

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  255292	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2024
NAME OF PROVIDER OR SUPPLIER  Legacy Manor Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1935 North Theobald Extension Greenville, MS 38704	

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>47158</p> <p>Based on resident and staff interview, observation, record review and facility policy review the facility failed to maintain a safe environment when a resident's toilet was noted to be loose for one (1) of 30 resident bathrooms observed. Resident #21.</p> <p>Findings include:</p> <p>Record review of the facility policy, titled, Resident Environment, dated 09/15 revealed It is the policy of this facility to provide a safe, clean, comfortable and homelike environment .</p> <p>In an interview and observation on 06/11/24 at 9:23 AM, with Resident #21, the resident stated the toilet in his bathroom is loose and moves when he sits on it. An observation of the toilet in Resident #21's bathroom revealed that three-fourths (3/4) of the caulking around the base of the toilet was missing.</p> <p>A record review of the facility's Maintenance and Repair Log for June 2024 revealed there were no entries reporting the condition of the toilet in Resident #21's room.</p> <p>On 6/12/24 at 11:04 AM, during an observation and interview with the Maintenance Man confirmed three-fourths (3/4) of the caulking around the base of the toilet in Resident #21's bathroom was missing, and the toilet was loose. He stated he was unaware the toilet was in this condition. The Maintenance Man stated that the condition of the toilet was dangerous, and the resident could fall and hurt himself.</p> <p>During an interview on 6/12/24 at 1:10 PM, the Administrator agreed staff should have reported the loose toilet and that the resident could fall and hurt himself.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46013</p> <p>Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to implement an Activities of Daily Living (ADL) care plan for residents who required nail care and facial grooming for two (2) or seventeen residents sampled. Resident #21 and Resident #34</p> <p>Findings include:</p> <p>A review of the facility's Care Plan Process policy, revision date of 08/17, revealed, Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision, and continence) . The Physician Orders, Medication Administration Record, and the Treatment Administration Record are part of the Comprehensive Care Plan .</p> <p>Resident #21</p> <p>A record review of Resident #21's Comprehensive Care Plan with Problem Onset: dated 6/18/21 revealed, Problem: .needs assist with ADLS . Approaches . Bathing-Physical help in bathing activity.</p> <p>On 6/11/24 at 10:00 AM, during an observation and interview revealed that Resident #21's fingernails on both hands were one-half (1/2) inch long past the tip of his fingers. Resident #21 was also noted to have patchy facial hair one (1) inch long. He stated he wanted his nails cut and his face shaved and was unsure of when it had been done last.</p> <p>On 6/12/24 at 9:35 AM, during an interview and observation of Resident #21 with Licensed Practical Nurse #1 (LPN) she confirmed that Resident #21's nails and facial hair were long and that he needed his nails cut and needed to be shaved. LPN #1 was unsure of the last time Resident #21 had his nails cut or was shaved.</p> <p>Record review of the Face Sheet revealed Resident #21 was admitted to the facility on [DATE] with diagnoses that included Primary Open-angle glaucoma and lack of coordination.</p> <p>Resident #34</p> <p>A record review of Resident #34's Comprehensive Care Plan with Problem Onset: dated 8/25/2023 revealed, Resident #34 needs assist with ADLS and was dependent on staff for bathing.</p> <p>On 06/11/24 at 9:55 AM and 2:30 PM, observations revealed Resident #34 sitting in his wheelchair, bilateral fingernails approximately one-half (1/2) inch long and jagged past the tip of fingers, and a brown substance under each nail. Facial hair was approximately 1/2 inch long and was noted to cheeks and chin.</p> <p>Observation on 06/12/24 at 08:25 AM, revealed Resident #34 lying in bed with no change in his appearance from the previous day.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/12/24 at 09:59 AM, observation and interview with the DON confirmed Resident #34's fingernails were long, jagged, and had a brown substance under the fingernails and needed to be cleaned and trimmed.</p> <p>An interview on 06/12/24 at 02:55 PM, with the Minimum Data Set (MDS) nurse revealed she is responsible for developing the care plans. She revealed the care plans are developed so the staff will know how to take care of the residents. She revealed under the ADL care plan that bathing includes nail care and shaving. She confirmed for Resident #21 and Resident #34 if they were not shaven and their nails were not clean and trimmed, then the plan of care was not being followed and it should have been.</p> <p>47158</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46013</p> <p>47158</p> <p>Based on observation, staff, and resident interviews, record review, and facility policy review, the facility failed to provide personal hygiene as evidenced by long, jagged nails with brown substance underneath nails, and unshaven facial hair for two (2) of 17 sampled residents. Resident #21 and Resident #34.</p> <p>Findings Include:</p> <p>Record review of the facility policy titled, Nail Care, latest review date 01/24, revealed, Purpose, To promote cleanliness, safety and a neat appearance.</p> <p>Record review of the facility policy titled, Shaving, latest review date 01/24, revealed, Purpose, To provide hygiene in accordance with the resident's preferences and preferred self-image.</p> <p>Resident #21</p> <p>An observation and interview on 6/11/24 at 10:00 AM, revealed that Resident #21's fingernails on both hands were one-half (1/2) inch long past his fingertips. Resident #21 was also noted to have patchy facial hair one (1) inch long. He stated he wanted his nails cut and his face shaved. He was unsure of when it had been done last.</p> <p>A record review of Active Orders for Resident #21 revealed an order for Nail Care Weekly. Check condition and clean as needed (PRN), with an onset date of 1/2/2024.</p> <p>A record review of Resident #21's Electronic Treatment Record (eTAR), for June 2024 revealed Nail Care Weekly. Check condition and clean prn, with no documentation that weekly nail care was performed during the month of June.</p> <p>A record review of the Resident Care Record for Resident #21, dated 5/1/24 through 6/12/24, revealed that there was no documentation that the resident had received nail care or been shaved during that time period.</p> <p>During an interview and observation of Resident #21 on 6/12/24 at 9:35 AM, with Licensed Practical Nurse #1 (LPN) she stated that the resident's nails are to be cut weekly. She stated that the nurse is responsible for cutting resident's nails if they are diabetic and the Certified Nursing Assistant (CNA) is responsible for cutting the resident's nails if they are not diabetic. LPN #1 was unsure of the last time Resident #21 had his nails cut or was shaved. She agreed that Resident #21's nails and facial hair were long and that he needed his nails cut and needed to be shaved.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview and observation of Resident #21, with CNA #1, on 6/12/24 at 9:45 AM, she verified that the CNAs are responsible for cutting residents nails if the resident is not diabetic. CNA #1 stated that Resident #21 was not diabetic, so she was responsible for cutting his nails. She stated that the resident's nails are cut, and they are shaved on their shower days if they need it. CNA #1 verified that Resident #21's nails and facial hair were long. She was unsure of the last time Resident #21 had his nails cut or had been shaved but agreed that it needed to be done.</p> <p>Record review of the Face Sheet revealed Resident #21 was admitted to the facility on [DATE] with diagnoses that included Primary Open-angle glaucoma and Lack of Coordination.</p> <p>Resident #34</p> <p>Observation on 06/11/24 at 9:55 AM and again at 2:30 PM, revealed Resident #34 sitting in his wheelchair, bilateral fingernails approximately one-half (1/2) inch long and jagged past the tip of fingers, with a brown substance under each nail. Facial hair was approximately one-half inch long on his cheeks and chin.</p> <p>Observation on 06/12/24 at 08:25 AM, revealed Resident #34 lying in bed with no change in his appearance from the previous day.</p> <p>An observation and interview on 06/12/24 at 09:15 AM, revealed CNA #2 shaving Resident #34, and the resident is supposed to be shaved during his shower days which are Tuesday, Thursday, and Saturday. CNA #2 revealed that yesterday was his shower day and stated, I wasn't here and I'm not sure why he didn't get shaved. She confirmed that with his long facial hair, it looked like he hadn't been shaved in quite a while. CNA #2 confirmed Resident #34's nails were long and had a brown substance under them and needed to be cleaned and trimmed.</p> <p>In an interview on 06/12/24 at 9:25 AM, the Director of Nurses (DON) revealed that the CNAs are responsible for shaving their residents during baths or shower times and cleaning and trimming residents' nails if they are non-diabetic. She confirmed Resident #34 was not a diabetic.</p> <p>Observation and interview on 06/12/24 at 09:59 AM, the DON confirmed Resident #34's fingernails were long, jagged, and had a brown substance under the fingernails and needed to be cleaned and trimmed.</p> <p>An interview on 06/12/24 at 02:41 PM, Registered Nurse (RN) #1 revealed I cut and cleaned Resident #34's fingernails this morning when it was brought to my attention that it needed to be done. She revealed the resident is not a diabetic and it was supposed to be done by his CNA. RN #1 confirmed when she went in to clean and trim his nails, they were long and had a brown substance under them. She revealed she wasn't sure how long it had been since his nails had been done.</p> <p>Record review of the Face Sheet revealed Resident #34 was admitted to the facility on [DATE] with diagnoses that included Cognitive Communication Deficit and Weakness.</p>		