STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045267	A. Building B. Wing	10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Health and Rehabilitation Center	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27905 Based on observation, record review and interview, the facility failed to ensure a resident who was at risk for elopement and was actively exhibiting exit-seeking behaviors was redirected in accordance with the plan of care to prevent elopement, when staff observed the resident heading toward the front of the facility unattended for 1 (Resident #1) of 3 (Residents #1, #2 and #3) sampled residents who had exit-seeking behaviors. The failed practice resulted in past noncompliance at the level of immediate jeopardy, which caused or could have caused serious harm, injury or death to Resident #1, who exited the facility undetected by staff, and had the potential to cause more than minimal harm to 9 residents who were at risk for elopement, as documented on a list provided by the Administrator on 10/1/21 at 9:00 AM. The Administrator was notified of the past immediate jeopardy situation on 10/1/21 at 1:55 PM. The findings are: 1. Resident #1 was admitted to the facility on [DATE] and had a diagnosis of Alzheimer's Disease. The Admission Minimum Data Set (MDS) was not yet completed at the time of the survey. An Admission assessment dated [DATE] at 12:24 PM by the Assistant Director of Nursing (ADON) documented, . Ambulated into facility with steady gait. Alert and oriented to self only . Wanderguard placed to left ankle . a. A Nurse's Note dated 9/28/21 at 3:18 PM documented, Resident is alert and oriented to self. Resident is very confused and exit seeking. Resident gets around on his own . b. An Elopement Risk Review dated 9/28/21 at 3:19 PM documented, .Risk Factor of Elopement (pick all that apply): Short-term Memory Problem, Alzheimer's or other Dementias, New Admission . Other Risk Factors (check all that apply): Has symptoms of confusion and can ambulate or propel wheelchair or other mobility device without assistance, Resident has packed his / her belongings in a suitcase, carryall or sack . Wandering: risk of getting to dangerous place: Yes . Resident is at risk related to: Intervention(s) in place to minimize risk of elopement . c. The Care Plan dated 9/28/21 documented, Potential for Elopement . Intervention . Listen and observe for potential signs of elopement . Redirect with conversation, activities, food, fluid, toilet, ambulation, appropriate exercise when observed exit seeking . Contact family / responsible party to sit with resident when exit seeking / exit attempts are observed . Alarm bracelet at all times - to left ankle . (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. A Nurse's Note dated 9/29/21 at 2:54 PM documented, Resident is alert and oriented to self. Some confusion noted. Resident mood has be [been] calm, and somber. Resident has been sitting down by the back door, with his bags packed . e. A Nurse's Note dated 9/29/21 at 4:26 PM documented, 3:10 PM during shift change resident noted to be outside the facility. Resident was ambulating with no problems with his overnight bag in his hand. Resident's wanderguard was in place and in working condition at this time. Resident was seen at the SE [Southeast] door just prior to being found outside the building . f. On 10/1/21 at 11:55 AM, Certified Nursing Assistant (CNA) #1 was asked, Can you tell me what transpired when you found [Resident #1] outside the facility? She stated, I had clocked out going home at 3:11 PM and went down the sidewalk in front of the facility. I was parked just across the alleyway between the facility and parking lot, where I was parked. He was standing in the alleyway approximately 122 feet from the front door. The CNA took the Surveyor to the area where the resident was found. Main Street was approximately 40 feet from where the resident was found. CNA #1 stated, It was also time for school to be let out, active, cars going both ways up and down 50th Street. He was dressed in street clothes carrying a floral tote bag. It was bigger than a purse but not bigger than a suitcase. I didn't recognize him as a resident. I suspected he was here to visit his wife and didn't know where to go. So, I started asking him if I could help, and he answered, but I was unable to understand him. He was confused. I asked him if we could go in and possibly find somebody that could help, and he came willingly. We went into the front door, and I told him to wait right there in the sitting area. It was shift change, and there were several residents with Wanderguards in the sitting area, so when I brought him through the front door, his or other residents Wanderguards could have set off alarms. I went to 3 nurses that were counting meds [medications] and asked if he was a resident or a resident's spouse or family. By this time, he was right behind me. One of the nurses told me he was a resident, and his room was on the Southeast Hall. I told her I had found him in the alleyway next to the street. They immediately went to the Administrator and started investigating what had happened and had me fill out a witness statement. I then went out with [Nurse Educator] and showed her like I did you. She took pictures of all different directions he could have come from, because no one, to my knowledge, knew what door he went out of. I suspect since he resided on Southeast Hall, he exited Southeast door into the alley. I was in- serviced on elopement the very next morning, then we all had an elopement drill yesterday afternoon. g. On 10/1/21 at 12:52 PM, Licensed Practical Nurse (LPN) #1 was asked, What do you know about the elopement of [Resident #1]? She stated, I was here the day he was admitted on [DATE]. He was assigned to my hall. We placed a Wanderguard on him at the time, because his wife told me he had really bad Sundowner's. The day he got out; I had been watching him all day. He had his bags packed all day, but not at the back Southeast exit door until 2:30 PM. That day, he was sitting in a chair. At 3:00 [PM], I heard the Southeast door alarm. I went to check on him, but he was in his room. I saw him immediately after this, heading up East Hall toward the front with his bag. We were in the middle of shift change. I was talking to one of the other nurses, and that's the last time I saw him. She was asked, What did you do when you saw him going toward the front of the facility? She stated, I did nothing, because there was a lot going on - shift change - I was also aware that he had been pushing on the Southeast door, because a CNA told me he had been pushing on that Southeast door. He'd been pretty depressed since he'd been here. He told me his wife did not love him anymore. 2. The facility removed the immediate jeopardy and corrected the failed practices on 9/29/21, prior to the survey, as evidenced by the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. A Care Plan revision dated 9/29/21 documented, Resident to be a 1:1. b. A Quality Issue / Problem form dated 9/29/21 and provided by the Director of Nursing (DON) on 10/1/21 at 1:49 PM documented, .Quality Issue/Problem: Resident [Resident #1] was found 150 feet from the front door of the facility at about 3:10 PM. Action: Resident was brought back into the facility and placed 1:1 [one-on-one supervision]. ADON [Assistant Director of Nursing] performed body audit with no negative findings found. Maintenance Director checked all doors to assure the Wanderguard system is in good working order. Residents who reside in the facility and have a Wanderguard in place were checked to assure their Wanderguard is in place and in good working order. Staff will be educated on elopement policy, elopement book and door alarms. DON / Designee will conduct random Elopement drills daily for seven days, then three times a week for four weeks, then weekly until substantial compliance is met . c. A Policy and Procedure for Elopements and Wandering Residents, provided by the Nurse Educator on 10/1/21 at 1:42 PM, documented the procedure for the Elopement drill on 9/30/21. d. An Inservice sheet dated 10/1/21 documented, AT ANY TIME YOU SEE A RESIDENT PACKING BAGS, STANDING BY DOORS, ATTEMPTING TO OPEN DOORS, TALKING OF LEAVING BUILDING YOU MUST NOTIFY DON ADMIN [ADMINISTRATOR] CHARGE NURSE. THESE ARE SIGNS OF RESIDENT ATTEMPTING TO LEAVE. RESIDENT MUST BE PLACED ON ONE-ON-ONE AT THAT TIME TILL FURTHER NOTICE. THERE IS AN ELOPEMENT BOOK AT FRONT NURSE STATION WITH PICTURES OF OUR RESIDENTS AT RISK. PLEASE REVIEW DAILY FOR NEW ADMITS OR CHANGES IN RESIDENTS.