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	12/02/2022

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 - Some	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** 46032 Based on observation, record review, and interview, the facility failed to ensure the resident environment was as free of accident fire hazards as possible, as evidenced by failure to immediately remove electrical power strips and extension cords that were improperly used in the facility before and after an incident where a power strip malfunctioned. This failed practice resulted in noncompliance at the level of Immediate Jeopardy that had the potential to cause serious injury, harm, or death to all 94 residents residing in the facility according to a Resident Census List provided by the Director of Nursing (DON) on 12/1/22. The Administrator was informed of the Immediate Jeopardy condition on 12/1/22 at 5:25 PM. The findings are: 1. During a facility tour on 12/1/22 between 11:25 AM and 12:45 PM, The Surveyor asked the Maintenance Director (MD) to enter each resident room and identify if there was an electrical power strip or electrical extension cord in the room and if he could identify what was plugged into it. The following observations were made: a. At 11:28 AM in [named] resident room the MD stated, There is an extension cord with a [oxygen] concentrator. The extension cord with an oxygen concentrator was plugged into the power strip that was plugged into an electrical outlet. b. At 11:30 AM in [named] resident room the MD stated, a power strip with a bed. the resident's bed was plugged into an electrical power strip that was plugged into an electrical outlet. c. At 11:31 AM in [named] resident room the MD stated, A power strip with a [electric] wheelchair charge box .a power strip with a bed and phone charger .I try not to overload them [power strips]. The resident bed and phone charger were plugged into an electrical power strip that was plugged into an electrical outlet. d. At 11:35 AM in [named] resident room the MD stated, A power strip with a concentrator, C-Pap machine, phone charger and updraft machine. An oxygen concentrator, Continuous Positive Airway Pressure (C-Pap) machine, phone charger and an [oxygen] updraft machine was plugged into a power strip that was plugged into an electrical outlet. (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 - Some	e. At 11:36 AM in [named] resident room the MD stated, A big one [power strip] oxygen concentrator, humidifier, updraft, C-pap, they have one plugged up from this big one to another one to go to that one .I guarantee you I didn't put it like that .they have her bed plugged in . A large power strip with an oxygen concentrator, humidifier, updraft, C-pap, and a second power strip was plugged into the first one and a third plugged into the second power strip. The third power strip had a small refrigerator and a tablet charger plugged into it; a power strip with a resident bed plugged into it. The power strips were plugged into an electrical outlet. f. At 11:40 AM in [named] resident room the MD stated, Power strip with phone charger, cooler, fan. An electrical power strip with a phone charger, small refrigerator cooler and a fan were plugged into the power strip that was plugged into an electrical outlet. g. At 11:41 AM in [named] resident room the MD stated, Power strip with phone charger, bed, tablet charger. A phone charger, resident bed, and tablet charger were plugged into an electrical power strip that was plugged into and electrical outlet. h. At 11:43 AM in [named] resident room the MD stated, Power strip with [phone] charger and bed. A phone charger and resident bed were plugged into an electrical power strip that was plugged into an electrical outlet. i. At 11:44 AM in [named] resident room the MD stated, Power strip with o2 [oxygen] concentrator and refrigerator. An oxygen concentrator and small refrigerator were plugged into an electrical power strip that was plugged into an electrical outlet. j. At 11:45 AM, Certified Nursing Assistant (CNA) #1 approached the MD and stated, .I wanted to say something about the extension cords .I didn't think she should have one plugged into another one . The MD stated, You should have said something, that is a fire hazard. Next time, say something. k. At 11:53 AM in [Named] resident room the MD stated, a breathing machine .not safe .exposed wire . An oxygen updraft machine with exposed wire connectors connected the original power cord coming from the machine to another piece of power cord. The machine was not connected to a power source at the time and the MD removed it from the resident room. l. At 12:01 PM in [Named] resident room the MD stated, Power strip with o2 concentrator, fan, refrigerator An oxygen concentrator, fan and small refrigerator were plugged into an electrical power strip that was plugged into an electrical outlet. m. At 12:08 PM in [Named] resident room the MD stated, That shouldn't be here .a regular extension cord with a TV. A small brown regular household extension cord without a ground prong with a tv plugged into it. The extension cord was plugged into an electrical outlet. n. At 12:28 PM in [Named] resident room the MD stated, A brown extension cord with the ground cut off . there is a clock and a power strip plugged in the extension cord with a phone charger. A small brown regular household extension cord with the ground plug removed-a clock and a power strip plugged in, the power strip had a phone charger plugged into it. The extension cord was plugged into an electrical outlet until the MD unplugged it from the outlet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	p. At 12:37 PM in [Named] resident room the MD stated, Power strip and bed. A small refrigerator and a resident bed were plugged into an electrical power strip that was plugged into an electrical outlet. q. At 12:42 PM in [Named] resident room the MD stated, Power strip going into the other, into the wall, computer modem, bed, not that is the mattress, and a power strip, it has a charger, bed, computer charger. There was a power strip plugged into an electrical outlet with a computer modem, low air loss mattress, and 2nd [second] power strip. The 2nd power strip had a phone charger, resident bed, and computer charger plugged into it. r. At 12:46 PM, the MD stated, .Extension cords shouldn't be in play, and we found 2-3 power strips plugged into each other .concentrators shouldn't be in a power strip because they pull a lot .or anything like a C-Pap . The Surveyor asked if any kind of medical equipment should be plugged into an electrical power strip or extension cord. He stated, I do know that that can be an issue. 2. On 12/1/22 at 12:53 PM, the Surveyor asked the MD if knew of any incidents that occurred with power strips. He stated, .got a call the fire alarm went off .a power strip that faulted and all they had in it was a TV [television] .I came and did an inspection on that hallway and reported it to The Administrator. The Surveyor asked when this occurred. He stated, Maybe 2 weeks ago. 3. On 12/1/22 at 3:12 PM, The Surveyor asked The Administrator, What the policy is for the use of extension cords and power strips in the facility? She stated, .We are not supposed to use them. We have .has 4 plugs on them, an adapter rather than extension cords .I haven't done an audit, but I will . The Surveyor asked, Was there an incident with a power strip? She stated, .We had a spark .Maintenance came in and handled it. I asked him if it was an approved plug, he said he thought so, if any resident was harmed, if there was smoke, he said everything was cleared The Surveyor asked, Should power strips be plugged into another power strip for use? She stated, absolutely not. The Surveyor asked if medical equipment such as an oxygen concentrator, should be plugged into a power strip. She stated, no The Surveyor asked if a non-grounded extension cord be used. She stated, no. The Surveyor asked the Administrator, Do you have any documentation about the incident with the power strip? She stated, I don't know, I'll have to look. I don't think I did a soft file on it. The Surveyor asked the Administrator for a policy and procedure for the use of electrical power cords and electrical extension cords. 4. On 12/1/22 at 3:30 PM, the Surveyor asked the Administrator, When did the incident with the power strip occur? She stated, .Saturday October 29th, the strip itself is what sparked. It only had a television plugged into it, so we threw it away. About 3:30 in the afternoon, He [Maintenance] checked the plug, he said it was fine. It was on the secure unit, no one was in the room. We put up the window, there was not smoke, but you could smell a plasticky smell so the windows were opened. The resident across the hall smelled it and alerted the staff . 5. On 12/1/11 at 3:39 PM, the Surveyor asked the MD, Just to clarify, did the power strip catch on fire, spark, smell? If the alarm went off, did the fire department come? He stated, .It was heating up the plastic of the power strip. A nurse called me to let me know, I could hear the alarm in the background. The fire department did come and cleared it before I got here .I came in and checked the room and every other room [on that hall] to make sure everything was ok .to make sure that nothing else was happening and the residents were safe and that there was no other reoccurrence in another room . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. On 12/1/22 at 6:08 PM, The Administrator handed The Surveyor a document and stated, This is the only policy I could find. It is old. The Policy documented, .Electrical Equipment .Power Cords/Extension Cords .To verify National Health Service (NHS) Facilities utilize power cords and extension cords per Centers for Medicare and Medicaid Services (CMS) and adopted National Fire Protection Association (NFPA) requirements . The Surveyor asked the Administrator if the facility had any other policy or resident instruction at admit that addressed the use of power strips or extension cords. She stated she would look. The Immediate Jeopardy was removed on 12/1/22 when the facility implemented the following Plan of Removal: POC Legacy: 1. On 12/1/22, upon learning of the IJ facility in-serviced all staff present how to properly utilize power strips for residents in the facility. 2. Facility will in-service all other nursing staff prior to the start of their shift how to properly utilize power strips for residents in the facility. 3. Facility will immediately audit patient room to ensure there is no unsafe utilization of power strips and remove any possible hazards immediately. 4. Facility will have all hazardous power strip situations removed by 7:00pm. 5. Administrator/designee will monitor for any hazardous power strip situations daily in each resident room for at least 7 days, and then weekly thereafter.