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	12/16/2022

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 - 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** 36821 Based on record review and interview the facility failed to ensure Care Plan interventions were in place to prevent a fall for 1 (Resident #1) of 1 (R #1) sampled resident. The failed practice resulted in past non-compliance at the level of Immediate Jeopardy, which caused or could have caused serious harm, injury, or death for Resident #1, who was at risk for falls and was left without the bed alarm that was Care Planned. This failed practice had the potential to cause more than minimal harm to 1 resident who was at risk for falls and had a fall that resulted in an ankle fracture as documented on a list provided by the Medical Records Clerk on 12/16/22. The Administrator was informed of the past immediate jeopardy condition on 12/15/22 at 12:21 PM. The Findings are: 1. R #1 had Diagnoses of Urinary Tract Infection, Alzheimer's Disease, Anxiety, and Hypertension, Admission MDS (Minimum Data Set) with an ARD (Assessment reference Date of 11/29/22 documented a BIMs (Brief Interview for Mental Status score of 4 (Severely cognitively impaired), required extensive assist with bed mobility, transfers, dressing, and personal hygiene, toileting, and bathing. a. R#1 was discharged from facility per discharge list provided by the Director of Nursing (DON) on 12/14/22. b. A Nurse's note dated 12/2/2022 documented, 2:51 PM Resident (R #1) got herself out of her bed, lost balance and fell to floor. Able to do ROM (Range of Motion) within Resident's usual range. No apparent injuries. Assisted back to bed. Notified Dr. (Doctor) [name] with orders for neuro checks x72 hrs [hours]. Daughter [named] notified. The electronic charting was signed by Licensed Practical Nurse (LPN) #1. c. A Nurse's note dated 12/2/22 at 11:24 PM documented, .Resident's [R #1] daughter here at 3:30 PM asked for Tylenol and ice pack for resident [R#1] states resident is C/O (complaining of) pain to right lower leg. Upon examining right lower leg large, raised area noted, no discoloration or heat noted from area, but resident screamed out in pain with light palpitation. Dr. [name] notified new order received to send to ER [emergency room] via [by way of] EMS [Emergency Medical Service]. EMS notified here at 4:05 PM for transport. Resident in severe pain, EMTs [Emergency Medical Technician] applied splint to leg before transfer to gurney resident was combative due to pain. Resident left facility at 4:25 PM Daughter to meet at hospital. (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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