

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Legacy Heights Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 900 West 12th St Russellville, AR 72801	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>37634</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 shower rooms were clean.</p> <p>The findings are:</p> <p>On 04/15/2024 at 02:17 PM, a brown substance was smeared on the floor in the bathroom on the Medicare Hall.</p> <p>On 04/15/2024 at 02:19 PM, Certified Nursing Assistant (CNA) #4 walked into the shower on the Medicare Hall. She was asked, What's the brown substance on the shower floor? She stated, I'm sure it's bowel movement.</p> <p>On 04/17/2024 at 09:56 AM, the Director of Nursing (DON) was asked, How often should the shower room be cleaned? She stated, After use and between residents.</p> <p>On 04/17/2024 at 10:06 AM, the Administrator was asked, How often should the shower room be cleaned? She stated, Soils should be cleaned after every shower, and deep cleaned at the end of the day. She was asked, Should there ever be feces on the shower room floor if the shower is not in use? She stated, No it should be cleaned up as soon as the resident has left the shower room.</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
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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>37634</p> <p>Based on interview and record review, the facility failed to ensure all medications were documented on the discharge summary for 1 (Resident #184) when discharging from the facility.</p> <p>The findings are:</p> <p>A review of the Admission Record, indicated the facility admitted Resident #184 with a diagnosis Acute systolic (congestive) heart failure.</p> <p>The Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/21/2024 revealed Resident #184 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact.</p> <p>On 04/17/2024 at 03:11 PM, the Administrator was asked, Did you have any residents receive the wrong medication upon discharge last month? She stated, Yes I believe her name was [Resident #184]. I don't do the discharges, but the care giver called up here and said [Resident #184] had someone else's medication and she was going to be bringing the medication back up here. I think she gave the medication to [Licensed Practical Nurse (LPN) #2] on Station 1.</p> <p>On 04/17/2024 at 03:39 PM, the discharge summary was reviewed. There was no documentation indicating what medications were sent home with the resident on 03/20/2024.</p> <p>On 04/17/2024 at 03:43 PM, the Director of Nursing (DON) was asked, What is the process for getting a residents medication ready for discharge? She stated, The nurse goes over the resident's orders then she pulls the medications. The Surveyor asked, Is there a discharge summary of all the medications that were sent home with [Resident #184]? She looked in the computer and pulled up a copy of the physician orders. She was asked, What medications were sent home with [Resident #184] that didn't belong to the resident? She stated, I'm not sure.</p> <p>On 04/17/2024 at 04:21 PM, LPN #2 was asked, What's the process for discharging a resident home with medication? She stated, The night shift pulled the PM meds [medications], and I pulled the AM meds. I put them all together and I put them in a bag. The Surveyor asked, Did you check the medications? She stated, No, I just put them in the bag since the night shift had already pulled them. The Surveyor asked, Why is it important that you check the medications against the physician orders? She stated, I should have. The discharge person does all the paperwork and the reconciliation form, and we just pull the meds. I just took for granted that everything was correct. The Surveyor asked, What could happen if a resident is discharged with the wrong medication? She stated, The caregiver called me and told me that [Resident #184] had the wrong medication, and she would bring them up here. She was asked, After this incident happened, were you in-serviced? She stated, Personally, no they didn't. The DON didn't know about it. I told the Administrator. It was an absolutely a freak mistake.</p> <p>(continued on next page)</p>		

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/2024 at 03:47 PM, the Administrator was asked, When were you made aware that the nurse had discharged [Resident #184] home with another resident's medication, and did you provide an in-service for the nurses? She stated, No I didn't. I just talked to LPN #2, and she told me that they were bringing the medications back up here.		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>37634</p> <p>Based on interview and record review, the facility failed to ensure 1 (Resident #184) did not receive medications that were not prescribed to them upon discharge.</p> <p>The findings are:</p> <p>A review of the Admission Record, indicated the facility admitted Resident #184 with a diagnosis of Acute systolic (congestive) heart failure.</p> <p>The Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/21/2024 revealed Resident #184 had a Brief Interview of Mental Status (BIMS) score of 14, indicating the resident was cognitively intact.</p> <p>On 04/17/2024 at 03:11 PM, the Administrator was asked, Did you have any residents receive the wrong medication upon discharge last month? She stated, Yes, I believe [the resident] name was [Resident #184]. I don't do the discharges, but the care giver called up here and said [Resident #184] had someone else's medication and she was going to be bringing the medication back up here. I think she gave the medication to [Licensed Practical Nurse (LPN) #2] on Station 1.</p> <p>On 04/17/2024 at 03:39 PM, the discharge summary was reviewed. There was no documentation indicating what medications were sent home with the resident.</p> <p>On 04/17/2024 at 03:43 PM, the Director of Nursing (DON) was asked, What is the process for getting a residents medication ready for discharge? She stated, The nurse goes over the resident's orders then she pulls the medications. The Surveyor asked, Is there a discharge summary of all the medications that were sent home with [Resident #184]? She looked in the computer and pulled up a copy of the physician orders. She was asked, What medications were sent home with [Resident #184] that didn't belong to her? She stated, I'm not sure.</p> <p>On 04/17/2024 at 04:21 PM, LPN #2 was asked, What's the process for discharging a resident home with medication? She stated, The night shift pulled the PM meds [medications], and I pulled the AM meds. I put them all together and I put them in a bag. The Surveyor asked, Did you check the medications? She stated, No, I just put them in the bag since the night shift had already pulled them. The Surveyor asked, Why is it important that you check the medications against the physician orders? She stated, I should have. The discharge person does all the paperwork and the reconciliation form, and we just pull the meds. I just took for granted that everything was correct. The Surveyor asked, What could happen if a resident is discharged with the wrong medication? She stated, The caregiver called me and told me that [Resident #184] had the wrong medication, and she would bring them up here. She was asked, After this incident happened, were you in-serviced? She stated, Personally no they didn't. The DON didn't know about it. I told the Administrator. It was an absolutely a freak mistake.</p> <p>On 04/17/2024 at 03:47 PM, the Administrator was asked, When were you made aware that the nurse had discharged [Resident #184] home with another resident's medication, and did you provide an in-service for the nurses? She stated, No I didn't. I just talked to [LPN #2], and she told me that they were bringing the medications back up here.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48483</p> <p>Based on observation and interview, the facility failed to ensure a medication cart was locked while unsupervised, and that controlled narcotics were contained in a locked and permanently affixed container.</p> <p>The findings are:</p> <p>On 04/17/2024 at 03:00 PM, the Surveyor observed the refrigerated plastic emergency kit located in the Station 1 refrigerator containing (5) 2 milligram (Mg)/1 milliliter (mL) oral Lorazepam syringes and (1) 2 Mg/1 mL injectable Lorazepam syringe was not in a locked and affixed container. Lorazepam is a controlled substance which can cause paranoid or suicidal ideation and impair memory, judgment, and coordination. Combining with other substances, particularly alcohol, can slow breathing and possibly lead to death.</p> <p>On 04/17/2024 at 03:13 PM, the Surveyor observed the medication cart on Station 2 to be unlocked and unattended.</p> <p>On 04/17/2024 at 03:14 PM, the Surveyor asked Licensed Practical Nurse (LPN) #1, Is the refrigerated emergency kit containing Lorazepam in a permanently affixed and locked container? LPN #1 stated No. The Surveyor asked, Should the medication cart on Station 2 be unlocked and unattended? LPN #1 stated No, it should not be.</p> <p>On 04/17/2024 at 03:56 PM, the Director of Nursing (DON) confirmed the medication cart on Station 2 was left unlocked and unattended.</p> <p>On 04/17/2024 at 04:16 PM, the Assistant Director of Nursing (ADON) confirmed the refrigerated emergency kit containing Lorazepam was not in an affixed and locked container.</p> <p>On 04/17/24 at 04:27 PM, the DON reported the facility did not have a Medication Storage Policy.</p> <p>A document provided by Human Resources on 04/18/2024 at 08:28 AM titled, Charge Nurse Job Description showed, .responsibilities .ensure proper .storage of medications and controlled substances .</p>

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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, interview and record review, 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 2 meals observed. This failed practice had the potential to affect 7 residents who received pureed diets from 1 of 1 kitchen.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. The menu for supper documented that the residents who received pureed diets were to receive two #8 scoops (totaling 1 cup) of pureed pimento cheese sandwich. 2. On 04/16/2024 at 05:06 PM, Dietary Employee (DE) #2 used a 4-ounce spoon to serve a single scoop (totaling 0.5 cups) of pureed pimento cheese sandwich to the residents on pureed diets, instead of two #8 scoops as specified on the menu. 3. On 04/17/2024 at 11:38 AM, the Surveyor asked DE #2 what spoon size she used to serve pureed pimento cheese and how many servings she had served to the residents who required pureed diets. DE #2 stated, I used 4-ounce spoon and gave a serving each.

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>03508</p> <p>Based on observation and interview, the facility failed to ensure the pureed food items were blended to a smooth, lump free consistency to minimize the risk of choking or other complications for residents who required pureed diets for 1 of 1 meal observed. The failed practice had the potential to affect 7 residents who received pureed diets.</p> <p>The findings are:</p> <ol style="list-style-type: none"> On 04/17/2024 at 07:40 AM, a pan of pureed sausage was on the steam table. The consistency of the pureed sausage was gritty and not smooth. The Surveyor asked Dietary Employee (DE) #5 to describe the consistency of the pureed sausage. DE #5 stated, It was a little gritty. I should have pureed it a little longer. On 04/17/2024 at 10:45 AM, DE #5 used a 6-ounce scoop to place 7 servings of lasagna into a blender, added beef broth and pureed. At 10:47 AM, DE #5 poured the pureed lasagna into a pan and placed it on the steam table. The consistency of the pureed lasagna was lumpy and not smooth. There were pieces of intact noodle visible in the mixture. On 04/18/2024 at 07:50 AM, the Surveyor asked DE #5 to describe the consistency of pureed lasagna. DE #5 stated, I should have pureed it longer. 		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</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 and interview, the facility failed to ensure food items stored in the refrigerator were covered, sealed, and dated, kitchen walls, door frames and baseboards were free of rotten wood, chipped walls were replaced, dietary staff washed their hands when contaminated to decrease the potential for food borne illness for residents who received food from 1 of 1 kitchen, 2 of 2 ice machines were maintained in a clean and sanitary condition and dietary staff washed their hands and changed their gloves before handling clean equipment or food items to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen. The failed practices had the potential to affect 82 residents who received meals from the kitchen (total census: 82).</p> <p>The findings are:</p> <ol style="list-style-type: none"> On 04/14/2024 at 10:15 AM, 17 individual 4 ounce (oz) containers of lemon flavor with other natural sweetener flavors added were on a shelf in the storage room. There was no received date on the box. On 04/17/2024 at 03:45 PM, there was a pink residue in the interior surface of the ice machine located in the kitchen. The Surveyor asked the Dietary Supervisor to wipe the right interior side of the ice machine where pink residue was found. She used a tissue to wipe the area, which had a pinkish residue on it and the pink substance easily transferred to the tissue paper. The Surveyor asked the Dietary Supervisor to describe the residue that was on the tissue, who uses the ice machine, and how often was it cleaned. The Dietary Supervisor stated, Pinkish, and we use it in the kitchen to fill beverages served to the residents at mealtimes. On 04/16/2024 at 03:46 PM, the cabinet below the deep fryer had 5 pilots, the pilots and the bottom of the cabinet which were covered with a buildup of greasy. The Surveyor asked the Dietary Supervisor how often they cleaned it. She stated, It is cleaned every week, but it has not been. On 04/16/24 at 03:47 PM, Dietary Employee (DE) #1 picked up a box of gloves, pulled the gloves out of the box and placed them on his hands, contaminating them. Without washing his hands and changing gloves, he picked up a clean blade and attached it to the base of the blender to be used in pureeing the food items to be served to the residents who received pureed diets. The Surveyor asked DE #1, What should you have done after touching dirty objects and before handling clean equipment? DE #1 stated, I should have washed my hands. On 04/16/2024 at 03:49 PM, there was a pink residue in the interior surface of the ice machine located behind the nurse's station on Station 3. The Dietary Supervisor asked DE #2 to wipe the left and the right interior side of the ice machine where pink residue was found. He used tissues to wipe the areas, which had a pinkish residue on them. The pink substance is easily transferred to the tissue paper. The Surveyor asked the Dietary Supervisor to describe the residue that was on the tissue, who uses the ice machine, and how often it was cleaned. The Dietary Supervisor stated, Pinkish and the housekeeping cleans it once a week. That's the ice machine the CNAs use for the water pitchers in the residents' rooms. <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 - Many</p>	<p>6. On 04/16/2024 at 04:15 PM, an opened box of bacon was on a shelf in the refrigerator. The box was not covered or sealed.</p> <p>7. On 04/16/2024 at 04:16 PM, during observation the following food items on a shelf in the freezer were not covered or sealed.</p> <ul style="list-style-type: none"> a. A box of biscuits. b. A box of hamburger patties. c. A box of biscuit dough. d. A box of garlic bread. e. A box of garlic biscuits. <p>8. On 04/16/2024 at 04:29 PM, the following observations were made in the kitchen.</p> <ul style="list-style-type: none"> a. The exit door frame from the kitchen leading to the hall was chipped, exposing the metal. b. The board against the wall of the door frame was loose. c. The bottom of the door frame was rotten, exposing the metal. d. The wall paint between the plate warmer and the steam table was peeling, exposing the cement. e. The wall on the right side of the steam table was chipped, exposing the sheet rock. f. The wall paint below the dish washing machine was peeling, exposing the cement. The area had sage color on it. <p>9. On 04/16/2024 at 05:02 PM, DE #1, who was on the tray line assisting with supper meal, was observed to pick up tray cards, packet of individual crackers and place them on the trays. Without washing his hands, he picked up the plates to be used in portioning the food items to be served to the residents for supper with his fingers inside of them on the trays. The Surveyor asked DE #1 what should have been done after touching dirty objects and before handling clean equipment. DE #1 stated, I should have washed my hands.</p> <p>10. On 04/16/2024 at 05:09 PM, DE #2, who was on the tray line assisting with the supper meal, picked up cartons of supplements, cans of soft drinks, ice cream cartons and placed them on the trays. Without washing his hands, he picked up glasses that contained beverages by their rims and placed them on the trays to be served to the residents at the supper meal. At 05:14 PM, the Surveyor asked DE #2 what should you have done after touching dirty objects and before handling clean equipment. DE #2 stated, I should have washed my hands.</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 - Many</p>	<p>11. On 04/16/2024 at 08:00 AM, DE #3 opened a cabinet and placed clean bowls in it. Without washing her hands, she picked up bowls to be used in portioning the food items to be served to the residents for lunch with her fingers inside of them. At 11:30 AM, the Surveyor asked DE #3 what should have been done after touching dirty objects and before handling clean equipment. DE #3 stated, I should have washed my hands.</p> <p>12. On 04/17/2024 at 10:25 AM, DE #5 placed 15 servings of brownie into a blender, then removed a gallon of milk from the refrigerator. DE #5 removed the lid from the gallon of milk and poured some on the brownie, added 3.5 tablespoon of thickener and pureed. Without washing her hands, DE #5 picked up a bowl from the counter with her fingers inside of it to be used in portioning dessert. When DE #4 was ready to transfer pureed dessert into a bowl to be served to the residents who required pureed diets for lunch, the Surveyor immediately asked DE #5, what should you have done after touching dirty objects and before handling clean equipment? DE #5 stated, I should have washed my hands.</p> <p>13. On 04/17/2024 at 11:01 AM, DE #4 opened a box of frozen bread sticks. Without washing her hands, she removed gloves from the glove box and placed them on her hands, she picked up bread sticks from the original box with her contaminated gloved hands and placed them on the trays to be baked and served to the residents for the lunch meal.</p> <p>14. On 04/17/2024 at 11:33 AM, a container of baking powder was in the cabinet with an expiration date of 12/13/2023.</p> <p>15. The facility policy titled, Hand Washing, provided by the Dietary Supervisor on 04/18/2024 at 07:54 AM documented, .Staff will wash hands and exposed portions of their arms: .To remove contamination after entering the kitchen, .during food preparation, .before donning gloves for working with food, and after engaging in other activities that contaminate the hands .</p>		