

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

PRINTED: 05/17/2006
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 05/04/2006
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 #11541 was substantiated (all or in part) with deficiencies cited at F225 and F226. Complaint #11551 was substantiated (all or in part) with a deficiency cited at F253. Complaint # 11581 was unsubstantiated.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225		
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.

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F 225	<p>Continued From page 1</p> <p>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #11541 was substantiated (all or in part) in these findings.</p> <p>Based on record review and interview, the facility failed to ensure an injury of unknown origin was immediately reported to the Administrator and investigated for 1 (Resident #4) and the authorities were notified in accordance with state law for 3 of 3 (Resident #2, #3 and #4) case mix residents with injuries of unknown origin. This failed practice had the potential to affect 72 cognitively impaired residents, according to the Director of Nursing (DON) on 5/4/06 at 1:50 p.m. The findings are:</p> <p>1. Resident #4 had diagnoses of Alzheimer's Disease, Dementia, Diabetes Mellitis II without complications, Anxiety State, Depressive Disorder, Severe Arthritis, Osteoporosis and Bilateral Total Knee Replacements in 2001. The Quarterly Minimum Data Set (MDS) dated 3/28/06 documented the resident had severely impaired cognitive skills for daily decision making and required total assistance with activities of daily living.</p> <p>a. An x-ray report dated 2/20/06 documented verbal report: "Knee RT (right): ...There is a</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>supracondylar fracture with slight posterior angulation. Total knee arthroplasty is still in alignment... Impression: Acute Supracondylar Fracture."</p> <p>b. Nurse's Notes dated 2/20/06 documented that Licensed Practical Nurse (LPN) #1 received a verbal x-ray report, from a local mobile x-ray company, of the resident's right knee fracture; there was no documentation that the LPN informed the Administrator, Director of Nursing or Assistant Director of Nursing (ADON) of the fracture or initiated an incident report.</p> <p>c. The DMS 7734 dated 2/24/06 documented:"Summary of Incident: Upon Resident [Resident #4] complaint of pain of Right knee, [Resident #4] was assessed by Nursing and the on-call physician was notified and physician ordered x-ray and results showed a fracture. The origin of the fracture has not been determined yet.</p> <p>d. An Incident/Accident report dated 2/24/06 documented fracture, unknown and ongoing investigation.</p> <p>e. Page 6 of 8 of the DMS 762 dated 2/24/06 documented that law enforcement was not notified of the injury.</p> <p>f. On 5/3/06 at 11:10 a.m., the Administrator was asked about the date on the DMS 7734 and the four day difference between the notification of the fracture and the beginning of the investigation and the administrator stated, "That's when I first knew about it [fracture] and I started my investigation."</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>g. On 5/3/06 at 3:00 p.m., the ADON stated, "The nurse is supposed to initiate the investigation, the incident report; they talk about the investigation at daily stand up, I don't know why [Administrator] didn't know about it."</p> <p>2. Resident #2 had diagnoses of Paralysis, Dementia, Osteoporosis, Psychosis, Parkinson's and Cerebral Vascular Accident. The Quarterly MDS dated 2/9/06 documented the resident had modified independence in cognitive skills for daily decision making and was totally dependent on staff for activities of daily living.</p> <p>a. The DMS (Division of Medical Services) 7734 dated 3/3/06 documented: Summary of Incident: Resident [resident] complaint of pain of Right LE. Resident [resident] was assessed by Nursing and Physician was notified and x-ray ordered. Results showed a Right knee dislocation and knee prosthesis. Investigation continues on origin of dislocation. Resident has diagnosis of Osteoporosis, septic arthritis and DJD.</p> <p>b. Page 6 of 8 of the DMS 762 documented no law enforcement agency was notified of the injury of unknown origin.</p> <p>3. Resident #3 had diagnoses of Cerebral Palsy, Seizures and Osteoporosis. The Annual MDS dated 2/5/06 documented the resident had moderately impaired cognitive skills for daily decision making, was non-ambulatory and was totally dependent on staff for transfers.</p> <p>a. The DMS (Division of Medical Services) 7734 dated 3/4/06 at 4:47 p.m. documented: Summary of Incident: Resident [resident] complaint of pain of Bilat. (bilateral) LE (lower extremities).</p>	F 225			

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F 225	Continued From page 4 Resident [resident] was assessed by nursing and physician was notified and x-ray ordered. Results showed a Right Knee Fracture and left distal Femur has an acute fracture and slightly impacted. Investigation continues on origin of fracture. Resident has diagnosis of Osteoporosis. b. Page 6 of 8 of the DMS 762 dated 3/4/06 documented Law Enforcement was not notified of the injury. 4. On 5/2/06 at 11:10 a.m., the Administrator stated, "I would have to treat those [injuries of unknown origin] like abuse and neglect." "We asked corporate staff if we needed to call the police and I don't know if we needed to call the police."	F 225			
F 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Complaint #11541 was substantiated (all or in part) in these findings. Based on record review and interview, the facility failed to ensure their policy on Abuse, Neglect, and Exploitation was implemented for 3 (Residents #2, #3 and #4) of 6 (Residents #1 thru #6) case mix residents with a history of falls and/or fractures. This failed practice had the potential to affect 72 cognitively impaired residents, according to the Director of Nursing on	F 226			

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F 226	Continued From page 5 5/4/06 at 1:50 p.m. The findings are: 1. The facility's policy on Abuse, Neglect, and Exploitation provided by the Administrator on 5/2/06 at 9:00 a.m. documented, " ... Report allegations or suspected abuse, neglect or exploitation immediately...when abuse, neglect or exploitation is suspected, the Licensed Nurse should: Notify the Director of Nursing and Administrator...complete an incident report and initiate an investigation immediately." 2. Resident #4 had diagnoses of Alzheimer's Disease, Dementia, Diabetes Mellitis II without complications, Anxiety State, Depressive Disorder, Severe Arthritis, Osteoporosis and Bilateral Total Knee Replacements in 2001. The Quarterly Minimum Data Set (MDS) dated 3/28/06 documented the resident had severely impaired cognitive skills for daily decision making and required total assistance with activities of daily living. a. An x-ray report dated 2/20/06 documented verbal report: "Knee RT (right):... There is a supracondylar fracture with slight posterior angulation. Total knee arthroplasty is still in alignment....Impression: Acute Supracondylar Fracture." b. Nurse's Notes dated 2/20/06 documented that Licensed Practical Nurse (LPN) #1 received a verbal x-ray report, from a local mobile x-ray company, of the resident's right knee fracture; there was no documentation that the LPN informed the Administrator, Director of Nursing or Assistant Director of Nursing (ADON) of the fracture or initiated an incident report.	F 226			

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F 226	<p>Continued From page 6</p> <p>c. The DMS 7734 dated 2/24/06 documented:"Summary of Incident: Upon Resident [Resident #4] complaint of pain of Right knee, [Resident #4] was assessed by Nursing and the on-call physician was notified and physician ordered x-ray and results showed a fracture. The origin of the fracture has not been determined yet.</p> <p>d. An Incident/Accident report dated 2/24/06 documented fracture, unknown and ongoing investigation.</p> <p>e. Page 6 of 8 of the DMS 762 dated 2/24/06 documented that law enforcement was not notified of the injury.</p> <p>f. On 5/3/06 at 11:10 a.m., the Administrator was asked about the date on the DMS 7734 and the four day difference between the notification of the fracture and the beginning of the investigation and the administrator stated, "That's when I first knew about it [fracture] and I started my investigation."</p> <p>g. On 5/3/06 at 3:00 p.m., the ADON stated, "The nurse is supposed to initiate the investigation, the incident report; they talk about the investigation at daily stand up, I don't know why [Administrator] didn't know about it."</p> <p>3. Resident #2 had diagnoses of Paralysis, Dementia, Osteoporosis, Psychosis, Parkinson's and Cerebral Vascular Accident. The Quarterly MDS dated 2/9/06 documented the resident had modified independence in cognitive skills for daily decision making and was totally dependent on staff for activities of daily living.</p>	F 226			

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F 226	<p>Continued From page 7</p> <p>a. The DMS (Division of Medical Services) 7734 dated 3/3/06 documented: Summary of Incident: Resident [resident] complaint of pain of Right LE. Resident [resident] was assessed by Nursing and Physician was notified and x-ray ordered. Results showed a Right knee dislocation and knee prosthesis. Investigation continues on origin of dislocation. Resident has diagnosis of Osteoporosis, septic arthritis and DJD.</p> <p>b. Page 6 of 8 of the DMS 762 documented no law enforcement agency was notified of the injury of unknown origin.</p> <p>4. Resident #3 had diagnoses of Cerebral Palsy, Seizures and Osteoporosis. The Annual MDS dated 2/5/06 documented the resident had moderately impaired cognitive skills for daily decision making, was non-ambulatory and was totally dependent on staff for transfers.</p> <p>a. The DMS (Division of Medical Services) 7734 dated 3/4/06 at 4:47 p.m. documented: Summary of Incident: Resident [resident] complaint of pain of Bilat. (bilateral) LE (lower extremities). Resident [resident] was assessed by nursing and physician was notified and x-ray ordered. Results showed a Right Knee Fracture and left distal Femur has an acute fracture and slightly impacted. Investigation continues on origin of fracture. Resident has diagnosis of Osteoporosis.</p> <p>b. Page 6 of 8 of the DMS 762 dated 3/4/06 documented Law Enforcement was not notified of the injury.</p> <p>5. On 5/2/06 at 11:10 a.m., the Administrator stated, "I would have to treat those [injuries of unknown origin] like abuse and neglect." "We</p>	F 226			

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F 226	Continued From page 8 asked corporate staff if we needed to call the police and I don't know if we needed to call the police."	F 226			
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Complaint #11551 was substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure fracture pans, bed pans, bath pans and urinals were clean and stored in a manner to prevent the spread of infection. This failed practice had the potential to affect 73 residents in the facility requiring assistance with toileting, as identified by the Minimum Data Set Care Plan Coordinator (MDS/CP) on 5/3/06 at 3:15 p.m. The findings are: 1. On 05/01/06 at 1:45 p.m., in Resident Room 60, a pink bed pan was lying on the bathroom floor in a clear plastic bag; a brown colored substance was on the inside walls of the bed pan. A wash cloth was lying on the top of the bed pan, outside of the plastic bag. There was also an unlabeled open urinal on the back of the commode. 2. On 5/01/06 at 2:22 p.m., in Resident Room 44, an unbagged, unlabeled bath pan was on the floor of the bathroom and an open unlabeled	F 253			

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F 253	Continued From page 9 urinal was on the back of the toilet. 3. On 5/1/06 at 1:35 p.m., one unmarked, open-to-air urinal was sitting on the floor next to the commode in the bathroom of Resident Room 20. 4. On 5/1/06 at 1:49 p.m., one unmarked, open-to-air urinal was sitting on the back of the commode in the bathroom of Resident Room 27. 5. On 5/1/06 at 1:52 p.m., two unmarked, open-to-air urinals were sitting on the back of the commode in the bathroom of Resident Room 25. 6. On 5/1/06 at 2:06 p.m., one pink fracture pan, unmarked and open-to-air, was sitting on the back of the commode in the bathroom of Resident Room 21. 7. On 5/1/06 at 2:22 p.m., one pink fracture pan, unmarked and open-to-air, was sitting on the back of the commode in the bathroom of Resident Room 48. 8. On 5/1/06 at 2:25 p.m., the Director of Nursing stated, "They [bed pans and urinals] are supposed to be bagged and stored in the bottom drawer of the nightstand." 9. The facility's policy on Disinfection of Bedpans and Urinals provided by the Director of Nursing on 5/4/06 at 9:40 a.m. documented: "...rinse bedpan and urinal with cool water to remove feces and urine... cover and return bedpan or urinal to designated area."	F 253			
F 315 SS=D	483.25(d) URINARY INCONTINENCE	F 315			

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F 315	<p>Continued From page 10</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure incontinent care was provided in a manner to prevent potential Urinary Tract Infections (UTI) for 1 (Resident #2) of 4 (Residents #1, #2, #4 and #5) case mix residents who were incontinent. This failed practice had the potential to affect 46 residents who were occasionally or frequently incontinent of bladder and/or 54 residents who were occasionally or frequently incontinent of bowel, according to the 'Residents who require any type of assistance with toileting' list provided by the Minimum Data Set(MDS) Coordinator on 05/04/06 at 9:50 a.m. The findings are:</p> <p>1. Resident #2 had diagnoses of Pneumonia, Hypertension, Paralysis, Dementia, Osteoporosis, Decubitus, Psychosis, Gastrostomy, Parkinson's, Depression, Cerebral Vascular Accident and Urinary Tract Infection. The Quarterly MDS dated 2/9/06 documented the resident had modified independence in cognitive skills for daily decision making and was incontinent of bowel and bladder.</p>	F 315			

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F 315	Continued From page 11 On 5/2/06 at 10:15, Resident #2 was provided incontinent care by Certified Nursing Assistant (CNA) #3, CNA #4 and CNA #5. The resident was turned to her back, the legs were separated and the resident was washed from to back (rectal area through labia to suprapubic area) to front. This procedure was repeated twice. On the second cleansing CNA #4 wiped from back to front and fecal material was wiped into the resident's vaginal and labia area. The resident was not dried prior to applying a brief.	F 315		
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident rooms were free of hazards. This failed practice had the potential to affect 10 cognitively impaired, self mobile residents residing on the East Hall as documented by the Director of Nursing (DON) on 5/3/06 at 9:15 a.m.. The findings are: On 5/1/06 at 1:52 p.m., in Resident Room 25, 1 eight-foot board containing eight sharp-pointed screws was off the wall where it had been attached. The board was pointed outward, off the floor and resting against a cord in the electrical outlet and the bed frame of Resident Bed B. The DON stated the board was a bumper guard	F 323		

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

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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 05/04/2006
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 323	Continued From page 12 and both residents in the room were self mobile when placed in their wheelchairs.	F 323			
F 441 SS=D	483.65(a) INFECTION CONTROL 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. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure Certified Nursing Assistants (CNA) did not use resident bed pillows on the floor to prevent the spread of infection for 1 (Resident #2) of 4 (Residents #1, #2, #4 and #5) case mix residents who were dependent on staff for turning and positioning. This failed practice had the potential to affect 48 residents who were dependent on staff for positioning, according to a list provided by the Minimum Data Set Coordinator on 05/04/06 at 9:50 a.m. The findings are: 1. Resident #2 had a diagnosis of Pneumonia, Hypertension, Paralysis, Dementia, Osteoporosis, Decubitus, Psychosis, Gastrostomy, Parkinson's, Depression, Cerebral Vascular Accident, Gastroesophageal Reflux Disease, Pyloric Ulcer Disease, Urinary Tract Infection and	F 441			

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F 441	Continued From page 13 Hypokalemia. The Quarterly Minimum Data Set dated 02/09/06 documented the resident had modified independence in cognitive skills for daily decision making. On 05/01/06 at 4:15 p.m., CNA #1 and CNA #2 were positioning the resident; a long pillow was on the floor under the resident's window. CNA #1 picked the pillow up off the floor, placed the pillow on the end of the bed and after turning the resident, placed the pillow to the back of the resident for support.	F 441			