

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2022
NAME OF PROVIDER OR SUPPLIER Legacy Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36821</p> <p>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:</p> <p>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.</p> <p>a. R#1 was discharged from facility per discharge list provided by the Director of Nursing (DON) on 12/14/22.</p> <p>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.</p> <p>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.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>d. On 12/15/22 at 8:28 AM, the Surveyor asked LPN #1, Tell me about [R #1's] fall on 12/2/22. LPN #1 stated she was working on 12/2/22 when an assistant, not sure which one, came and told me that they found [R #1] on the floor. It was just before the end of my shift when she fell . I went immediately to assess her. She thought she was ambulatory, but she wasn't well she wasn't safe. She was confused and was yelling 'get me up', 'get me up'. She told me she was trying to walk to the bed side commode and fell . I assessed her range of motion and her vital signs. She was fine. We assisted her back to bed, and she didn't complain of anything bothering her. I asked her if her hips were hurting, and she said no. She calmed down and wasn't yelling after we got her back in bed. I notified the doctor and he ordered neuro checks every 15 minutes. I can't remember if I or [LPN #2] notified her daughter. It was change of shift, so I gave report to [LPN #2], who works the second shift. The Surveyor asked LPN #1, How often do you do neuro checks after an unwitnessed fall? She stated, We do them every 15 min [minutes] for 4 hours then every 30 minutes for 4 hours then every hour for four hours. She stated, [R#1] was usually confused and hollers sometimes . I was off a few days. When I returned, I found out she was in the hospital with a fractured ankle.</p> <p>e. On 12/15/22 at 9:08 AM, the Director of Nursing (DON) stated, We don't have the neuro check documentation for [R #1]. The Surveyor asked the DON, What is a potential negative outcome if the neuro checks are not completed/documented when a physician has ordered them for a resident after a fall? The DON stated, If something was going on they couldn't watch it.</p> <p>f. On 12/15/22 at 9:17 AM, R #1's Care Plan dated 11/29/22 was reviewed. The Care Plan documented, .At risk for falls .Tab alarm while in bed .tab alarm while in chair .PT (Physical Therapy) for eval .Night light . Nonskid footwear .</p> <p>g. On 12/15/22 at 9:45 AM, the Surveyor asked LPN #1, Was [R #1's] bed alarm sounding when she fell ? LPN #1 stated, No, we don't use alarms. The Surveyor asked, Was she wearing nonskid socks? LPN #1 stated, She had socks on, but I can't tell you if they were nonskid or not.</p> <p>h. On 12/15/22 at 9:47 AM, the Surveyor asked the DON, Did [R #1] have a bed/chair alarm? She stated, I don't know why that is on her care plan. We don't use alarms.</p> <p>i. On 12/15/22 at 9:47 AM, the DON stated, We use the Incident policy as our fall policy. We don't have fall Assessment's in our computer system. When she was asked for R #1's Fall Assessment and the facility's fall policy.</p> <p>j. An I&A (Incident and Accident) report provided by the DON dated 12/2/22 documented, R #1 .Immediate Post-Incident Action: FALL MAT NEXT TO BED .</p> <p>k. Nursing Management Manual policy provided by the DON on 12/15/22, titled: Incidents and Accidents documents, .when an accident occurs, prompt response and reporting occur. Process: assess resident . Access neurological signs, notify family, Notify physician. Remember, fractures in the elderly, .cannot readily be detected visually. Frequently, the elderly does not experience pain .Interventions should be documented in the nurse's notes .initiate investigation .</p> <p>l. The [named] hospital document received from the DON on 12/15/22 documented, 12/2/22 .R #1 .closed fracture of right lower leg .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>m. On 12/15/22 at 10:57 AM, The Surveyor asked CNA #1 (Certified Nursing Assistant) who was working the South Hall on 12/2/22, Will you tell me about [R #1's] fall on December 2nd [second]? CNA #1 stated, She was down on the floor. I think she had Dementia because she was talking about a plane crash. The nurse came in and made sure she was okay, and we put her to bed. The Surveyor asked CNA #1,, Did you see anything unusual? She stated, Nothing we could see.</p> <p>n. On 12/15/22 at 11:44 AM, the Surveyor asked the DON, Should the bed alarm have been in place for [R #1] since it was care planned? She stated, No, because it is considered a restraint and we don't use them.</p> <p>o. On 12/15/22 at 11:44 AM, the Surveyor asked the DON, Should the neuro checks been done since they were ordered by the physician after [R #1] was found on the floor? She stated, Yes.</p> <p>p. On 12/15/22 at 12:20 PM, the Surveyor asked the Administrator, Who is responsible for ensuring the Care Plan interventions are correct and being followed? The Administrator stated, The Care Unit Manager and the nursing sub committees discuss those throughout the week.</p>		