

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2009
FORM APPROVED
OMB NO. 0938-0391

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #14261, substantiated (all or in part) with a deficiency cited at F314. Complaint #14274, unsubstantiated. Complaint #14284, substantiated (all or in part) with deficiencies cited at F309 and F332.	F 000		
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Complaint #14284, substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure indwelling catheter tubing was cleaned during incontinent care for 2 (Residents #2 and 5) of 3 case mix residents who had Foley catheters (Residents #1, 2, and 5). The facility failed to ensure excoriated areas of skin were promptly identified and treated for 1 of 1 case mix residents who had excoriated skin under the skin folds (Resident #2). These failed practices had the potential to affect 9 residents who had an indwelling catheter according to the Resident Census and Conditions of Residents form dated 2/17/09 and 37 residents who were at risk for excoriation under skin folds according to the MDS (Minimum Data Set) Coordinator on 2/24/09. The findings are:	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 1 1. Resident #2 had diagnoses of Diabetes Mellitus, Congestive Heart Failure, Renal Failure and Dermatitis. The Annual Minimum Data Set (MDS) dated 1/9/09 documented the resident was independent in cognitive skills for daily decision making, required extensive assistance with personal hygiene, was incontinent of bowels, had an indwelling catheter, rashes and ointments/medications were applied to skin areas other than feet. a. The facility's policy titled "Protocol for CNA [Certified Nurses Assistant] and Licensed Nurse Skin Inspections" documented "Intent: To identify any skin concerns in residents immediately and implement early intervention. Procedure for CNA Daily Inspections: CNA's will conduct a body inspection on all assigned residents. Results of inspection will be documented on the body audit sheet beside appropriate resident's name. Any skin concern identified by the CNA will be reported to assigned Licensed Nurse immediately. CNA will document the Nurse it was reported to on the body audit sheet. All body audit sheets will be shared with the assigned Licensed Nurse and Licensed Nurse will submit to the DON [Director of Nurses]/designee. The body audit sheets will be reviewed by the designated Treatment Nurse on a daily basis and new skin concerns will be presented at the morning meetings... Procedure for Licensed Nurse Weekly Inspections: Designated Licensed Nurse will conduct body inspection on all residents on a weekly basis, per schedule... Licensed Nurse will document findings of inspection on the Licensed Nurse Body Audit Sheet which is individualized for each resident. Any skin concerns identified by the licensed nurse will be reported to designated Treatment Nurse immediately for evaluation and	F 309			

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 2 treatment orders. If Treatment Nurse is not available, nurse identifying concern should evaluate wound and notify MD [Medical Doctor] for initial treatment orders..." b. The "Care Plan" updated on 9/8/08 documented, "Problem/need: Potential for skin tears r/t [related to] fragile skin... Approaches: Inspect for skin changes daily... Apply creams and powders topically as ordered d/t [due to] chronic excoriation 9/8/08." c. "Licensed Nurse Weekly Body Audit" forms and "Departmental Notes" from 12/1/08 thru 1/12/09 documented the following skin issues: 1) The "Licensed Nurse Weekly Body Audit" form dated 12/1/08 completed by Licensed Practical Nurse (LPN) #5 documented, "pink" with circles drawn on a picture of a body at the bilateral axillary, bilateral breast and abdominal fold areas. 2) The "Licensed Nurse Weekly Body Audit" form dated 12/15/08 completed by Licensed Practical Nurse (LPN) #5 documented, "pink" with lines drawn on a picture of a body at the bilateral breast and abdominal fold areas. 3) The "Licensed Nurse Weekly Body Audit" form dated 12/22/08 completed by Licensed Practical Nurse (LPN) #3 documented, "reddened" with a circle drawn on a picture of a body at the perineal area. 4) The "Licensed Nurse Weekly Body Audit" form dated 12/29/08 completed by Licensed Practical Nurse (LPN) #5 documented, "self inflicted scratches" with a line drawn on a picture of a body at the waist area.	F 309			

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 3 5) The "Departmental Notes" dated 12/29/08 at 10:38 a.m., written by LPN #5 documented, "...Often gets redness under breast and abdominal folds..." 6) The "Licensed Nurse Weekly Body Audit" form dated 1/12/09, completed by Licensed Practical Nurse (LPN) #5, documented, "redness" with lines drawn on a picture of a body at the bilateral breast and abdominal fold area. d. Physician orders dated 2/2/09 documented, "Apply Caldesene powder to bilat [bilateral] axillary q [every] shift. Dx [diagnosis]: Dermatitis. Apply Caldesene powder to abd [abdominal] fold q shift. Dx: Dermatitis." e. As of 2/19/08 the Nurse Consultant could not provide any "Licensed Nurse Weekly Body Audit" forms or Departmental Notes from 1/12/09 until 2/13/09 for skin assessments. Additionally there were no CNA body audit sheets provided as per facility policy. On 2/20/09 the Treatment Nurse ran lists of Physician Order List for Wound Care and Nystatin use from 5/1/08 thru 2/20/09. There was no documentation on these lists of any treatment orders for skin concerns until 2/2/09. 1) On 2/20/09 at 3:25 p.m., the Treatment Nurse was asked if she could find any treatment orders for the skin problems that were documented for the resident beginning 12/1/08. The Treatment Nurse stated, "No." The Treatment Nurse was asked, "How often are you supposed to review the "Licensed Nurse Weekly Body Audit"?" The Treatment Nurse stated, "Weekly, but I've not been doing them like I should."	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2009
FORM APPROVED
OMB NO. 0938-0391

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 4</p> <p>2) On 2/20/09 at 4:55 p.m., LPN #5 was asked to review the "Licensed Nurse Weekly Body Audit" and the "Departmental Notes dated 12/29/08. LPN #5 was asked, "What do you do when you find skin breakdown under [Resident #2's] breast, arms, abdominal folds?" LPN #5 stated, "I usually tell [Treatment Nurse]." LPN #5 was asked if she called the physician from 12/1/09 through 12/29/08 when she documented the redness and skin breakdown. LPN #5 stated, "I usually do." LPN #5 was asked, "Can you find any physician orders to treat the redness and skin breakdown on or after 12/1/08 through 12/29/08?" LPN #5 stated, "No, I usually go to [Treatment Nurse] for that."</p> <p>f. "Departmental Notes" from 2/13/09 thru 2/17/09 documented the following skin issues:</p> <p>1) The "Departmental Notes" dated 2/13/09 at 6:58 p.m., written by LPN #6, documented, Caldesene Powder was applied to the bilateral axillary and abdominal folds areas.</p> <p>2) The "Departmental Notes" dated 2/16/09 at 3:38 p.m., written by LPN #3, documented, "Late entry for 2/15/09... Resident noted to have continuing redness to abd [abdominal] fold and under bilateral breast. Caldesene applied to areas. Resident keeps rolled towel to abd fold..."</p> <p>3) The "Departmental Notes" dated 2/16/09 at 3:57 p.m., written by LPN #3 documented, "...Resident given shower this shift with Caldesene applied to affected areas per orders...."</p> <p>4) The "Departmental Notes" dated 2/17/09 at 4:05 p.m., written by the Treatment Nurse</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2009
FORM APPROVED
OMB NO. 0938-0391

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 5 documented, "This nurse went into room to apply Caldesene powder per orders for day shift, resident told this nurse that charge nurse [had] already applied powder. This nurse assessed reddened areas. Powder noted to bilat axillaries and abd fold. Excoriation to bilat axillaries and abd fold healing well. Pillow case noted to abd fold to absorb moisture. Resident denies pain @ this time..." g. On 2/18/09 at 2:15 p.m., the Treatment Nurse applied Caldesene powder under the resident's bilateral axillary areas and under the abdominal fold. The Treatment Nurse stated she was done with treatments and this surveyor requested that the resident's breast be lifted. The resident had a reddened area under both breast. The Treatment Nurse assisted with a skin audit. The resident had excoriation, reddened skin with a yellow substance covering the majority of the reddened area, in the right axillary area extending from mid inner arm to mid chest area across the width of the right inner arm and the chest was the same width. The resident had excoriation, reddened area, under the left axillary area approximately 8 centimeters by 6 centimeters in size. The resident had excoriation, redness under the bilateral breast approximately 8 centimeters by 6 centimeters in size. The resident had excoriation, redness with bleeding, under the abdominal fold across the entire abdominal fold that was approximately 6 inches wide. The Treatment Nurse removed a folded pillow case from under the residents abdominal fold that was wet with a a yellow serous drainage and blood. There was excoriation, redness with one area that was bleeding, of the residents bilateral inner thighs across the front 1/2 of the thigh down to mid thigh level. The Treatment Nurse was requested to	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2009
FORM APPROVED
OMB NO. 0938-0391

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 6</p> <p>provide documentation of all areas of excoriation, and open areas with measurements. The Treatment Nurse was asked what treatment was being provided under the resident's breast. The Treatment Nurse stated, "None, I didn't know it was there." CNA #9, who was assisting with the treatment, stated, "It's [excoriation under breast] been there a couple of weeks, and it looks so much better than last week."</p> <p>The "Departmental Notes" dated 2/18/09 at 5:47 p.m., written by the Treatment Nurse, documented, "This nurse with another LPN was performing body audit... This nurse noted multiple scabbed areas to left calf. This nurse noted areas to left calf where resident had scratched scab off. Wound measures 0.9 x 0.8 red/pink in color. No drainage/odor detected from wound. New treatment orders received to apply TAO [triple antibiotic ointment] with band aid to wound qd [every day] until healed. Resident also noted excoriation under bilat [bilateral] breast. Orders received to apply Caldesene powder q shift..."</p> <p>On 2/20/09 at 3:25 p.m., the Treatment Nurse was asked, "Did you know about the excoriation under [Resident #2's] breast and perineal area prior to the 2/18/09 body audit with me.?" The Treatment Nurse stated, no.</p> <p>h. The "Departmental Notes" dated 2/19/09 at 11:50 a.m., written by the Treatment Nurse documented, "This nurse performed skin assessment on this resident this a.m... Excoriation noted to bilat axillaries... Excoriation noted under bilateral breast... Also noted to have excoriation under abd [abdominal] fold. Open area noted to right abd fold measuring 0.3 x 0.3</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2009
FORM APPROVED
OMB NO. 0938-0391

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 7</p> <p>[centimeters]. Open area to left abd for measuring 0.1 x 1.5 [centimeters]. Scant amount blood noted from bilat abd sites,... Resident also with noted excoriation noted to peri area... Multiple self inflicted scratches to right thigh. Resident also with multiple self inflicted scratches to entire left leg... "</p> <p>i. On 2/24/09 at 1:45 p.m., the facility provided documented measurements written by the Treatment Nurse for excoriation and dated 2/19/09 for the resident as follows: "[Left] breast 22 x [by] 10 cm [centimeters], [Left] axilla 13 x 6 cm, [right] breast 30 x 7 cm, [right] axilla 20 x 18 cm, and abd fold 85 cm x 22 cm."</p> <p>j. Physician orders dated 9/1/08 documented, "Foley catheter... Foley catheter care per policy q shift..."</p> <p>1) On 2/19/08 at 8:40 a.m., CNA #6 gave the resident a shower. During the shower, CNA #6 washed the mid labia and labia area in a back and forth motion. CNA #6 did not clean the Foley catheter tubing.</p> <p>2) On 2/19/09 at 9:00 a.m., after the resident was returned to bed from the shower, CNA #6 used a towel with periwash to clean down each groin and mid labia with one wipe each time with a different area of the towel. CNA #6 did not clean the urinary meatus or the Foley catheter tubing.</p> <p>2. Resident #5 had diagnoses of Peritoneal Abscess and Stage IV Pressure Ulcer. The Admission Minimum Data Set dated 1/20/09 documented the resident was independent in cognitive skills for daily decision making, dependent on staff for personal hygiene and had</p>	F 309		

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 8 an indwelling catheter. a. Physician orders dated 1/21/09 documented, "[Foley] catheter ... Foley care per policy q [every] shift." b. On 2/18/09 at 9:50 a.m., CNA #5 gave the resident a bed bath, but did not clean the Foley catheter tubing. 3. The facility's policy titled, "Urinary Catheter Care" documented "Purpose: Urinary catheter care helps prevent urinary tract infection... Process:... II. Catheter Care. a) Wash perineal area per policy. b) Cleanse area of catheter insertion well using soap and water... c) Wash the catheter itself by holding onto the catheter at the insertion site; wash with one stroke downward approximately 3 inches from the meatus while holding the catheter to prevent pulling... d) Rinse perineal area well and rinse the catheter by holding on the insertion site; rinse with one stroke downward approximately 3 inches for the meatus while holding the catheter to prevent pulling..."	F 309			
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all soiled areas were cleaned during incontinent care for 1 (Resident #3) of 4 case mix residents who were	F 312			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2009
FORM APPROVED
OMB NO. 0938-0391

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	Continued From page 9 incontinent (Resident #1, 3, 6 and 7). This failed practice had the potential to affect 57 residents who were incontinent according to the Resident Census and Conditions of Residents report dated 2/17/09. The findings are: Resident #3 had diagnoses of Quadriplegia, Pyelonephritis and Chronic Urinary Tract Infection. The Annual Minimum Data Set dated 12/11/08 documented the resident was independent in cognitive skills for daily decision making, required total assistance with personal hygiene and was incontinent of bowel and bladder. a. On 2/17/09 at 6:39 p.m., CNA (Certified Nursing Assistant) #7 and CNA #8 provided incontinent care after the resident was incontinent of bowel and bladder. CNA #8 obtained warm, wet wash clothes from the bathroom. CNA #7 cleansed the rectal area 3 times. CNA #7 stated, "We should have done this in the shower." The CNA's were asked, "Are those wet clothes treated with soap or peri wash." CNA #7 stated, "We usually always use wet, soapy wash clothes, but usually we have wipes because they have skin barrier in them, but she (pointing at CNA #8) is new." CNA #8 removed the dirty and wet incontinent brief and wet sheet, left the room and returned with peri wipes. Using 1 wipe, CNA #8 cleansed from back to front of the rectal area, CNA #7 stated, "Remember front to back." CNA #8 cleansed the rectal with 13 peri wipes. The resident was rolled onto the back. CNA #7 cleansed the right groin area, downward 1 time, then using the same wipe cleansed the scrotum, holding the penis up off of the scrotum with the left hand. CNA #7 cleansed around the base of the penis and scrotum and underneath the	F 312			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2009
FORM APPROVED
OMB NO. 0938-0391

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	Continued From page 10 scrotum. The CNA's did not clean the left groin area or penis, buttocks or mons pubis area before applying a clean incontinent brief. The resident had redness noted in the bilateral groin areas.	F 312			
F 314 SS=E	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Complaint #14261, substantiated (all or in part) in these findings. Base on observation, record review and interview, the facility failed to ensure a pressure ulcer dressing on coccyx was free of feces for 1 of 1 case mix resident (Resident #5) who had a pressure ulcer of the coccyx. The facility failed to ensure wound care was provided in a manner to prevent possible infections for 2 (Residents # 5 and 6) of 3 case mix residents who received wound care for pressure ulcers (Residents # 1, 5 and 6) The facility failed to ensure heel protectors were used as care planned for 1 (Resident #7) of 3 case mix residents had or had history of pressures ulcers to the feet (Residents #5, 6 and 7). These failed practices had the potential to affect 2 residents who had dressings on the coccyx according to the listing provided by the Nurse Consultant on 2/20/09, 20 residents who	F 314			

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 11 received wound care according to the wound care list provided by the Director of Nurses on 2/17/09 and 8 residents who had heel protectors or sage boots according to the wound care list provided by the Director of Nurses on 2/17/09. The findings are: 1. Resident #5 had diagnoses of Peritoneal Abscess and Pressure Ulcer Stage IV. The Admission Minimum Data Set (MDS) dated 1/20/09 documented the resident was independent in cognitive skills for daily decision making, had a wound infection, and one Stage IV pressure ulcer. a. A physician order dated 1/14/09 documented, "Wound Stage IV. Site coccyx. Change dsg [dressing] q [every] M-W-F [Monday, Wednesday, Friday]. Cleanse w/WCW [with wound cleanser] and 4 x [by] 4's. Pack lightly with Aquacel. Apply Hydrocolloid...." b. A physician order dated 1/22/09 documented, "5% Morphine/2% Lidocaine gel to sacral wound prior to dressing application." c. A physician order dated 2/18/09 documented, "Wound Stage IV. Site lower spine. Change dsg q M-W-F. Cleanse w/WCW and x [times] 10 gze [gauze] 4 x 4. Apply Hydrocolloid. ..." d. On 2/20/09 at 10:45 a.m., the Treatment Nurse placed a plastic bag that contained clean wound supplies, an opened packet of 4 x 4's from the top of the treatment cart, a bottle of wound cleanser from the top of the treatment cart and a medication cup filled with Morphine and Lidocaine gel on the over bed table. The Treatment Nurse did not set up a clean field nor clean the over bed	F 314			

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 12</p> <p>table. After opening the supplies, putting on gloves and turning the resident to the right side, the Treatment Nurse sprayed the coccyx, buttocks, two wounds on the lower spine and left hip with wound cleanser. The Treatment Nurse then used one 4 x 4 to wipe in a back and forth motion across the wounds on the left coccyx, two wounds on the lower spine and left hip. After changing gloves the Treatment Nurse took a 4 x 4 and scooped out some Morphine and Lidocaine gel from the medication cup. Next the Treatment Nurse patted the two wounds on the lower spine and the right hip with the 4 x 4 that contained the medicated gel.</p> <p>e. On 2/20/09 at 5:30 p.m., the Treatment Nurse was asked, "Are you supposed to pat clean from one wound to another?" The Treatment Nurse stated no. The Treatment Nurse was asked why not. The Treatment Nurse stated, "Cross contamination". The Treatment Nurse was asked if she was supposed to set up a clean field. The Treatment Nurse stated "Yes". The Treatment Nurse was asked if she set up a clean field. The Treatment Nurse stated no.</p> <p>2. Resident #7 was admitted to the facility on 11/25/08 with a diagnosis of Left Unilateral Amputation Foot. The Initial Minimum Data Set (MDS) dated 12/3/09 documented the resident was moderately impaired in cognitive skills for daily decision making, had one Stage 2 and one Stage 3 pressure ulcers and received preventative or protective foot care.</p> <p>a. The Care Plan dated 11/25/08 documented, "Problem/Need: Actual skin breakdown ... Approaches: ... Float heels. Heel protectors. ..."</p>	F 314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2009
FORM APPROVED
OMB NO. 0938-0391

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 13</p> <p>b. On 2/18/09 at 12:50 p.m., 2:07 p.m., 3:25 p.m. and 4:10 p.m., and 2/19/09 at 8:10 a.m., 9:20 a.m., 12:45 p.m. and 2:05 p.m., there was no heel protector on the resident's left foot and the heels were not floated off the mattress.</p> <p>c. On 2/19/09 at 2:15 p.m., the Director of Nurses (DON) was shown the resident's feet. The resident had a heel protector on the right foot, no heel protector on the left foot and the heels were not floated off the mattress. The DON was asked if the resident was supposed to have one heel protector or two. The DON stated, "I believe he's supposed to have two."</p> <p>3. Resident #1 had diagnoses of End Stage Alzheimer's, Osteoarthritis, and Pressure Ulcer of Coccyx. The Quarterly MDS dated 1/14/09 documented the resident was severely impaired in cognitive skills for daily decision making and had one Stage III pressure sore.</p> <p>a. The Plan of Care documented a problem onset on 10/2/08 of "Actual skin breakdown related to impaired mobility, decreased mobility and debility." with an approach of "11/11/08 Treatment as ordered to stage 3 per wound nurse or charge nurses."</p> <p>b. A physician order dated 2/18/09 documented, Cleanse pressure ulcer Monday - Wednesday-Friday and PRN (as needed). Cleanse with wound cleanser and 4x4 and apply Mepilex (dressing).</p> <p>c. On 2/17/09 at 7:15 p.m., CNA #10 was changing the bed linen. There was a dressing on the resident's coccyx dated 2/16/09. The dressing had feces on the bottom fifth and under the</p>	F 314			

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 14 bottom edge. There was also brown coloration on the lower buttocks and upper thighs. At 8:00 p.m., the dressing on the coccyx still had dried feces.	F 314			
F 315 SS=E	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure a back and forth motion was not used during incontinent care for 2 (Resident #2 and 5) and a different washcloth was used for different areas of the body during incontinent care for 1 (Resident#5) of 4 case mix residents who were incontinent (Resident #1, 3, 6 and 7). This failed practice had the potential to affect 57 residents who were incontinent according to the Resident Census and Conditions of Residents report dated 2/17/09. The findings are: 1. The facility's policy titled "Perineal Care" documented, "Purpose: Good perineal care helps prevent infection, irritation and skin breakdown.... Process:... II. Female Resident. a) Wash pubic area first, washing from front to back; use a different corner or a new wipe area with each	F 315			

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	<p>Continued From page 15</p> <p>wipe. If resident has catheter, wash catheter at this time... III. Male Resident. a) Wash perineal area starting with the urethra opening to the base of the penis. b) Continue to wash the perineal area including the penis, scrotum and inner thigh. c)... If resident had catheter, wash catheter at this time..."</p> <p>2. Resident #2 had diagnoses of Diabetes Mellitus, Congestive Heart Failure, Renal Failure and Dermatitis. The Annual Minimum Data Set (MDS) dated 1/9/09 documented the resident was independent in cognitive skills for daily decision making, required extensive assistance with personal hygiene, was incontinent of bowels, had an indwelling catheter, rashes and ointments/medications were applied to skin areas other than feet.</p> <p>On 2/19/08 at 8:40 a.m., CNA #6 gave the resident a shower. During the shower, CNA #6 washed the mid labia and labia area in a back and forth motion.</p> <p>3. Resident #5 had diagnoses of Peritoneal Abscess and Stage IV Pressure Ulcer. The Admission Minimum Data Set dated 1/20/09 documented the resident was independent in cognitive skills for daily decision making, dependent on staff for personal hygiene and had an indwelling catheter.</p> <p>a. Physician orders dated 1/21/09 documented, "[Foley] catheter ... Foley care per policy q [every] shift."</p> <p>b. On 2/18/09 at 9:50 a.m., CNA #5 gave the resident a bed bath. CNA #5 bathed the</p>	F 315			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2009
FORM APPROVED
OMB NO. 0938-0391

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	Continued From page 16 resident's arms, hands, abdomen and chest. CNA #5 then sprayed the penis and scrotum with periwash. CNA #5 used the same washcloth used for bathing the resident's arms, hands, abdomen and chest and washed the pubic area, then the tip of the penis in a back and forth motion, multiple times. CNA #5 then cleaned a dried yellowish tan substance from the resident's inner left thigh and scrotum, then cleaned the urethra again still using the same washcloth. CNA #5 rinsed the cloth and used it to rinse the scrotum and penis.	F 315			
F 322 SS=E	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure tube feedings were administered as ordered for 1 of 1 case mix resident who had a physician order for continuous tube feedings (Resident #7) and tube feeding placement was verified prior to administration of medications or fluids for 2 (Residents #7 and 9) of 3 case mix residents who had gastrostomy tubes (Residents #7, 9 and 20). This failed practice had the potential to affect 11 residents who had a feeding tube according to the MDS (Minimum Data Set)Coordinator on 2/24/09. The findings are:	F 322			

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 322	Continued From page 17 1. The facility's policy titled "Enteral Feedings" documented, "... 4. Turn off feeding pump. Regardless of the type of tube check for proper placement before administering medications or water. This is done in 2 ways, auscultation and aspiration of gastric contents. ..." 2. Resident #7 had diagnoses of Dysphagia and Gastrostomy Status. The Admission MDS dated 12/3/08 documented the resident had modified independence in cognitive skills for daily decision making and a feeding tube through which 76% to 100% of total calories and 2001 or more cc/day of fluid intake was received. a. A physician order dated 2/14/09 documented, "Tube feeding: water flush only ... flush with 25 cc [cubic centimeters] H2O [water] q [every] hr by Quantum pump. ... Tube feeding: Glucerna 1.2 to infuse via Quantum pump continuously @ 70 cc/hr..." b. On 2/19/09 at 9:22 a.m., Licensed Practical Nurse (LPN) #5 entered the resident's room to assess the resident. The tube feeding tubing was loose and the tube feeding solution was leaking on the resident's right side of the bed. LPN #5 disconnected the tube feeding tubing from the gastrostomy tube, capped the gastrostomy tube, turned the Quantum pump off, and hung the tubing over the tube feeding pole. c. On 2/19/09 at 12:45 p.m., the tube feeding tubing was still disconnected and the Quantum pump was still off. d. On 2/19/09 at 2:00 p.m., the tube feeding tubing was still disconnected and the Quantum	F 322			

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 322	<p>Continued From page 18</p> <p>pump was still off. LPN #2 was asked to come into the resident's room with the surveyor to check the resident's tube feeding. LPN #2 was asked if she knew that the tube feeding was stopped. LPN #2 stated, "No, it's supposed to be continuous."</p> <p>e. On 2/19/09 at 2:05 p.m., LPN #3 took the end of the tube feeding tubing and reconnected it to the gastrostomy tube. LPN #3 then turned the Quantum pump on at 70 cc/hr. LPN #3 stated, "It's [tube feeding tubing] just coming back out." LPN #3 left the room. LPN #3 returned to the room with a large syringe and no stethoscope. LPN #3 put the syringe into the gastrostomy tube and attempted to aspirate with no return. LPN #3 then flushed the gastrostomy tube with 30 cc of water without checking for placement. LPN #3 then reconnected the tube feeding tubing to the gastrostomy tube and the tubing did not stay.</p> <p>f. On 2/19/09 at 2:55 p.m., LPN #5 checked placement, flushed the gastrostomy tube with 30 cc of water and restarted the tube feeding at 70 cc/hr. LPN #5 was asked, "Why did you unhook the pump this a.m.?" LPN #5 stated, "It came apart and it was all over him." LPN #5 was asked who did you tell. LPN #5 stated, "[LPN #2]."</p> <p>3. Resident #9 had diagnoses of Dysphagia and Gastrostomy Status. The Quarterly MDS dated 1/7/09 documented the resident was severely impaired in cognitive skills for daily decision making and had a feeding tube.</p> <p>a. A physician order dated 7/10/08 documented, "Potassium Chloride 10% soln. [solution] give 30 meq [milliequivalents] to = 23 cc via PEG [percutaneous endoscopic gastrostomy] tube bid</p>	F 322			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2009
FORM APPROVED
OMB NO. 0938-0391

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 322	Continued From page 19 [twice a day] (measure with syringe for accurate dosaging, dilute with at least 4 oz [ounce] of water ... Lasix 20 mg tablet, give three to = 60 mg [milligrams] via PEG tube bid. ... Glucerna Select @ 50 cc/hr per PEG tube..."	F 322			
F 332 SS=E	b. On 2/20/09 at 8:42 a.m., LPN #3 flushed the gastrostomy tube with 30 cc of water, gave the Potassium and Lasix and flushed with 30 cc of water. LPN #3 did not check placement by auscultation or aspiration prior to administering the medications. c. On 2/20/09 at 8:50 a.m., LPN #3 was asked if she checked placement prior to administering medications. LPN #3 stated no. 483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Complaint #14284, substantiated (all or in part) in these findings. Based on observation of the 12:00 p.m. and 4:00 p.m. medication passes on 2/19/09 and the 8:00 a.m. and 2:00 p.m. medication passes on 2/20/08, and record review and interview, the facility failed to ensure that the medication error rate was less that 5%. Physician orders were not followed on 3 (Resident #3, 8, and 9) of 15 residents observed during the medication passes resulting in medication errors. Medication errors were made by 3 Licensed Practical Nurses (LPN #1, 2 and 3) of 8 nurses who administered	F 332			

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 332	Continued From page 20 medications during the medication passes. The medication error rate was 10.42% based on administration of 48 medications and 5 medication errors observed. This failed practice had the potential to affect 54 residents who resided on the Southeast, Northeast and East halls where medication errors were made according to the listing provided by the Nurse Consultant on 2/20/09. The findings are: 1. Resident #3 had a physician order dated 2/5/09 for "Prednisone 20 mg [milligrams] one p.o. [by mouth] tid [three times a day] [with] food." a. On 2/19/09 at 11:15 a.m., LPN #1 administered Prednisone 20 mg with a glass of water. No food was given or offered. b. On 2/19/09 at 12:05 p.m., the resident received his lunch tray. 2. Resident #8 had a physician order dated 2/12/09 for "Lactulose 10 gm [gram]/15 ml [milliliters] soln. [solution], give 30 ml to = 20 gm po q [every] 6 hrs (hold if diarrhea)." a. On 2/19/09 at 12:32 p.m., LPN #2 took the medication into the room. The resident told the nurse he'd had diarrhea for three days and asked the nurse if this was the medication that caused diarrhea. LPN #2 told the resident she didn't know what the medication was for and had the resident take the medication. b. On 2/19/09 at 2:05 p.m., Certified Nurses Assistant (CNA) #1 was asked if the resident had diarrhea today. CNA #1 stated yes. c. A physician order dated 2/14/09 for "Albuterol	F 332			

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 332	<p>Continued From page 21</p> <p>Sul [sulfate] 1.25 mg/3 ml sol. [solution], give one unit dose via nebulizer tid ..."</p> <p>On 2/19/09 at 1:30 p.m., LPN #2 set up the unit dose Albuterol in the nebulizer chamber. LPN #2 started the breathing treatment at 1:32 p.m. At 1:47 p.m., LPN #2 stated the treatment was done but medication vapor was still coming out the end of the nebulizer mouthpiece. LPN #2 restarted the treatment after checking the medication chamber. At 1:50 p.m. medication vapor was still coming out the end of the nebulizer mouthpiece. LPN #2 removed the mouthpiece from the resident's mouth, took off her gloves and started to put the nebulizer away. LPN #2 was asked to measure the amount of medication still present in the medication chamber. LPN #2 measured the amount with a syringe and obtained 0.7 cc of medication.</p> <p>3. Resident #9 had physician orders dated 7/10/08 for "Potassium Chloride 10% soln. give 30 meq [milliequivalents] to = 23 cc [cubic centimeters] via PEG [Percutaneous Endoscopic Gastrostomy] tube bid [twice a day] (measure with syringe for accurate dosaging, dilute with at least 4 oz [ounce] of water ... Advair 500/50 diskus, one puff qd (wait at least 5 min's [minutes] btw [between] diff [different] inhalers, rinse mouth after use to prevent thrush like conditions)."</p> <p>a. On 2/20/09 at 8:26 a.m., LPN #3 drew up Potassium Chloride solution using a 12 cc syringe. LPN #3 drew up 12 cc and put the solution into a medication cup, then drew up more solution to the 11 cc line. LPN #3 stated "It's 11 milliliters, that's 23 cc's". There was 1 cc of air in the top of the syringe making the total dose 22 cc, not 23 cc as ordered.</p>	F 332			

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 22	F 332		
F 441 SS=E	<p>b. On 2/20/09 at 8:40 a.m., LPN #3 administered one puff of Advair diskus. LPN #3 did not offer or instruct the resident to rinse her mouth, nor did LPN #3 clean the resident mouth with a toothette.</p> <p>c. On 2/20/09 at 8:50 a.m., LPN #3 was asked did you have the resident rinse her mouth after the Advair. LPN #3 stated no.</p> <p>483.65(a) INFECTION CONTROL</p> <p>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure wound care was provided in a manner to prevent possible infections for 3 (Residents #5, 6 and 7) of 5 case mix residents who received wound care for (Residents #1, 3, 5, 6 and 7). These failed practices had the potential to affect 20 residents who received wound care according to the wound care list provided by the Director of Nurses on 2/17/09. The findings are:</p> <p>1. The facility's policy titled "Dressings - Clean"</p>	F 441		

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 23 documented "Purpose: To provide guidelines for the care of wounds and soiled dressings, to decrease the potential for nosocomial infection... Process:... 3. A disposable cloth (paper towel is adequate) is placed on the over bed table to establish a clean field; if the table is soiled, wipe with a clean towel first, place only supplies to be used per wound on the clean field at one time... 6. Loosen the tape and remove the existing dressing, moisten with prescribed cleansing solution if needed to remove dressing. 7. Pull your glove off the hand and over the dressing; discard into appropriate receptacle. 8. Wash hands and put on clean gloves.... 10. Liquid solution should be poured directly on gauze sponges. 11. Cleanse the wound as ordered; pick up moistened sponges and wipe the area, cleaning one wound at a time do not contaminate other skin surfaces,..." 2. Resident #5 had diagnoses of Peritoneal Abscess and Pressure Ulcer Stage IV. The Admission Minimum Data Set (MDS) dated 1/20/09 documented the resident was independent in cognitive skills for daily decision making, had a wound infection, and one Stage IV pressure ulcer. a. A physician order dated 1/14/09 documented, "Wound Stage IV. Site coccyx. Change dsg [dressing] q [every] M-W-F [Monday, Wednesday, Friday]. Cleanse w/WCW [with wound cleanser] and 4 x [by] 4's. Pack lightly with Aquacel. Apply Hydrocolloid...." b. A physician order dated 1/22/09 documented, "5% Morphine/2% Lidocaine gel to sacral wound prior to dressing application."	F 441			

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 24</p> <p>c. A physician order dated 2/18/09 documented, "Wound Stage IV. Site lower spine. Change dsq q M-W-F. Cleanse w/WCW and x [times] 10 gze [gauze] 4 x 4. Apply Hydrocolloid. ..."</p> <p>d. On 2/20/09 at 10:45 a.m., the Treatment Nurse placed a plastic bag that contained clean wound supplies, an opened packet of 4 x 4's from the top of the treatment cart, a bottle of wound cleanser from the top of the treatment cart and a medication cup filled with Morphine and Lidocaine gel on the over bed table. The Treatment Nurse did not set up a clean field nor clean the over bed table. After opening the supplies, putting on gloves and turning the resident to the right side, the Treatment Nurse sprayed the coccyx, buttocks, two wounds on the lower spine and left hip with wound cleanser. The Treatment Nurse then used one 4 x 4 to wipe in a back and forth motion across the wounds on the left coccyx, two wounds on the lower spine and left hip. After changing gloves the Treatment Nurse took a 4 x 4 and scooped out some Morphine and Lidocaine gel from the medication cup. Next the Treatment Nurse patted the two wounds on the lower spine and the right hip with the 4 x 4 that contained the medicated gel.</p> <p>e. On 2/20/09 at 5:30 p.m., the Treatment Nurse was asked, "Are you supposed to pat clean from one wound to another?" The Treatment Nurse stated no. The Treatment Nurse was asked why not. The Treatment Nurse stated, "Cross contamination". The Treatment Nurse was asked if she was supposed to set up a clean field. The Treatment Nurse stated "Yes". The Treatment Nurse was asked if she set up a clean field. The Treatment Nurse stated no.</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2009
FORM APPROVED
OMB NO. 0938-0391

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 25</p> <p>3. Resident #7 had a diagnosis of Unilateral Amputation Foot. The Initial Minimum Data Set dated 12/3/09 documented the resident was moderately impaired in cognitive skills for daily decision making and received surgical wound care.</p> <p>a. A physician order dated 2/9/09 documented, "Surgical wound site left foot. Change dsg [dressing] q M-W-F [Monday, Wednesday, Friday]. Cleanse area with WCW [wound cleanser] and 4 x 4's. Apply Xeroform. Cover with ABD pad. Wrap with Kerlix. Secure with Coban..."</p> <p>b. On 2/20/09 at 9:32 a.m., the Treatment Nurse placed a plastic bag with wound care supplies, a packet of 4 x 4's and a bottle of wound cleanser on the over bed table. The Treatment Nurse did not set up a clean field or clean the over bed table prior to placing the plastic bag, packet of 4 x 4's and bottle of wound cleanser on the over bed table. The Treatment Nurse then sprayed the surgical wound with the bottle of wound cleanser, patted the wound dry multiple times with the same area of the 4 x 4 and then placed the soiled 4 x 4 on the foot of the bed. The Treatment Nurse stated, "I forgot bio bag." Without changing gloves, the Treatment Nurse then placed the Xeroform gauze on the incision site, placed an ABD pad over the Xeroform gauze, wrapped the foot with Kerlix and then with Coban. The Treatment Nurse then picked up the soiled 4 x 4 from the foot of the bed and pulled a glove off over the dressing. The Treatment Nurse then put the glove with the dressing back on the foot of the bed, picked up the trash from the over bed table and the soiled gloves from the foot of the bed and took them out to the biohazardous bag</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2009
FORM APPROVED
OMB NO. 0938-0391

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 26</p> <p>on the side of the dressing cart. The Treatment Nurse then returned to the room, washed her hands, picked up the plastic bag with unused wound care supplies inside it, the package of 4 x 4's and the bottle of wound cleanser. The Treatment Nurse placed the plastic bag with unused wound care supplies back inside the treatment cart and the packet of 4 x 4's and bottle of wound cleanser was placed on top of the cart.</p> <p>c. On 2/20/09 at 4:10 p.m. the Treatment Nurse was asked if she should have put the wet 4 x 4 used to clean the incision on the foot of the bed. The Treatment Nurse stated, "No, I should have had a red bag on the foot of the bed." The Treatment Nurse was asked, if she set up a clean field for you supplies. The Treatment Nurse stated no.</p> <p>4. Resident #6 had diagnoses of Failure to Thrive-Adult, and Osteoarthritis. The 14 day MDS dated 2/4/09 documented the resident had modified independence in cognitive skills for daily decision making and a two Stage 4 pressure ulcers.</p> <p>a. On 2/20/09 at 11:50 a.m., LPN (Licensed Practical Nurse) #4 provided wound care to pressure sore areas and other abrasions. LPN #4 provided wound care to right and left heels, left shin, and skin tear to the left foot. The LPN wadded up the gloves, used 4x4's after cleansing each area of treatment and placed all used (contaminated) supplies onto the resident's bed next to the resident's right heels. The LPN stated, "I forgot my red bag." After dressing and treatment were completed the nurse put a large wrapper from the DuoDerm on the bed and placed all used supplies onto the wrapper next to</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2009
FORM APPROVED
OMB NO. 0938-0391

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 27 the resident's right heel on the bed.	F 441		
F 445 SS=E	<p>b. On 2/20/09 at 3:30 p.m., LPN #4 was asked, "Are you aware where you placed your supplies when you prepared to provide wound care?" The LPN stated, "I put everything on the bedside table." LPN #4 was asked, "Did you provide a clean field for your supplies?" The LPN stated, "No, I guess not." The LPN was asked, "What would be the benefit of a clean field for the dressings?" The LPN stated, "To prevent contamination." The LPN was asked, "Are you aware of where you placed your used 4x4's?" LPN #4 stated, "I guess I put them on the bed. I forgot my red bag, it can cause cross contamination."</p> <p>483.65(c) INFECTION CONTROL - LINENS</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure clean and soiled linens were handled in a manner to prevent possible cross contamination for 1 (Resident #5) of 6 case mix residents who were incontinent of bowel or bladder and were dependent or required assistance for bed baths (Residents #1, 2, 3, 5, 6, and 7). This failed practice had the potential to affect 53 residents who were incontinent of bowel and bladder and required assistance with bathing according to the listing provided by the Nurse Consultant on 2/20/09. The findings are:</p> <p>1. The facility's policy titled "Soiled Linen</p>	F 445		

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 445	Continued From page 28 Disposal" documented, "Purpose: to prevent the spread of infection through soiled linen or laundry items potentially contaminated with infectious agents. ... Process: 1. Soiled linen should be handled as potentially infectious. ..." 2. Resident #5 had diagnoses of Peritoneal Abscess and Pressure Ulcer Stage IV. The Admission Minimum Data Set (MDS) dated 1/20/09 documented the resident was dependent on staff for bathing. a. On 2/18/09 at 9:50 a.m., Certified Nurses Assistant (CNA) #5 entered the resident's room with linens held under her left arm against her uniform with a bath basin in her hands. CNA #5 placed the clean linens in the recliner on top of a plastic container with a stethoscope, gloves, etc and a hard plastic clip board container approximately 1 inch thick. CNA #5 proceeded to bathe the front of the resident, then turned the resident on to his right side to wash his buttocks and back and stacked the washcloths on top of an open packet of 4 x 4 's. CNA #5 used 3 more washcloths to clean the area, stacking them up level with and against the top of the water pitcher. CNA #5 added a towel to the stack when the resident was dried. CNA #5 then tucked the soiled linens under the resident, put a fitted sheet on the bed, folded a draw sheet in half and dragged it across the floor while folding it. After the resident was turned over and the bed linens were removed CNA #5 placed the soiled linens from the bed and the over bed table in a plastic bag. The resident's colloid dressing was 1/2 off the left buttock and was not covering the coccyx. There was a large amount of yellowish tan drainage present on the Chux. CNA #5 used a washcloth to clean the buttocks and back, then	F 445			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2009
FORM APPROVED
OMB NO. 0938-0391

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 C 02/20/2009
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 445	Continued From page 29 placed the washcloth on the over bed table, unbagged the open pack of 4 x 4's, which were wet, and placed them in the resident's second drawer of the dresser. CNA #5 cleaned the over bed table using a dry towel then a wash cloth, wet with water and dried the over bed table with a paper towel. b. On 2/20/09 at 10:03 a.m., CNA #5 was asked where she put the washcloths she used on 2/18/09 when the resident was on his side and she washed his back and buttocks. CNA #5 stated, "I put the washcloths on the over bed table." CNA #5 was asked what did she wash. CNA #5 stated, "His back and stacked that one up, then washed his bottom and stacked that one up and kept on with towels and all." CNA #5 was asked if she used a bag for the soiled linens. CNA #5 stated, "Not till I'm done then I bagged them all up and took them to the linen barrel." CNA #5 was asked what did she clean the over bed table with. CNA #5 stated, "Water, I don't know if they use anything or not. I was taught to clean it off with water." CNA #5 was asked if she asked anyone for disinfectant. CNA # 5 stated no. CNA #5 was asked what kind of concerns where there with the soiled washcloths. CNA #5 stated, "Because of the drainage and germs."	F 445			