

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2025
NAME OF PROVIDER OR SUPPLIER Legacy Village Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3251 West 5400 South Taylorsville, UT 84129	

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 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>Based on interview and record review, it was determined that for 16 of 40 sampled residents, that the facility did not electronically transmit encoded, accurate, and complete Minimum Data Set (MDS) data to the CMS System. Specifically, the facility did not electronically transmit 16 discharge MDS assessments to the CMS System. Resident Identifiers: 4, 10, 12, 30, 42, 46, 54, 62, 64, 68, 69, 70, 71, 72, 73, and 75.</p> <p>Findings Include:</p> <p>Minimum Data Set (MDS) Assessments and medical records were reviewed from 5/12/25 through 5/15/25 for residents 4, 10, 12, 30, 42, 46, 54, 62, 64, 68, 69, 70, 71, 72, 73, and 75.</p> <p>Resident 4's discharge assessment date was 1/4/25.</p> <p>Resident 10's discharge assessment date was 1/21/25.</p> <p>Resident 12's discharge assessment date was 4/7/25.</p> <p>Resident 30's discharge assessment date was 1/2/25.</p> <p>Resident 42's discharge assessment date was 1/8/25.</p> <p>Resident 46's discharge assessment date was 1/10/25.</p> <p>Resident 54's discharge assessment date was 1/22/25.</p> <p>Resident 62's discharge assessment date was 1/24/25.</p> <p>Resident 64's discharge assessment date was 1/7/25.</p> <p>Resident 68's discharge assessment date was 1/9/25.</p> <p>Resident 69's discharge assessment date was 1/11/25.</p> <p>Resident 70's discharge assessment date was 1/5/25.</p> <p>Resident 71's discharge assessment date was 2/19/25.</p> <p>(continued on next page)</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 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 72's discharge assessment date was 1/25/25.</p> <p>Resident 73's discharge assessment date was 1/2/25.</p> <p>Resident 75's discharge assessment date was 1/8/25.</p> <p>The MDS discharge assessment for all of these residents had been completed, but not transmitted to CMS.</p> <p>On 5/15/25 at 11:11 AM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that he meets weekly with a Registered Nurse from the memory care side of the building and that the registered nurse signs off on the MDS assessments. The MDS Coordinator stated that after the MDS is signed, a transmission file is generated. The MDS Coordinator stated that if there are any rejections, the MDS is corrected and then resent.</p> <p>On 5/15/25 at 1:19 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the MDS coordinator was responsible for completing MDS assessments.</p>		

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that for 3 of 40 sample residents, that the facility did not ensure that a registered nurse signed and certified that the assessment was completed. Specifically, there were three MDS assessments submitted to CMS that did not have a registered nurse signature certifying that that assessment was completed. Resident Identifiers: 90, 246, and 249.</p> <p>Findings Include:</p> <p>Minimum Data Set (MDS) Assessments and medical records were reviewed from 5/12/25 through 5/15/25 for residents 90, 246, and 249.</p> <p>Resident 90's entry MDS dated [DATE] did not have a Registered Nurse (RN) signature certifying that the assessment was completed.</p> <p>Resident 246's entry MDS dated [DATE] did not have a RN signature certifying that the assessment was completed.</p> <p>Resident 249's entry MDS dated [DATE] did not have a RN signature certifying that the assessment was completed.</p> <p>On 5/15/25 at 11:11 AM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that he meets weekly with a Registered Nurse from the memory care side of the building and that the registered nurse signs off on the MDS assessments.</p> <p>On 5/15/25 at 1:19 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the MDS coordinator was responsible for completing MDS assessments.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice. Specifically, for 1 of 40 sampled residents, the resident did not have properly labeled oxygen tubing and the humidification bottle was not being changed in a timely manner. Resident identifier: 298.</p> <p>Findings included:</p> <p>Resident 298 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, acute respiratory distress syndrome, respiratory failure with hypoxia, chronic obstructive pulmonary disease, and obstructive sleep apnea.</p> <p>On 5/12/25 at 9:24 AM, an observation was made in resident 298's bathroom of the oxygen concentrator. The humidifier had no water and was not dated. There was a dry white substance on the inside of the humidifier container. The nasal cannula was observed not to be dated. The concentrator was set at 6 LPM (liters per minute). There was no indication that the cannula had been changed.</p> <p>On 5/12/25 at 12:56 PM, a second observation was made in resident 298's bathroom of the oxygen concentrator. The humidifier was still empty.</p> <p>On 5/13/25 at 10:18 AM, a third observation was made in resident 298's bathroom of the oxygen concentrator. The humidifier was still empty.</p> <p>On 5/13/25 at 10:15 AM, an interview was conducted with Registered Nurse (RN) 1 who stated she was not sure who was in charge of oxygen. RN 1 stated the Certified Nursing Assistants (CNA) set up the rooms with oxygen. RN 1 stated the residents should have orders to change the oxygen tubing.</p> <p>On 5/13/25 at 10:31 AM, an interview was conducted with CNA 1 who stated the CNAs have access to the oxygen storage room. CNA 1 stated they put on the cannulas and connect them to the oxygen tanks or concentrators. CNA 1 stated when a resident was admitted they were asked if they were using oxygen. CNA 1 stated portable oxygen tanks were behind wheelchairs in a safe area. CNA 1 stated distilled water was in the humidifiers and all the residents had them. CNA 1 stated the humidifiers had a water trapper on the cannula. CNA 1 stated he believed the night shift CNA's were responsible for changing out the cannulas on Wednesdays. CNA 1 stated the humidifiers did not get changed. CNA 1 stated there were orange stickers with the date that were placed on the cannulas, humidifiers and concentrators.</p> <p>On 5/13/25 at 11:49 AM, an interview was conducted with RN 2 who stated the CNAs were responsible for changing out the cannulas. RN 2 stated she thought the cannulas were changed every 72 hours. RN 2 stated if she found a cannula on the floor she would discard it and replace it. RN 2 stated the cannulas were supposed to be dated and she thought there were tags with the dates on them. RN 2 stated when the cannulas were not in use they should go into a bag that zips. RN 2 stated all residents should have humidified oxygen that was managed by the CNAs.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/13/25 at 11:53 AM, RN 2 was taken to resident 298's bathroom to observe the oxygen concentrator. The humidifier was observed to be empty. RN 2 stated that resident 298 was on the highest level of oxygen and needed the humidification.</p> <p>On 5/13/25 at 11:55 AM, an interview was conducted with the Director of Nursing (DON) who stated the CNAs on the night shift on Fridays were responsible for changing the oxygen tubing. The DON stated she was told by CNA 2 that oxygen tubing was being changed out on Wednesdays. The DON stated it should be done weekly. The DON stated the CNAs were supposed to label and date the nasal cannulas. The DON stated a ziplock bag should be provided for the nasal cannula when it was not being used. The DON stated she was unsure if all residents had humidifiers. The DON stated if a resident used 2 liters of oxygen or more, typically they had humidification.</p> <p>On 5/14/25 at 1:56 PM, a second interview was conducted with the DON who stated residents had physician orders to change oxygen tubing on Fridays. The DON stated humidification should be used if a resident used 2 liters of oxygen or more. The DON stated the humidifiers should be changed when they were empty and the bottles were disposable so they could be taken off and a new one could be placed on.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and interview, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, food items in the walk-in freezer and walk-in refrigerator were open to the air.</p> <p>Findings included:</p> <p>On 5/12/25 at 8:53 AM, an initial walk-through was conducted in the kitchen.</p> <p>In the walk-in freezer, a box of plant based patties was observed to be open to air and a box of frozen dinner rolls was open to air.</p> <p>On 5/15/25 at 10:11 AM, a second walk-through was conducted in the kitchen.</p> <p>In the dry storage room, a bag of potato chips was observed not to be closed. In the walk-in refrigerator, a bag of sliced ham was not sealed and was open to air. In the walk-in freezer, a box of pork sausage was observed open to air, a box of ground beef patties was open to air, a box of plant based patties was open to air, a box of bread dough was open to air, a box of mixed vegetables was open to air, and a box of cut green beans was open to air.</p> <p>On 5/15/25 at 10:33 AM, an interview was conducted with the Dietary Manager (DM) who stated the Registered Dietitian (RD) performed an audit of the kitchen once per month that included checking the temperatures of the refrigerators and freezers, taking the temperatures of the food, watching the staff plate the food, doing a meal audit, and checking the dates on the food items in the refrigerator. The DM stated the RD would provide education if she found mistakes. The DM stated he also provided education to the kitchen staff once per month. The DM stated he conducted his own audits for the freezers and refrigerators. The DM stated the food in the refrigerators and freezers should be sealed up properly to prevent ice burn and preserve food quality.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, it was determined that the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility was not able to provide documentation that the facility had conducted testing of the facility water supply for Legionella since 2021, there were observations of staff collecting dirty laundry in an uncovered bin that was pushed through resident hallways, and there were observations of staff not using aprons while loading soiled laundry into the washing machine.</p> <p>Findings Include:</p> <p>1. On 5/13/25 at 8:05 AM, an interview was conducted with the Infection Preventionist (IP). The IP stated that the maintenance department is responsible for testing the facility water supply for Legionella.</p> <p>On 5/13/25 at 10:53 AM, an interview was conducted with the Director of Maintenance (DOM). The DOM stated that he tests to see how hard the water is at the facility. The DOM stated that he needed to test the water at the facility for Legionella and that he was not sure if there was documentation of the testing.</p> <p>On 5/13/25 at 11:44 AM, an interview was conducted with the Administrator. The Administrator stated that the maintenance department is in charge of testing the facility water supply for Legionella. The Administrator stated that he would have to ask the maintenance department for testing records. The Administrator stated that he would look for records of tests for Legionella in the water.</p> <p>On 5/13/25 at 11:50 AM, the Administrator provided a copy of the facility's Water Management Program plan dated 7/19/18. The plan stated that, Twice per year we do internal testing with a water kit to test for Legionella and waterborne pathogens. The plan contained documentation of Legionella tests dated 1/22/21, 1/20/20, and 1/18/19.</p> <p>On 5/15/25 at 11:44 AM, an additional interview was conducted with the Administrator. The Administrator stated that the facility contacted the former Director of Maintenance and that he did not have documentation of water testing for Legionella from 2022 or subsequent years.</p> <p>2. On 5/15/25 at 10:08 AM, an observation was made of Laundry Aide (LA) 1 traveling down the hallway with a bin that contained soiled linens. The bin did not have a cover on top.</p> <p>On 5/15/25 at 1:04 PM, an observation was made of LA 2 placing soiled laundry into a washing machine without wearing an apron or protective gown.</p> <p>On 5/15/25 at 9:56 AM, an interview was conducted with LA 2. LA 2 stated that the laundry staff do not put on a gown when putting soiled laundry into the washing machine, but that they do wear gloves.</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/25 at 1:11 PM, an interview was conducted with the Director of Maintenance (DOM). The DOM stated when staff gather laundry from resident rooms, they should place the laundry in a bin and cover the bin with a lid on the way to the laundry room. The DOM stated that laundry staff should wear an apron while putting soiled laundry into the washing machine.		