

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  01/31/2025
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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>50924</p> <p>Based on observations, interviews, record review, facility document review and facility policy review, it was determined that the facility failed to ensure an accurate account of a controlled medication for 1 of 3 medication carts reviewed for controlled medication reconciliation.</p> <p>Findings include:</p> <p>A review of a facility pharmacy policy book titled, Policy and Procedure Manual for Nursing Facilities contained a policy titled, Medication Administration Procedures Controlled Medication Administration Policy 7.1, dated April 2020 indicated, medication included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal and state law regulations. When a controlled medication is to be administered, the licensed nurse removing the medication immediately enters the following information on the controlled drug record, A. Date and time of removal, B. Amount removed, C. Signature.</p> <p>A review of the Physician Order Report, indicated Resident #107 had an active order for (Brand Name antianxiety medication) 0.5 milligram (mg) scheduled every eight hours to be administered at 9:00 AM, 5:00 PM, and 1:00 AM.</p> <p>During a concurrent observation and interview on 01/29/2025 at 1:41 PM, Licensed Practical Nurse (LPN) #9 removed Resident #107 's (brand name antianxiety medication) card from the locked box of the medication cart and revealed a count of 63 tablets. The controlled medication book was open to the corresponding controlled medication page labeled 24. The reconciliation count in the controlled medication book was 64 and the last entry was on 01/29/2025 at 1:00 AM, about 12-hour prior. LPN #9 immediately stated, I forgot to sign out the dose I gave. LPN #9 stated she administered the controlled medication at 9:00 AM, almost 5 hours prior and the reason it should be signed out immediately was to keep an accurate count of controlled medications in the facility.</p> <p>During an interview on 01/29/2025 at 2:52 PM, the Director of Nursing (DON) stated, the nurses should sign a controlled medication out in the controlled medication book at the time of administration.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 045267	If continuation sheet Page 1 of 11

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>03508</p> <p>Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served according to the planned written menu to meet the nutritional needs of the residents for 1 of 1 meal observed.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. The 01/27/2025 lunch menu documented the residents who required pureed diets were to receive 3 ounces of pureed breaded pork patty, 4 ounces (1/2 cup) of pureed vegetables, 2 ounces of gravy, and 2 ounces of pureed dinner roll.</li> <li>2. A facility recipe titled, recipe for pureed Breaded Pork Patty not dated and provided by the Dietary Manager on 01/28/2025 indicated; .Notes: 1. For pureed measure desired # (number) of servings into food processor. Blend until smooth and add broth or gravy if product needs thinning .             <ol style="list-style-type: none"> <li>a. On 01/27/2025 at 11:37 AM, Dietary [NAME] (DC) #11 placed 7 servings of breaded fried pork into a blender, added 2 cups of water from the food preparation sink, instead of broth or gravy. At 11:40 AM, DC #11 was interviewed and was asked how much water she added to the meat, and she estimated it was about 3/4 cup. When DC #11 was asked to measure the amount of water precisely, DC #11 removed the pork patties from the blender, poured the water into a measuring cup and confirmed she had used 2 cups of water. DC #11 then placed the 7 servings of fried breaded pork patties into the blender, added 2 cups of water and continued pureeing it. On 01/28/2025 at 12:09 PM, DC #11 was interviewed and asked how fried breaded pork patties pureed with water would taste, and she stated it will taste bland.</li> </ol> </li> <li>3. On 01/27/2025 at 12:46 PM, the following observations were made during the noon meal service:             <ol style="list-style-type: none"> <li>a. Dietary [NAME] (DC) #11 used a #20 scoop, equivalent to 1.5 ounces, to serve 2 servings of pureed cut green beans, totaling 1/3 cup, to each resident who received pureed alternative cut green beans, instead of using a number #8 scoop, which is equivalent to 1/2 cup.</li> <li>b. There was no gravy served to the residents who required pureed diets with their meal.</li> <li>c. There was no pureed bread served to the residents who required pureed diets. There were no substitutions served in place of the dinner roll.</li> <li>d. On 01/27/2025 at 1:06 PM, DC #11 was interviewed and asked what scoop size she had used to serve the pureed cut greens, and how many servings she gave to each resident who received pureed cut green beans. She stated she used a #20 scoop which is equivalent to 1.5 ounces and gave 2 servings of pureed cut green beans each, totaling 1/3 cup, instead of 1/2 cup. DC #11 was asked the reason residents on pureed diets did not receive gravy and a pureed dinner roll. She stated she was unaware they were supposed to receive gravy, and she forgot to fix pureed dinner rolls.</li> </ol> </li> </ol>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>49866</p> <p>Based on observations, interviews, record review, and facility document review, it was determined the facility failed to serve and offer double portions as ordered for 1 (Resident #73) of 1 resident reviewed for therapeutic diet.</p> <p>The findings include:</p> <p>A review of a facility's, Admission Agreement, dated 11/2016, indicated, E. Dietary Services. The Facility maintains a food service program monitored by a registered dietician. The Facility shall provide you regular meals and will use its best efforts to provide you with therapeutic diets and snacks prescribed by your attending physician.</p> <p>A review of the Face Sheet, indicated the facility admitted Resident #73 with diagnoses which included Huntington ' s disease, major depressive disorder, nausea with vomiting, disease of salivary glands, and pain.</p> <p>The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/13/2025 revealed Resident #73 had a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident had moderate cognitive impairment. Resident #73 was recorded as a weight of 88 pounds (lbs). Resident #73 was identified with weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and not on a physician-prescribed weight loss regimen. Which is defined in the Centers for Medicare &amp; Medicaid Services (CMS) Resident Assessment Instrument (RAI) 3.0 Manual Page K-8 as a significant weight loss. No swallowing disorders were identified.</p> <p>A review of a dietary physician order started 10/10/2024 revealed Resident #73 had a Regular diet order with pureed consistency and special instructions Double Portions.</p> <p>A review of a flowsheet titled, Vitals, revealed Resident #73 consumed 76-100% of the breakfast meal on 01/30/2025 at 7:15 AM.</p> <p>During an observation on 01/30/2025 at 8:17 AM, Resident #73 was eating breakfast with the assistance of Certified Nursing Assistant (CNA) #29 and the meal card on the resident's plate indicated the resident should be receiving double portions. Double portions were not observed.</p> <p>During an interview on 01/30/2025 at 8:27 AM, CNA #29 stated, Resident #73 was not served double portions. CNA #29 stated she let the resident tell her if the resident wanted more and the resident did not. CNA #29 stated Resident #73 had a supplemental shake prior to breakfast.</p> <p>During an interview on 01/30/2025 at 3:14 PM, Licensed Practical Nurse (LPN) #8 stated, Resident #73 was ordered a regular, pureed diet with double portions and supplement shakes. LPN # 8 stated because the resident moved around a lot and burned calories the resident had lost weight. The CNA should have gotten the other portions and offered them, we are required to serve what is ordered and it is up to the resident if they choose to eat it. LPN #8 utilized the Electronic Health Record (EHR) and reported Resident #73's current weight was 76 lbs.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/30/2025 at 11:30 AM, the Dietary Manager (DM) #1 stated she was also the cook for breakfast and prepared Resident #73's breakfast tray. DM #1 reviewed Resident #73's meal card and stated double portions should be served but had not served double portions to Resident #73 as ordered. DM #1 stated she was not aware if Resident #73 had a weight loss or not, but it was important the residents were served what was ordered because it was ordered for a reason.</p> <p>During an interview on 01/31/2025 at 8:15 AM, the Director of Nursing (DON) stated, if double portions were ordered by the physician they should be served. It was important because it may be an intervention or a resident request. The DON stated the CNA should have returned to the kitchen and obtained another plate to equal double portions, not offering double portions could lead to weight loss.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>03508</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure food items in the refrigerator, freezer and storage room were covered or sealed; 1 of 2 ice machines was maintained in clean and sanitary condition; dietary staff washed their hands before handling food or clean equipment; ceiling tiles, air vents, dish washer wall, kitchen door frames were free of, debris, dirt, rust, stains; baseboards were secured; and hot food items were maintained at temperature of 135 degrees or above for 2 of 2 meals observed.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>On 01/27/2025 at 11:28 AM, an observation of the inside back panel of the ice machine in the kitchen as well as the area where ice formed before dropping into the ice collector had wet pink residue on it. The areas were pointed out to the Dietary Manager (DM) #1 and during an interview she was asked if the residue build up could be wiped off, how often she cleans the ice machine, and who used the ice from the machine. She used tissue papers and wiped the wet pink residue off. The wet pink residue easily transferred to the tissue, and she confirmed there was wet pink residue in the area. DM #1 instructed Dietary Aide (DA) #10 to use tissue papers and wipe down the inside back panel of the ice machine. When DA #10 did, a black residue easily transferred to the tissue paper. DM #1 stated the maintenance man cleaned it once a month. The kitchen staff used it to fill beverages served to the residents at mealtimes and CNAs [Certified Nursing Assistants] used it for the water pitchers in the residents' rooms.</li> <li>On 01/27/2025 at 11:45 AM, the following observations were made in the freezer: <ol style="list-style-type: none"> <li>An opened box of vegetable blend was on a shelf in the freezer. The box was not covered or sealed.</li> <li>An opened box of cookies was on a shelf in the freezer. The box was not covered or sealed.</li> <li>An opened box of hamburger patties was on a shelf in the freezer. The box was not covered or sealed.</li> <li>An open box of dinner rolls was on a shelf in the refrigerator. The box was not covered or sealed.</li> </ol> </li> <li>On 01/27/2025 at 11:51 AM, an opened bag of coffee was on a counter where the coffee machine was located. The opened coffee bag was pointed out to Dietary Manager #1, and she confirmed that the coffee bag should not have been left out and should have been kept in a sealed bag.</li> <li>On 01/27/2025 at 11:54 PM, an opened box of sausage was on a shelf in the refrigerator. The box was not covered or sealed.</li> <li>On 01/27/2025 at 12:12 PM, the temperatures of the food items when checked and read on the steam table by the DC #11 were:</li> </ol> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. Breaded fried pork steak - 119 degrees Fahrenheit.</p> <p>b. Ground breaded fried pork steak - 125 degrees Fahrenheit.</p> <p>c. Macaroni and cheese - 126 degrees Fahrenheit.</p> <p>d. Pureed cut green - 116 degrees Fahrenheit.</p> <p>The above food items were not reheated before being served to the residents.</p> <p>6. On 01/27/2025 at 12:15 PM, the following observations were made in the kitchen areas:</p> <p>a. The wall above the door frames leading to the outside; the wall between the door leading to the outside; the hand washing sink; the wall above the thermostat leading to the dishwashing machine room; and above the rack by the walk-in refrigerator where storage containers were kept had cobwebs hanging down from them.</p> <p>b. The door behind the rack by the walk-in refrigerator where clean containers were kept had sage color stains on it.</p> <p>c. The wall by the janitor's closet leading to the storage room and the walls in the dishwashing machine room were chipped and exposed the concrete.</p> <p>d. The door frames leading to the dining room, outside, janitor's closet, storage room, and dishwashing machine were chipped, the chipped areas were covered with rust.</p> <p>e. The wooden shelves where clean pans were kept had loose food crumbs on them.</p> <p>f. The (brand name) countertop covering above the counter where clean pans were kept was chipped which exposed the wood.</p> <p>g. The baseboard below the dishwashing machine had sage residue on it.</p> <p>h. The floor tiles in the dishwashing machine were missing; the areas where tiles were missing were covered with black dirt. There was loose salt, pepper, pink sugar and regular sugar packets on it.</p> <p>i. The floor between the ice machine and the 2-compartment sink had a wet accumulation of black residue on it. The pipes attached to the ice machine had black stains on them. The wall above this area had brown stripes of residue on it.</p> <p>7. On 01/27/2025 at 12:25 PM, the following observations were made in the storage room:</p> <p>a. A bottle of lemon juice, on a rack in the storage room, was opened and partially used. Dietary Manager #1 was interviewed and was asked what she used the lemon juice for, and she stated kitchen staff use it when baking various desserts and that she was unaware it needed to be stored in the refrigerator after being opened. The manufacturer specification on the bottle indicated to refrigerate after opening.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. An opened box of chicken fried steak was on a shelf in the storage room freezer.</p> <p>c. An opened bag of chips was on a shelf in the freezer. The bag was not sealed.</p> <p>8. On 01/28/2025 at 11:27 PM, DC #11 picked up a box of mashed potato flakes, emptied it into a pan of hot water on the stove, and mixed it with a whisk, contaminating her hands in the process. Without washing her hands, DC #11 picked up a clean blade and attached it to the base of the blender to be used in pureeing food items to be served to the residents on pureed diets for lunch. DC #11 was interviewed and was asked what she should have done after touching dirty objects and before handling clean equipment and stated she should have washed her hands.</p> <p>9. On 01/28/2025 at 11:58 AM, Dietary [NAME] (DC) #12 was wearing gloves on his hands when he removed a block of butter from the refrigerator and placed it on the counter, in the process, his gloved hands were contaminated. DC #12 then unwrapped the butter, picked up a knife, cut a piece, and placed it on the noodles in a pan on the steamtable mixing it before serving it to the residents. DC #12 was interviewed and was asked what he should have done after touching dirty objects and before handling clean equipment and he stated he should have removed the gloves and washed his hands.</p> <p>10. A review of facility policy titled, Handwashing Guidelines, initiated 1/2002, provided by Dietary Manager #1 on 01/28/2025 indicated, hands should wash every time an employ enters the kitchen, at the beginning of the shift, their hands before starting work, and after touching anything unsanitary.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50924</p> <p>35684</p> <p>Based on observations, interviews, record review, facility document review, and facility policy review, the facility failed to ensure (1) hand hygiene was performed between residents during medication administration observation for Resident #21; (2) clean personal protective equipment (PPE) was used during medication administration for Resident #17 who was on enhanced barrier precautions (EBP); (3) transmission based precautions (TBP) were posted outside a secure unit when a parasitic infestation was identified; (4) and provide re-education to staff when infection trends were identified during a review of the facility's infection control practices.</p> <p>The findings include:</p> <p>1. A review of a facility pharmacy policy book titled, Policy and Procedure Manual for Nursing Facilities contained a policy titled, Medication Administration, Medication Administration-General Guidelines Policy 6.2, dated April 2020 indicated 6. Cleanse hands with antimicrobial soap and water or facility approved hand sanitizer before handling medication and before and after direct contact with resident.</p> <p>A review of a facility policy titled, Hand Hygiene, dated 06/11/2020, indicated, Hand hygiene continues to be the primary means of preventing the transmission of infection. Hand Hygiene is required upon and after coming into contact with a resident/guest intact skin.</p> <p>During an observation on 01/29/2025 at 8:05 AM, Licensed Practical Nurse (LPN) #18 administered oral medications to Resident #5 and left the room without performing hand hygiene. LPN #18 returned to the medication cart and prepared insulin for an unidentified resident. LPN #18 entered the resident's room and administered the insulin without performing hand hygiene. LPN #18 returned to the medication cart without performing hand hygiene and prepared insulin for Resident #21. LPN #18 entered Resident #21's room and administered two insulin injections without performing hand hygiene.</p> <p>During an interview on 01/29/2025 at 8:15 AM, LPN #18 was asked about infection control practices. LPN #18 stated he forgot to perform hand hygiene between residents.</p> <p>2. A review of the facility's policy titled, Enhanced Barrier Precautions, dated 04/29/2024 indicated, Multi drug-resistant organisms (MDRO) transmission is common in [Long-term Care] LTC, contributing to substantial resident morbidity and mortality. Enhanced barrier precautions are approach to the use of PPE as a strategy to decrease transmission of CDC [Centers for Disease Control] targeted MDROs when contact precautions do not apply. EBP are indicated for residents with indwelling medical devices including feeding tubes and PPE should be utilized during high contact care.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 01/29/2025 at 11:50 AM, LPN #18 entered Resident #17's room and donned personal protective equipment (PPE) including a gown and gloves for enhanced barrier precaution (EBP) related to Resident #17's feeding tube. An extra gown fell on the floor, LPN #18 picked up the now dirty gown and placed it on top of a dresser in the resident's room. After LPN #18 administered Resident #17's medication he took off the PPE, threw it away, and returned to the cart. LPN #18 retrieved Resident #17's sliding scale insulin, then donned PPE including the dirty gown from the dresser. Resident #17's insulin was administered in their exposed abdomen while wearing the dirty gown which touched the resident's bed and linens. Resident #17 had a percutaneous endoscopic gastrostomy (PEG) tube which was the access for feedings/medication administration and a colostomy present on their abdomen. LPN #18 stated, this is the gown I dropped on the floor, I should not have done that when he was informed he was wearing the dirty gown.</p> <p>During an interview on 01/29/2025 at 2:52 PM, the Director of Nursing (DON) stated hand hygiene should be performed when going in between residents and providing care. PPE should be put on prior to direct resident care, we use it with anyone who has an open area from a line or device with a compromised immune system. A gown on the floor would be considered dirty and should be thrown away and not used.</p> <p>3. A review of a facility policy titled Scabies and Lice with an effective date of May 11, 2017, was reviewed and read in part, to prevent the spread of scabies and lice. Process 1. A) implement contact precaution, B) change the resident 's linen daily for seven days, use water soluble and red bags for all laundry .General lice information, head lice are transmitted through personal contact and by objects such as hats, combs, and brushes ., sources of infestation, hats, clothing, or bedding should be cleaned through laundering. Combs and brushes should be disinfected with germicidal solution and hot water then soak for 15 minutes in isopropyl alcohol.</p> <p>A review of Resident #36 's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 11/13/2024 revealed, Resident #36 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.</p> <p>A review of Resident #36 's Care Plan revised on 01/20/2025 revealed Resident #36 had diagnoses of schizoaffective disorder, bipolar, major depressive disorder, mental disorder, and cognitive communication deficit. Interventions included assistance of one staff with all activities of daily living, provide simple cues, prompts and reminders as needed, encourage safe decisions, encourage to keep focused on task or subject at hand, use reminders, prompts or cues to keep on task and when attention wanders guide her gently back to what she is doing.</p> <p>A review of a Prescription Order for Resident #36 with a received and start date of 01/27/2025 revealed (Name Brand) solution one application, one time. The order was received on 01/29/2025 after LPN #25 was questioned regarding the physician' s order for treatment Resident #36 received on 01/27/2025.</p> <p>On 01/27/2025 at 12:32 PM during initial rounds on the secure unit, Resident #36 was observed with haircare being performed by CNA #24 with a nit comb. CNA #24 was asked if resident #36 had head lice and the response was yes. No signage for Transmission Based Precautions was observed either in the secure unit or on the door to enter the secure unit. No Personal Protective Equipment (PPE) was available on entry to the secure unit.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>01/27/2025 12:35 PM 10 residents and 2 staff members were observed in the dining room. Resident #36 was without any type of hair covering, ambulatory, and moving freely through the room with the other residents.</p> <p>01/27/2025 at 01:01 PM Resident #36 was observed without any hair covering, sitting in the dining room at the table with 2 other residents.</p> <p>A review of Resident #36's progress notes revealed a documented late entry dated 01/29/2025 at 10:31 AM for 1/27/2025 that read in part, resident head was itching, when checked by staff live head lice were present.</p> <p>During an interview on 01/29/2025 at 10:01 AM LPN #25, reported the first resident was infested with head lice and treated on Friday 01/24/2025. Resident #36 was found to have live head lice on Monday 1/27/2024. LPN #25 confirmed the whole unit should have been placed on isolation when the first resident was identified 01/24/2025. LPN #25 stated there were no precautions put into place initially when the first resident was identified on 01/24/2025. LPN #25 reported all the residents who resided on the secure unit were being treated, but none were identified as being infested with head lice, they were being treated as a precaution. LPN #25 stated the residents, and the staff were wearing hair coverings. LPN #25 confirmed transmission-based precautions were put into place on 01/29/2025, five days after the initial case.</p> <p>During an interview on 01/29/2025 at 10:11 AM the Infection Preventionist (IP) identified head lice as being considered transmission-based precautions because it can be transferred from person to person. The IP reported the whole secure unit should have been placed on isolation due to the identified infestation of head lice. The IP reported the first resident was identified on Friday 01/24/2025 and was treated. Resident #36 was identified on Monday 01/27/2025 and treated. The IP was asked to explain the facility policy regarding head lice. The IP denied knowing what the facility policy was regarding residents identified as infested with head lice. The IP indicated no precautions had been taken for the residents' laundry or personal items due to the outbreak, but the laundry should have been isolated and personal items that would not be able to be laundered should have been bagged for isolation. The IP confirmed responsibility for ensuring precautions were taken to prevent the spread of head lice was hers.</p> <p>On 01/29/2025 at 01:19 PM, the secure unit residents were observed being treated for head lice. LPN #25 confirmed the secure unit residents were being treated, but there were no further confirmed cases. The staff and residents were observed wearing hair coverings. There was PPE available at the entry of the secure unit, with instructions on the door to contact the nurse for further information.</p> <p>(continued on next page)</p>		

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  01/31/2025
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. A review of a facility policy titled Infection Prevention and Control Program Overview with an effective date of September 14, 2020, was reviewed and read in part, the goals of the infection prevention and control program are to reduce the risk of infection to residents by breaking the chain of infection, preventing development and transmission of communicable diseases. To monitor the occurrence of and implement control measures including isolation if necessary. To identify and correct problems related to infection control practices. To provide a safe, comfortable and sanitary environment. II A. There should be ongoing monitoring and preventative measures in place to prevent the spread of infections. Preventing the spread of infections would be accomplished by using standard precautions, barriers, and treatments. Staff education to focus on the risk of infection and decreasing the risk for prevention of infection. B. Systems should be in place to identify an increase in infections as well as trends or outbreaks. D. Staff Education, staff should be trained during new staff orientation and retrained as needed according to the incidence of infections. III A. The DON is ultimately responsible for the Infection Prevention and Control Program.</p> <p>A review of a facility policy titled Antibiotic Stewardship Program with an effective date of September 1, 2017 was reviewed and read in part, to educate and follow protocol for appropriate treatment of infections</p> <p>During an interview on 01/29/2025 at 10:11 AM the IP reviewed the infection control tracking and trending logs. The IP identified trends that involved wounds, urinary tract infections and respiratory infections. The analysis was documented weekly.</p> <p>A Weekly Infection Analysis form dated 8/26-9/1/24 (08/26/2024-09/01/2024) was reviewed by the IP, who identified 4 urinary tract infections, 2 skin, 1 mouth, and 1 conjunctival infection recorded for the week with no re-education reported in the log.</p> <p>A Weekly Infection Analysis form dated 10/10-10/20/24 (10/10/2024-10/20/2024) was reviewed by the Infection Preventionist, who identified 6 wound infections, 3 urinary tract infections, 3 respiratory infections and 2 other infections recorded for the week with no re-education reported in the log.</p> <p>A Weekly Infection Analysis form dated 12/12-12/22/24 (12/12/2024-12/22/2024) was reviewed by the Infection Preventionist, who identified 3 urinary tract infections, 3 respiratory infections, 1 skin, 1 mouth and 1 conjunctival infection recorded for the week with no re-education reported in the log.</p> <p>A Weekly Infection Analysis form dated 1/6-1/12/2025 (01/06/2025-01/12/2025) was reviewed by the Infection Preventionist, who identified 2 urinary tract infections, 8 respiratory infections and 1 wound infection recorded for the week with no re-education reported in the log.</p> <p>During an interview on 01/29/2025 at 10:11 AM the Infection Preventionist confirmed the tracking and trending of the infections identified as being a trend and denied having provided any re-education to staff for the identified trends in infections. The Infection Preventionist was asked if re-education should have been provided when the trend was identified. The Infection Preventionist confirmed retraining should have been provided to staff related to what the concern had identified.</p>		