should have reported it, it's been like that. The vinyl is peeling, sharp, and pointed on the footboard, and it could scratch someone, the nightstand, the paint is peeling, it needs to be replaced.<br><br>On 03/21/2024 at 10:04 AM, Licensed Practical Nurse (LPN) #3 was asked, what do you do if something in the facility needs to be fixed? LPN #3 stated, In the computer, we can click on an icon, and it creates a work order. LPN #3 was asked, Have you reported anything that needs repair on the South Hall this week? LPN #3 stated, No, not on South Hall. LPN #3 was asked to describe the 4-drawer dresser, footboard, and the nightstand in room [ROOM NUMBER] B. LPN #3 stated, The dresser is a safety issue, the nails can cause injury. The foot board has hard, pointed, vinyl peeling and sticking out, that's another issue that could cause injury. The nightstand finish is worn, I wouldn't have that in my house. LPN #3 was asked to describe the mattress in room [ROOM NUMBER] A. LPN #3 stated, It is torn in multiple placed on the bottom, exposing the inside, it should be replaced. LPN #3 was asked, Who is supposed to report things that need repair, and should these things have been reported? LPN #3 stated, Any staff could report, we are all responsible, and yes, it should have been reported.<br><br>On 03/21/2024 at 10:30 AM, Maintenance was asked, How do staff notify maintenance if something needs to be repaired? Maintenance stated, We have maintenance logs at the nurses ' stations, and they can go to the icon in the computer. I have only been here 4 days, and before I got here, they did everything verbally. Maintenance was asked, Has there been anything reported for repairs on the South Hall? Maintenance stated, No. Maintenance was asked to measure the staples protruding out of the dresser drawer from room [ROOM NUMBER] B. Maintenance stated, They are 1 inch and that could cause an injury. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045267 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/21/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Legacy Health and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 3310 North 50th Street Fort Smith, AR 72904 | |

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) |
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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>48390<br><br>Based on interview and record review, the facility failed to ensure Dementia in-service training was provided in the past year. The findings are:<br><br>1. On 03/21/2024 at 8:20 AM, the Surveyor reviewed in-services and competency training for the past year and did not locate a Dementia in-service. The Surveyor requested the Dementia In-Service.<br><br>2. On 03/21/2024 at 9:00 AM, the LPN #2 stated We looked through all the in-services and could not find one for Dementia.<br><br>3. On 03/31/2024 at 9:00 AM, LPN #2 indicated that she had just taken this position over and was trying to get everything in order but was unsure if staff had dementia training prior to her taking this position.<br><br>. |