STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Health and Rehab	811 Keylon Street Manchester, TN 37355

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100 Based on facility policy review, medical record review, observations, and interviews, the facility failed to ensure the call light was in reach for 1 resident (Resident #7) of 52 residents observed for call light accessibility. The findings include: Review of the facility's policy titled, Answering the Call Light, dated 3/2021, showed .When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident . Resident #7 was admitted to the facility on [DATE] with diagnoses including Multiple Sclerosis, Anxiety, and Muscle Weakness. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident was moderately cognitively impaired and required substantial/ maximum staff assistance with personal hygiene. Review of Resident #7's comprehensive care plan revised 4/2/2024, showed .Resident has need for extensive to total care related to .decreased functional status .call light within reach . During an observation and interview on 4/8/2024 at 9:50 AM, in Resident #7's room, showed Resident #7 was seated in a reclining chair with her call light clipped to the privacy curtain. Further observation showed Resident #7's call light was out of her reach. Resident #7 stated when she needed help from the staff, she used her call button to alert them. Further interview showed Resident #7 did not know where her call light was located. During an observation and interview on 4/8/2024 at 9:52 AM, in Resident #7's room, Licensed Practical Nurse (LPN) #1 confirmed Resident #7's call light was not within the resident's reach and was not accessible for the resident's use. During an observation and interview on 4/9/2024 at 10:25 AM, in the resident's room, with Certified Nursing Assistant (CNA) #1, showed Resident #7 was seated in a reclining chair with the call light draped over the side of the bed. Further observation showed the resident's call light was out of her reach and not accessible for use. CNA #1 stated the call light is supposed to be within the resident's reach and confirmed the call light was not accessible to Resident #7. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445383	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER: Legacy Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 811 Keylon Street Manchester, TN 37355	

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/2024 at 1:05 PM, the Director of Nursing (DON) stated it was the facility's expectation when residents are in the bed or sitting up in the chairs in their rooms, the call lights would be in their reach and available for use. DON confirmed the facility failed to ensure the call light was accessible for Resident #7's use.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50480 Based on facility policy review, medical record review, and interview, the facility failed to provide a resident with information regarding a resident's right to formulate an advanced directive upon admission to the facility for 1 resident (Resident #3) of 18 residents reviewed for advanced directives. The findings include: Review of the facility policy titled Advance Directives, revised 12/2016, showed .Upon admission, the resident will be provided with written information .to formulate an advance directive . Resident #3 was admitted to the facility on [DATE] with diagnoses including Schizoaffective Disorder, Bipolar Type, Dementia, Psychotic Disorder with Hallucinations, Anxiety Disorder, and Hypertension. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], showed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 7 which indicated the resident had severe cognitive impairment. Review of Resident #3's Advanced Directive Acknowledgement form showed the resident nor the resident representative had not signed the form upon the resident's admission to the facility on [DATE]. During an interview on 4/10/2024 at 8:22 AM, the Admissions Director stated Resident #3 nor the resident's representative was provided information regarding the right to formulate an advanced directive upon the resident's admission to the facility on [DATE].

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38810 Based on facility policy review, review of a daily room cleaning check off sheet, observations, and interviews the facility failed to maintain a safe, clean, homelike environment for 6 residents (Residents #30, #25, #50, #3, #35, and #17) on 1 of 4 hallways observed. The findings include: Review of the facility's policy titled, Homelike Environment, revised 2/2021, showed .Residents are provided with a safe, clean .and homelike environment .The facility staff and management maximizes .the characteristics of the facility that reflect a personalized, homelike setting .The characteristics include .clean, sanitary .environment . Review of an Environmental Services/Housekeeping Daily Room Cleaning Check-Off sheet undated, showed .Toilet Cleaned .Floors Mopped . Resident #30 was admitted to the facility on [DATE] with diagnoses including Diabetes, Schizophrenia, Anxiety Disorder, and Depression. During an observation on 4/8/2024 at 8:05 AM, showed Resident #30's bathroom door frame had missing, chipped paint and there was a rust like substance where the paint was missing. Further observation showed the floor around the toilet had a brownish/black dirty residue at the crease around the toilet where it contacted the floor. Further observation showed the closet door frame and entry door frame had chipped paint. During an observation on 4/9/2024 at 7:50 AM, showed Resident #30's bathroom door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed the floor around the toilet had a brownish/black dirty residue at the crease around the toilet where it contacted the floor. Further observation showed the closet door frame and entry door frame had chipped paint. During an observation on 4/10/2024 at 8:00 AM, showed Resident #30's bathroom door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed the floor around the toilet had a brownish/black dirty residue at the crease around the toilet where it contacted the floor. Further observation showed the closet door frame and entry door frame had chipped paint. Resident #25 was admitted to the facility on [DATE] with diagnoses including Fracture of Femur, Acute Kidney Failure, Dementia, and Repeated Falls. Resident #50 was admitted to the facility on [DATE] with diagnoses including Schizoaffective Disorder, Bipolar Type, Anxiety Disorder, Hypertension, and Cognitive Communication Deficit. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/8/2024 at 8:10 AM, showed Resident #25 and #50 were roommates and shared a bathroom. The bathroom door frame and the closet door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed the floor around the toilet had a brownish/black dirty residue at the crease around the toilet where it contacted the floor. Resident #25's bedside table had chipped wood around the edges of the top of the table and a black 2 drawer dresser with one handle missing on the top left drawer. During an observation on 4/9/2024 at 7:55 AM, showed Resident #25 and #50 were roommates and shared a bathroom. The bathroom door frame and the closet door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed the floor around the toilet had a brownish/black dirty residue at the crease around the toilet where it contacted the floor. Resident #25's bedside table had chipped wood around the edges of the top of the table and a black 2 drawer dresser with one handle missing on the top left drawer. During an observation on 4/10/2024 at 8:23 AM, showed Resident #25 and #50 were roommates and shared a bathroom. The bathroom door frame and the closet door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed the floor around the toilet had a brownish/black dirty residue at the crease around the toilet where it contacted the floor. Resident #25's bedside table had chipped wood around the edges of the top of the table and a black 2 drawer dresser with one handle missing on the top left drawer. Resident #3 was admitted to the facility on [DATE] with diagnoses including Schizoaffective Disorder, Bipolar Type, Dementia, Psychotic Disorder with Hallucinations, Anxiety Disorder, and Hypertension. During an observation on 4/8/2024 at 8:15 AM, showed Resident #3's bathroom door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed the closet door frame had chipped paint and there was a 4-drawer dresser which showed the 2nd and 4th drawer had missing handles. Further observation showed a 3-drawer nightstand with the 2nd and 3rd drawers broken. During an observation on 4/8/2024 at 8:05 AM, showed Resident #3's bathroom door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed the closet door frame had chipped paint and there was a 4-drawer dresser which showed the 2nd and 4th drawer had missing handles. Further observation showed a 3-drawer nightstand with the 2nd and 3rd drawers broken. During an observation on 4/10/2024 at 8:29 AM, showed Resident #3's bathroom door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed the closet door frame had chipped paint and there was a 4-drawer dresser which showed the 2nd and 4th drawer had missing handles. Further observation showed a 3-drawer nightstand with the 2nd and 3rd drawers broken. Resident #35 was admitted to the facility on [DATE] with diagnoses including Dementia, Diabetes, Chronic Pain, and Major Depressive Disorder. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/8/2024 at 8:30 AM, showed Resident #35's bathroom door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed the floor around the toilet had a brownish/black dirty residue at the crease around the toilet where it contacted the floor, and the toilet seat contained a black stain. The closet door frame had chipped paint. A 3-drawer metal dresser was observed, the legs of the dresser had missing chipped paint with a rust substance showing and a missing knob on the top drawer. During an observation on 4/9/2024 at 8:40 AM, showed Resident #35's bathroom door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed the floor around the toilet had a brownish/black dirty residue at the crease around the toilet where it contacted the floor, and the toilet seat contained a black stain. The closet door frame had chipped paint. A 3-drawer metal dresser was observed, the legs of the dresser had missing chipped paint with a rust substance showing and a missing knob on the top drawer. During an observation on 4/10/2024 at 8:30 AM, showed Resident #35's bathroom door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed the floor around the toilet had a brownish/black dirty residue at the crease around the toilet where it contacted the floor, and the toilet seat contained a black stain. The closet door frame had chipped paint. A 3-drawer metal dresser was observed, the legs of the dresser had missing chipped paint with a rust substance showing and a missing knob on the top drawer. Resident #17 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Psychosis, Anxiety Disorder, and Chronic Pain. During an observation on 4/8/2024 at 8:35 AM, showed Resident #17's bathroom door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed a 3-drawer metal dresser and the legs of the dresser had missing chipped paint with a rust substance showing where the paint was chipped. During an observation on 4/9/2024 at 8:48 AM, showed Resident #17's bathroom door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed a 3-drawer metal dresser and the legs of the dresser had missing chipped paint with a rust substance showing where the paint was chipped. During an observation on 4/10/2024 at 8:36 AM, showed Resident #17's bathroom door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed a 3-drawer metal dresser and the legs of the dresser had missing chipped paint with a rust substance showing where the paint was chipped. During an observation and interviews on 4/10/2024 at 8:37 AM, with the Assistant Administrator (AA), Housekeeping Director (HD), and the Maintenance Director (MD) showed Resident #3's bathroom door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed the closet door frame had chipped paint. There was a 4-drawer dresser which showed the 2nd and 4th drawer had missing handles. Further observation showed a 3-drawer nightstand with the 2nd and 3rd drawers broken. The AA, HD, and MD confirmed Resident #'3 room was not maintained in a safe, clean, homelike environment. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interviews on 4/10/2024 at 8:40 AM, with the AA, HD, and MD showed Resident #25 and #50 were roommates and shared a bathroom. The bathroom door frame and the closet door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed the floor around the toilet had a brownish/black dirty residue at the crease around the toilet where it contacted the floor. Resident #25's bedside table had chipped wood around the edges of the top of the table and a black 2 drawer dresser with one handle missing on the top left drawer. The AA, HD, and MD confirmed Resident #25 and #50's room was not maintained in a safe, clean, homelike environment. During an observation and interviews on 4/10/2024 at 8:44 AM, with the AA, HD, and MD showed Resident #30's bathroom door frame had missing, chipped paint and there was a rust like substance where the paint was missing. Further observation showed the floor around the toilet had a brownish/black dirty residue at the crease around the toilet where it contacted the floor. Further observation showed the closet door frame and entry door frame had chipped paint. The AA, HD, and MD confirmed Resident #30's room was not maintained in a safe, clean, homelike environment. During an observation and interviews on 4/10/2024 at 8:48 AM, with the AA, HD, and MD showed Resident #17's bathroom door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed a 3-drawer metal dresser and the legs of the dresser had missing chipped paint with a rust substance showing where the paint was chipped. The AA, HD, and MD confirmed Resident #17's room was not maintained in a safe, clean, homelike environment. During an observation and interviews on 4/10/2024 at 8:53 AM, with the AA, HD, and MD showed Resident #35's bathroom door frame had missing, chipped paint and there was a rust like substance where the paint was chipped. Further observation showed the floor around the toilet had a brownish/black dirty residue at the crease around the toilet where it contacted the floor, and the toilet seat contained a black stain. The closet door frame had chipped paint. A 3-drawer metal dresser was observed, the legs of the dresser had missing chipped paint with a rust substance showing and a missing knob on the top drawer. The AA, HD, and MD confirmed Resident #35's room was not maintained in a safe, clean, homelike environment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40640 Based on review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, medical record review, observation, and interview, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 3 Residents (Resident #31, #20, and #14) of 10 Residents reviewed for anticoagulant use, and failed to accurately capture active diagnoses for 1 resident (Resident #14) of 18 resident reviewed for accurate MDS assessments. The findings include: Review of the RAI Version 3.0 Manual, Chapter 3, dated 10/2023, showed .Anticoagulant [medication used to prevent blood clotting] .Which may or may not require laboratory monitoring .should be coded on MDS . during the 7-day look-back period .code if taking and indication noted .if the item was used . Resident #31 was admitted to the facility on [DATE] with diagnoses including Pulmonary Embolism, Benign Prostatic Hyperplasia, Diverticulitis, and Depression. Review of Resident #31's current physician order dated 1/5/2024, showed .Eliquis (anticoagulant medication) 2.5 mg [milligram] take one by mouth twice daily . Review of a quarterly MDS assessment dated [DATE], showed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. Further review showed the MDS did not include an anticoagulant medication. During an interview on 4/9/2024 at 3:50 PM, Licensed Practical Nurse (LPN) MDS Coordinator stated Resident #31 received an anticoagulant medication. LPN MDS Coordinator confirmed the anticoagulant medication was not captured accurately on the quarterly MDS assessment dated [DATE]. 49568 Resident #20 was admitted to the facility on [DATE] with Heart Failure, Chronic Obstructive Pulmonary Disease, and Atrial Fibrillation. Review of Resident #20's current physician order dated 2/29/2024, showed .Eliquis 2.5 mg take one by mouth twice daily . Review of a quarterly MDS assessment dated [DATE], showed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. Further review showed the MDS did not include an anticoagulant medication. During an interview on 4/10/2024 at 9:10 AM, the Registered Nurse (RN) MDS Coordinator stated Resident #20 received an anticoagulant medication and confirmed the anticoagulant medication was not captured accurately on the quarterly MDS assessment dated [DATE]. 48100 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #14 was admitted to the facility on [DATE] with diagnoses including Bipolar Disorder, Anxiety Disorder, Major Depressive Disorder, Bipolar Disorder, and Venous Thrombosis (blood clot). Review of Resident #14's current physician order dated 8/26/2023, showed .Eliquis 5 mg take one by mouth twice daily . Review of a quarterly MDS assessment dated [DATE], showed Resident #14 had a BIMS score of 11, which indicated the resident was moderately cognitively impaired and the active diagnosis list did not include diagnoses of Anxiety Disorder, Depression, and Bipolar Disorder. Further review showed Resident #14 did not take an anticoagulant medication. During an interview on 4/10/2024 at 8:10 AM, the RN MDS Coordinator stated Resident #14 received an anticoagulant medication and had active diagnoses of Depression, Anxiety, and Bipolar Disorder. The RN MDS Coordinator confirmed the anticoagulant medication and the active diagnoses of Depression, Anxiety, and Bipolar Disorder was not accurately captured on the quarterly MDS assessment dated [DATE].

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40640 Based on facility policy review, medical record review, and interview, the facility failed to develop a comprehensive care plan to include a colostomy (a surgical procedure which places a hole in the abdominal wall which allows waste to leave the body) for 1 resident (Resident #31) of 18 residents reviewed for care planning. The findings include: Review of the facility's policy titled, CARE PLAN POLICY, dated 12/2016, showed .A comprehensive, person centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed .for each resident .person centered care plan will . incorporate identified problem areas .reflect the residents expressed wishes regarding care and treatment goals .reflect currently recognized standards of practice for problem areas and conditions . Resident #31 was admitted to the facility on [DATE] with diagnoses including Pulmonary Embolism, Benign Prostatic Hyperplasia, Diverticulitis, Depression, and Dementia with Behavioral Disturbance. Review of an admission Minimum Data Set (MDS) dated [DATE], showed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact, required moderate assistance for activities of daily living (ADLs), and had an ostomy (colostomy). Review of Resident #31's comprehensive care plan revised 3/28/2024, showed the facility had not developed a care plan related to the resident's colostomy. Review of Resident #31's current physician orders dated 4/2024, showed .change colostomy and provide colostomy care . During an interview on 4/9/2024 at 3:50 PM, the Unit Manager confirmed Resident #31's colostomy was not identified on the comprehensive care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100 Based on facility policy review, medical record review, observation, and interview, the facility failed to revise a comprehensive care plan to reflect a new fall intervention for 1 resident (Resident #14) of 18 residents reviewed for care plans. The findings include: Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated 12/2016, showed . care plans are revised as information about the residents and the residents' conditions change . Resident #14 was admitted to the facility on [DATE] with diagnoses including Abnormalities of Gait and Mobility, Muscle Weakness, and Need for Personal Care. Review of a post fall investigation dated 2/16/2024, showed Resident #14 was reaching for a drink and fell on to the floor from the bed. The immediate fall intervention was to remove the air mattress from the bed and place a regular mattress on the bed. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident was moderately cognitively impaired and was dependent upon staff assistance for transfers. Further review showed Resident #14 had a fall since admission. Review of Resident #14's comprehensive care plan revised 4/5/2024, showed .Alternating air mattress .At risk for fall related injury related to: mobility impairments .previous fall hx [history] . During an observation and interview on 4/9/2024 at 11:10 AM, in the resident's room, showed Resident #14 had a regular mattress applied to the bed. Resident #14 stated the air mattress was removed from the bed after his last fall (2/16/2024). During an interview on 4/10/2024 at 8:45 AM, the Unit Manager (UM)/LPN MDS Coordinator stated Resident #14's immediate fall intervention implemented on 2/16/2024 was to remove the resident's air mattress from the bed and to apply a regular mattress to the resident's bed. The UM/LPN MDS Coordinator stated it was the facility's expectation to update the care plan after fall interventions are implemented. The UM/LPN MDS Coordinator confirmed Resident #14's care plan had not been updated to reflect the fall intervention to remove the air mattress from the bed.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49786 Based on review of the facility's Payroll Based Journal (PBJ) report dated 10/1/2023-12/31/2023, daily nursing staff posting sheets, time clock punches, and interviews, the facility failed to provide the minimum requirement of 8 hours per day of Registered Nurse (RN) coverage on 20 days reviewed on the PBJ report and 12 days reviewed on 1/1/2024-4/10/2024 (not a PBJ report). The findings include: Review of the facility's PBJ dated 10/1/2023-12/31/2023 showed the following dates with no RN coverage: 10/7/2023 (Saturday), 10/14/2023 (Saturday), 10/15/2023 (Sunday), 10/29/2023 (Sunday), 11/4/2023 (Saturday), 11/5/2023 (Sunday), 11/12/2023 (Sunday), 11/18/2023 (Saturday), 11/26/2023 (Sunday), 12/2/2023 Saturday), 12/10/2023 (Sunday), 12/24/2023 (Sunday), and 12/31/2023 (Sunday). Review of the facility's daily staffing posting sheets, and time clock punches showed: 10/1/2023 (Sunday): 1.25 hours of RN coverage 10/21/2023 (Saturday): 3.02 hours of RN coverage 10/28/2023 (Saturday): 5.25 hours of RN coverage 11/11/2023 (Saturday): 2.83 hours of RN coverage 11/23/2023 (Monday): 1.48 hours of RN coverage 12/16/2023 (Saturday): 2.5 hours of RN coverage 12/23/2023 (Saturday): 1.13 hours of RN coverage Review of the facility's daily staffing posting sheets showed the following: 1/6/2024 (Saturday), 1/17/2024 (Wednesday), 1/18/2024 (Thursday), 3/10/2024 (Sunday), 3/16/2024 (Saturday), 3/23/2024 (Saturday), 3/24/2024 (Sunday), 3/30/2024 (Saturday), 3/31/2024 (Sunday), 4/5/2024 (Friday), 4/6/2024 (Saturday), and 4/7/2024 (Sunday): no RN coverage. During an interview on 4/8/2024 at 10:40 AM, the Staff Development Coordinator (SDC)/Infection Control Nurse stated the facility typically had an RN daily Monday-Friday. The RN who was scheduled to work Saturday and Sundays quit a few weeks ago and the facility was actively trying to hire a replacement. The SDC/Infection Control Nurse confirmed the facility did not have consistent RN coverage currently on Saturday and Sundays During an interview on 4/10/2024 at 1:35 PM, the Administrator, Assistant Administrator, Director of Nursing, and the Controller confirmed the facility failed to meet the minimum requirement of 8 hours RN coverage per day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445383	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Legacy Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 811 Keylon Street Manchester, TN 37355	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 49786 Based on facility policy review, observation and interview the facility failed to post accurate staffing information to reflect daily staffing levels. The findings include: Review of the facility policy titled, Posting Direct Care Daily Staffing Numbers, revised 7/2016, showed .Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents During an observation on 4/8/2024 at 7:40 AM, of the daily nurse staffing showed the staffing information posted was the staff scheduled for 4/5/2024 and had not been updated to reflect the current staff in the facility on 4/8/2024. During an interview on 4/10/2024 at 2:035 PM, the Director of Nursing stated the Unit 1 Charge Nurse was responsible for posting the daily staffing sheet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445383	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50480 Based on facility policy review, observation, and interviews, the facility failed to ensure resident medications were secured in a locked location for 1 resident (Resident #30) of 2 residents reviewed for medication administration. The findings include: Review of the facility policy titled, Storage of Medications, revised 9/2020, showed .Drugs and biologicals used in the facility are stored in locked compartments .Only persons authorized to prepare and administer medications have access to locked medications .nursing staff is responsible for maintaining medication storage and preparation areas . Review of the facility policy titled, Administering Medications, revised 4/2019, showed .No medications are kept on top of the cart .the cart must be .inaccessible to residents or others passing by . Resident #30 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes, Schizophrenia, and Anxiety Disorder. During an observation on 4/9/2024 at 8:55 AM, Licensed Practical Nurse (LPN) #2 prepared medications for Resident #30 in the medication room. LPN #2 left the medication room, the medication cart was left in the medication room, and the medication door was not locked. The LPN left a 473 ml (milliliter) bottle of Valproic Acid 250mg (milligram)/5mL liquid, approximately 1/4 full, on top of the medication cart. The LPN walked away from the medication cart, went across the hall and administered medications to Resident #30. The medication cart was not visible to LPN #2. During an interview on 4/9/2024 at 9:05 AM, LPN #2 confirmed she left a 473 ml bottle of Valproic Acid, approximately 1/4 full, on top of the medication cart unsecured. During an interview on 4/10/2024 at 8:24 AM, the Director of Nursing stated it was the facility's expectation for medications to be secured and locked.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445383	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Legacy Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 811 Keylon Street Manchester, TN 37355	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49568 Based on facility policy review, observations, and interviews, the failed to ensure there was hot water was available for staff to wash/sanitize their hands in 1 of 2 kitchen hand washing sinks. The facility failed to maintain kitchen equipment in a sanitary manner and failed to ensure the kitchen floor was maintained in a sanitary manner, which had the potential to affect 52 of 52 residents. The findings include: Review of the facility policy titled, Sanitization, revised 10/2008, showed .All .kitchen areas .shall be kept clean .free from litter and rubbish .all equipment shall be kept clean .washed to remove soils .using mechanical means necessary . Observation and interview on 4/8/2024 at 8:35 AM, with the Dietary Manager (DM), at the kitchen handwashing station (located at the entry door), showed this surveyor attempted to wash her hands and the water remained cold. Further observation showed the water temperature did not change. The DM stated this sink had been transitioned from an eye wash station into a hand washing sink and the hot water had not been hooked up. Observation of the food preparation area on 4/8/2024 at 8:50 AM, with the DM, showed the outer door and bottom edge of the food warmer and the 6 temperature dials had thick layers of sticky, black food debris. Observation of the dishwashing area on 4/8/2024 at 8:55 AM, with the DM, showed the floor area under the dishwasher had food debris scattered on the floor. Further observation showed a plastic cup and plastic fork was on the floor beneath the dishwasher. Observation of the dishwashing area on 4/9/2024 at 9:00 AM, with the DM, showed the floor area under the dishwasher had food debris scattered on the floor. Further observation showed a plastic cup and plastic fork was on the floor beneath the dishwasher. During an interview on 4/9/2024 at 9:10 AM, the DM stated it was her expectation the kitchen equipment and kitchen floors were cleaned daily and deep cleaned weekly. The DM confirmed the kitchen equipment and kitchen floors were not maintained in a sanitary condition. During an interview on 4/9/2024 at 9:59 AM, the DM stated it was her expectation hot water would be available for kitchen staff use at the handwashing station. The DM confirmed hot water was not available for the kitchen staff at the handwashing station.