

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

PRINTED: 05/02/2006
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 12/02/2005
NAME OF PROVIDER OR SUPPLIER LEGACY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3310 NORTH 50 STREET FORT SMITH, AR 72904	
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F 000	INITIAL COMMENTS	F 000		
F 225 SS=E	<p>Complaint # 11139 was substantiated (all or in part) with deficiencies cited at F225 and F226. Complaint # 11137 was unsubstantiated.</p> <p>483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported 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</p>	F 225		1/1/06

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>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 # 11139 was substantiated (all or in part) in these findings.</p> <p>Based on record review and interview, the facility failed to ensure an allegation of neglect was reported immediately to Administration and thoroughly investigated for 1 (Resident # 1) of 4 case mix residents (Residents #1 - #4) who required staff assistance with eating. This failed practice had the potential to affect 25 cognitively impaired residents dependent on staff for eating as identified by the Director of Nursing (DON) on 12/2/05 at 8:10 a.m.. The findings are:</p> <p>Resident # 1 had diagnoses of Cancer of the Colon, Osteoarthritis, and Osteoporosis. The Medicare 90 Day Minimum Data Set dated 11/24/05 documented the resident had moderately impaired cognitive skills for daily decision making, short and long term memory problems and required set up help for eating.</p> <p>1. The DMS (Division of Medical Services) 7734 (Incident and Accident Report) dated 11/3/05 documented under Summary of Incident: "It was reported to DON [Director of Nursing's name] and ADM [Administrator's name] on November 3rd regarding an allegation towards CNA [Certified Nursing Assistant #1's name] not taking feeder trays to resident's rooms and writing on the meal ticket that the resident ate 50% when they never received their meals. Our witnesses suspected</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>this allegation but never saw the CNA do this." The report further documented: "Internal investigation begun. The family was notified, [Physician's name] was notified, ADM [Administrator's name] and [police department name] was notified. Staff Development Nurse will conduct inservice to Nursing Staff regarding Abuse, Neglect, the importance of passing trays for feeders for all shifts, and Resident rights. Will QA (Quality Assurance) this incident and will monitor this resident on a monthly basis during our QA meeting. Will have Social Service director follow-up with Resident and family to make sure she is receiving her tray."</p> <p>A DMS 762 witness statement by Dietary Cook #1 dated 11/2/05 at 6:15 p.m. documented: "I sent the feeders out, they had put them on a cart outside the window, and they never got passed and [CNA #1] went through and pulled the cards off and wrote they ate 50% on them and [Resident #1's] daughter came looking for her mom's tray and we found it on the cart with the paper pulled, found on the table and it said she ate 50%. [CNA #1] said one of the residents did it. Went and asked [Dietary aide #2] if [Resident #1's] tray got passed she said look on the cart outside the window and that's where we found it. [Resident's #1's] daughter was very mad."</p> <p>A DMS 762 witness statement by CNA #1 dated 11/3/05 documented: "On Tuesday , 11-1-05 there was some residents trays put on a cart during dinner tray pass. There is one of our male residents that picks up the trays on a cart. He takes the tickets off and we don't know what percentage they ate. I fed on 2 tables in the dining room [and] then took a feeder to the hall [and] fed a resident."</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>A DMS 762 witness statement by Dietary Aide #2 dated 11/1/05 (untimed) documented: "went to pull dishes from trays that had not been past. One CNA said the other one was taking the cookies off."</p> <p>An unsigned witness statement dated 11/1/05 documented: "[Dietary Manager's name], they asked for feeders we sent them and they got put on a cart outside the window and [CNA #1] come through and pulled the papers off of them and wrote down they ate 50% of there food. So some people didn't get fed."</p> <p>The DMS 762 documented under complete description of incident: "...Upon completion of our investigation, our DON found out another resident [name] was cleaning up the Dining Room and was putting dirty trays in the feeder rack and was also pulling the dietary cards off the trays as he was thinking he was helping the Dietary Department out by cleaning up dirty trays. When CNA [CNA #1] came back to get the feeder tray for the resident there were none to get from the dining room as there were dirty trays with the others and no dietary cards to check to see if there tray was passed...CNA [CNA #1] was suspended during the investigation." Under Findings and Action Taken it documented: "...The CNA was brought back to work and we have begun inservicing our staff regarding feeder tray and making sure all resident have their trays and to watch for any resident trying to put dirty trays on the feeder tray."</p> <p>Only 1 other witness statement was attached to the DMS 762 and that was of the Administrator.</p>	F 225			

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F 225	Continued From page 4 On 12/1/05 at 9:50 a.m., the Administrator stated he didn't interview any resident on that hall as most of them aren't cognitively alert to interview. He further stated he did not interview staff working that night. At 10:45 a.m., the Administrator stated it happened on the 1st of November and we didn't find out about it until the 3rd. On 12/1/05 at 11:10 a.m., the DON stated the Dietary Manager got witness statements from evening shift and that no aides or nurses that worked on November 1 were interviewed. 2. On 12/1/05 at 1:50 p.m., the Dietary Cook # 1 stated there were about 5 feeder trays on the cart-lids were still on them. Lids weren't taken off and she saw [CNA #1] take them off and write on the tray cards. As far as she knew she wrote 50% on all of them. Resident #1's tray was on the cart untouched and identified as the only mechanical soft diet prepared for the hall feeders after the resident's daughter asked the Dietary Cook #1 where the resident's supper tray was and why the resident did not receive her supper tray. She saw another resident putting dirty dishes on the cart but never saw him write on the tray cards. The Dietary Cook #1 stated she did not report the incident until the next day. When asked why she did not report it immediately, the Dietary Cook #1 stated, " I didn't know who to report it to. I told my supervisor the next morning (11/2/05) and we went to the Don and told her." She further stated, "No I never thought about the other four who didn't get their supper that night."	F 225			
F 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written	F 226		1/1/06	

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F 226	<p>Continued From page 5</p> <p>policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint # 11139 was substantiated (all or in part) in these findings.</p> <p>Based on record review and interview, the facility failed to implement their policy and procedure for Abuse, Neglect, and Exploitation as evidenced by the facility's failure to ensure allegations of neglect were immediately reported to Administration and failure to conduct a thorough investigation for an allegation of neglect for 1 (Resident # 1) of 4 case mix residents (Residents #1-#4) who required staff assistance with eating. This failed practice had the potential to affect 25 cognitively impaired residents dependent on staff for eating as identified by the Director of Nursing (DON) on 12/2/05 at 8:10 a.m.. The findings are:</p> <p>1. The facility's Policy and Procedure for Abuse, Neglect, and Exploitation provided by the Administrator on 11/30/05 at 9:45 a.m. documented: "... When suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur, an investigation is immediately warranted. Interview the involved resident, if possible, and document all responses. If resident is cognitively impaired, interview the resident several times to compare responses. Interview all witnesses separately. Include roommates, residents in adjoining rooms, staff members in the area, and visitors in the area..." The policy further documented: "When abuse,</p>	F 226			

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F 226	Continued From page 6 neglect or exploitation is suspected . . . a. Respond to the needs of the resident and protect them from further incident, b. Notify the Director of Nursing and Administrator, c. Complete an incident report and initiate an investigation immediately, d. Notify the attending physician, resident's family/legal representative and Medical Director." 2. Resident # 1 had diagnoses of Cancer of the Colon, Osteoarthritis, and Osteoporosis. The Medicare 90 Day Minimum Data Set dated 11/24/05 documented the resident had moderately impaired cognitive skills for daily decision making, short and long term memory problems and required set up help for eating. a. The DMS (Division of Medical Services) 7734 (Incident and Accident Report) dated 11/3/05 documented under Summary of Incident: "It was reported to DON [Director of Nursing's name] and ADM [Administrator's name] on November 3rd regarding an allegation towards CNA [Certified Nursing Assistant #1's name] not taking feeder trays to resident's rooms and writing on the meal ticket that the resident ate 50% when they never received their meals. Our witnesses suspected this allegation but never saw the CNA do this." The report further documented: "Internal investigation begun. The family was notified, [Physician's name] was notified, ADM [Administrator's name] and [police department name] was notified. Staff Development Nurse will conduct inservice to Nursing Staff regarding Abuse, Neglect, the importance of passing trays for feeders for all shifts, and Resident rights. Will QA (Quality Assurance) this incident and will monitor this resident on a monthly basis during our QA meeting. Will have Social Service director	F 226			

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F 226	<p>Continued From page 7</p> <p>follow-up with Resident and family to make sure she is receiving her tray."</p> <p>A DMS 762 witness statement by Dietary Cook #1 dated 11/2/05 at 6:15 p.m. documented: "I sent the feeders out, they had put them on a cart outside the window, and they never got passed and [CNA #1] went through and pulled the cards off and wrote they ate 50% on them and [Resident #1's] daughter came looking for her mom's tray and we found it on the cart with the paper pulled, found on the table and it said she ate 50%. [CNA #1] said one of the residents did it. Went and asked [Dietary aide #2] if [Resident #1's] tray got passed she said look on the cart outside the window and that's where we found it. [Resident's #1's] daughter was very mad."</p> <p>A DMS 762 witness statement by CNA #1 dated 11/3/05 documented: "On Tuesday , 11-1-05 there was some residents trays put on a cart during dinner tray pass. There is one of our male residents that picks up the trays on a cart. He takes the tickets off and we don't know what percentage they ate. I fed on 2 tables in the dining room [and] then took a feeder to the hall [and] fed a resident."</p> <p>A DMS 762 witness statement by Dietary Aide #2 dated 11/1/05 (untimed) documented: "went to pull dishes from trays that had not been past. One CNA said the other one was taking the cookies off."</p> <p>An unsigned witness statement dated 11/1/05 documented: "[Dietary Manager's name], they asked for feeders we sent them and they got put on a cart outside the window and [CNA #1] come through and pulled the papers off of them and</p>	F 226			

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F 226	<p>Continued From page 8</p> <p>wrote down they ate 50% of there food. So some people didn't get fed."</p> <p>The DMS 762 documented under complete description of incident: "...Upon completion of our investigation, our DON found out another resident [name] was cleaning up the Dining Room and was putting dirty trays in the feeder rack and was also pulling the dietary cards off the trays as he was thinking he was helping the Dietary Department out by cleaning up dirty trays. When CNA [CNA #1] came back to get the feeder tray for the resident there were none to get from the dining room as there were dirty trays with the others and no dietary cards to check to see if there tray was passed...CNA [CNA #1] was suspended during the investigation." Under Findings and Action Taken it documented: "...The CNA was brought back to work and we have begun inservicing our staff regarding feeder tray and making sure all resident have their trays and to watch for any resident trying to put dirty trays on the feeder tray."</p> <p>Only 1 other witness statement was attached to the DMS 762 and that was of the Administrator.</p> <p>On 12/1/05 at 9:50 a.m., the Administrator stated he didn't interview any resident on that hall as most of them aren't cognitively alert to interview. He further stated he did not interview staff working that night. At 10:45 a.m., the Administrator stated it happened on the 1st of November and we didn't find out about it until the 3rd.</p> <p>On 12/1/05 at 11:10 a.m., the DON stated the Dietary Manager got witness statements from evening shift and that no aides or nurses that</p>	F 226			

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F 226	Continued From page 9 worked on November 1 were interviewed. b. On 12/1/05 at 1:50 p.m., the Dietary Cook # 1 stated there were about 5 feeder trays on the cart-lids were still on them. Lids weren't taken off and she saw [CNA #1] take them off and write on the tray cards. As far as she knew she wrote 50% on all of them. Resident #1's tray was on the cart untouched and identified as the only mechanical soft diet prepared for the hall feeders after the resident's daughter asked the Dietary Cook #1 where the resident's supper tray was and why the resident did not receive her supper tray. She saw another resident putting dirty dishes on the cart but never saw him write on the tray cards. The Dietary Cook #1 stated she did not report the incident until the next day. When asked why she did not report it immediately, the Dietary Cook #1 stated, " I didn't know who to report it to. I told my supervisor the next morning (11/2/05) and we went to the Don and told her." She further stated, "No I never thought about the other four who didn't get their supper that night."	F 226			