STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045267	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Health and Rehabilitation Center	3310 North 50th Street Fort Smith, AR 72904

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, it was determined that the facility failed to keep residents free from abuse and neglect for 2 residents (Residents #68 and #84) who received physical abuse from another resident. The findings include: A review of a policy titled, Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation, stated, residents have the right to be free from abuse, neglect, exploitation, and misappropriation of property. An in-service on Abuse/Neglect/Misappropriation to all staff was provided dated 10/16/2024 specifically keeping residents free from resident-to-resident abuse where a cognitive resident intentionally and willfully hits another resident. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/25/2024 revealed Resident #68 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. A review of an Incident and Accident report dated 11/11/2024 at 2:30 PM, revealed Resident #68 was hit on the side of the head when another resident (Resident #109) walked past and stated to Resident #68 to move out of the way. Certified Nursing Assistant (CNA) #22 separated the residents and reported the incident to the nurse. Registered Nurse (RN) #13 assessed Resident #68 and no injuries were noted. An in-service on abuse, neglect, and misappropriation, specifically resident-to-resident abuse where a cognitive resident intentionally and willfully hits another resident, was initiated on 11/11/2024 along with a copy of the facility's policy and procedures on abuse. Witness statements were collected, Resident #109 was placed on 1:1 supervision with staff. The quarterly MDS with an ARD of 11/25/2024 revealed Resident #84 had a BIMS score of 15, which indicated the resident was cognitively intact. A review of an Incident and Accident report dated 11/24/2025 at 8:20 PM, revealed Resident #84 was hit on the leg while outside on smoke break by Resident #109. Resident #109 became upset because the resident ' s cigarette was not lit first. The residents were separated, and Resident #109 was placed on 1:1 supervision. A body audit was done on Resident #84 with no negative findings. The police and physician were notified, and witness statements were collected. The quarterly MDS with an ARD of 09/10/2024 revealed Resident #109 had a BIMS score of 15, which indicated the resident was cognitively intact. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #109's care plan dated 10/29/2024 indicated, Resident #109 had the potential for behaviors of aggression and agitation towards others, and staff were to monitor the resident while awake. Listed interventions were 1:1 staff supervision, approach resident in a calm manner, do not argue with resident, and reach out to family for their input. On 01/28/2025 at 12:20 PM, during an interview CNA #23 indicated she had witnessed resident-to-resident aggressions, but none that had caused injuries. CNA #23 stated any resident-to-resident aggression is reported to the charge nurse at the time the incident occurred. On 01/28/2025 at 12:35 PM, during an interview, CNA #22 confirmed she had witnessed the resident-to-resident aggression and reported it to the nurse. CNA #22 also confirmed that the aggressor was no longer in the facility and stated that the resident who was hit did not sustain any injuries. On 01/28/2025 at 2:35 PM, during an interview, Licensed Practical Nurse (LPN) #16 confirmed resident-to-resident aggression had happened and when it did, the residents were immediately separated and the charge nurse, administration, physician, and family were all notified. The severity of the incident determined the interventions taken. The aggressor may be placed on 1:1 supervision, lab work may be ordered, or the resident may require a psychiatric evaluation. On 01/31/2025 at 2:10 PM, during an interview the Administrator stated that when the resident-to-resident interactions occurred the residents were separated, body audits performed, police, family, and the physician were notified, and an investigation was initiated. Staff and resident interviews were conducted. The Administrator confirmed the aggressor was cognitive and did hit other residents. When the incidents occurred, residents were separated, and interventions were put in place. On 01/31/2025 at 2:21 PM, during an interview the Director of Nursing (DON) stated, when resident-to-resident aggressions occurred, the staff intervened by separation and resident redirection. The Administrator was notified and was also the facility's Abuse Coordinator. The DON confirmed Resident #109 hit Resident #68 and Resident #84 but did not remember Resident #109's cognition. The DON confirmed the aggressor was transferred to a facility which conducted psychiatric interventions to decrease behaviors.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on observations, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to ensure a resident was not exploited for money from a staff member for 1 (Resident #42) of 10 residents reviewed for abuse. Specifically, the staff member accepted money from the resident for personal favors and borrowed money from the resident. The findings include: A review of a facility policy titled, Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation, dated 05/01/2023, indicated, All of our resident/guest(s) have the right to be free from abuse, neglect, exploitation, and misappropriation of resident/guest property. Exploitation is defined as taking advantage of a resident/guest for personal gain through use of manipulation, intimidation, threats, or coercion. An example is monetary assistance provided to staff after informing resident/guest that they are in a financial crisis, gifts to staff by resident/guest(s) based on staff persuasion. A review of the Employee Handbook, contained the Code of Conduct Guidelines which indicated, Employees should always conduct themselves in a manner that will protect the interests and safety of fellow employees, residents, and the facility ensuring orderly operations and the best possible work environment. Employee should Report abuse, neglect, misappropriation/handling of resident property or other concerns to the abuse coordinator, or Administrator. The Behavior Guidelines stated, Type A Violations will result in disciplinary actions up to and including immediate discharge without prior warning. 8. Inappropriate behavior with the public, residents or staff. 12. Abuse, destruction or waste of company, resident or employee property. 17. Resident abuse. 21. Failure to report any observed abusive and/or negligent conduct through designated reporting channels. A review of CNA #17's employee file revealed CNA #17 acknowledged the Abuse, Neglect, Misappropriation of resident property, injuries of unknown source was reviewed and a copy provided at the time of orientation. The Employee Handbook Acknowledgement was torn from the back of the handbook and was present in the employee file signed. CNA #17 was hired in 08/2023. On 10/09/2024, CNA #17 received a verbal warning from the Director of Nursing (DON) listed as a Type A Violation with the offense cited as Violation of Company Policy (specify) and Other: Failure to report allegation of Abuse, the Description of Infraction was listed as On 10/08/2024 you failed to report an allegation of Abuse to the Abuse coordinator who is the Administrator. The Plan for Improvement was Any allegations to be reported to the Admin [Administrator]/Abuse Coordinator immediately. It was signed and dated by both CNA #17 and the DON on 10/09/2024. CNA #17 remained an active employee. A review of the Face Sheet, indicated the facility admitted Resident #42 with diagnoses that included cerebrovascular disease, repeated falls, hemiplegia and hemiparesis, chronic obstructive pulmonary disease, paroxysmal atrial fibrillation, anxiety disorder, and depression. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/2024 revealed Resident #42 had a Brief Interview of Mental Status score of 15 which indicated the resident was cognitively intact. A review of Resident #42's Care Plan, revised 01/24/2025, revealed the resident had a potential for impaired cognition/decision making ability related to a past CVA (cerebral vascular accident) which required staff to anticipate their needs. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/29/2025 at 3:44 PM, Resident #42 stated Certified Nursing Assistant (CNA) #17 had taken them to town in her private vehicle so Resident #42 could get a manicure. Resident #42 reported, when this occurred the resident would give CNA #17 $20 [dollars] for gas money. After one occasion, CNA #17 asked to borrow some money from Resident #42 stating she had an issue at home and was attempting to get custody of her children which required a drug test. Resident #42 stated $40 cash was loaned to CNA #17. Resident #42 stated they had received a back check from federal benefits and CNA #17 was aware the money was available. Resident #42 stated the resident had loaned money a second time to CNA #17 in the amount of $30 cash, CNA #17 borrowed a total of $70.00 dollars from Resident #42. Resident #42 stated, CNA #17 would no longer drive the resident to get a manicure and when Resident #42 attempted to get the money, CNA #17 stated she did not have it. Resident #42 reported the plan was to use the money owed to call a cab for transportation to the nail salon. A review of an Incident and Accidents (I&A) report for Resident #42 contained a written statement dated 01/13/2025 from CNA #17 indicated that she had taken Resident #42 to the nail salon on three occasions by private vehicle. On two occasions CNA #17 accepted $20.00, but not on the third occasion. CNA #17 stated she had discussed her situation regarding her children and a hair follicle drug test to obtain custody but denied borrowing money from the resident. CNA #17 stated she did tell Resident #42 she couldn't take her to the nail salon following the third occasion. During an interview on 01/29/2025 at 4:11 PM, the Financial Specialist Assistant (FSA) stated she was the employee who handled the resident trust accounts. FSA stated Resident #42's federal benefits check was deposited in the resident trust account every month, then the resident would come and withdraw her balance after expenses in cash. It was usually the standard $40.00, except for one occurrence. On 08/26/2024, a deposit of $1916.00 was deposited for Resident #42, after a back balance was settled with the facility and a petty cash settlement for a manicure, a balance of $1605.24 remained and Resident #42 withdrew the full amount on 09/16/2024. A review of an I&A report for Resident #42 contained an in-service titled, You cannot accept gifts or money from resident/guests. This is policy and doing so is a breach of the Code of Conduct. You may not take resident's money to go to the store or buy something for them with their money. There are only 2 people allowed to do that (activities & social) dated 01/09/2025 and signed by 58 employees. A second in-service titled, Misappropriation of resident/guest property on 01/09/2025 was signed by 55 employees. During an interview on 01/29/2025 at 3:56 PM, the Director of Nursing (DON) stated, Resident #42 was their own legal representative and could sign out of the facility, but it was not the facility's policy to take a resident out in an employee's private vehicle or accept money from them. The DON stated CNA #17 reported to her they no longer took the resident for manicures because the resident was missing showers. The DON stated an investigation was completed and no other residents reported any money issues with CNA #17, but CNA #17 admitted to taking gas money from Resident #42 however, denied borrowing money. The DON stated CNA #17 was terminated from the facility for taking money from Resident #42 and not following company policy. A review of CNA #17's employee file revealed she was terminated on 01/13/2025 for a Type A Violation, Description of Infraction was #8 Inappropriate behavior with the public, residents, or staff. Using a personal vehicle to take resident to nail appointments. Accepting tip from resident. It was signed and dated by CNA #17, the DON, and the Administrator on 01/13/2025.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, it was determined that the facility failed to ensure residents were free from accidents and hazards for 1 (Resident #68) of 6 sampled residents reviewed for accidents and hazards, by not ensuring cleaning agents were kept locked up and out of the resident's reach. The findings include: A review of the facility's policy titled, I&A Policy dated 11/10/2014, indicated the facility was to remain as free of accidents and hazards as possible. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/05/2024 revealed, Resident #68 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. Resident #68's care plan dated 12/04/2025 indicated Resident #68 required partial/moderate assistance with daily living activities, was unable to walk 10 feet without partial/moderate assistance, and was able to self-propel a manual wheelchair for independent mobility. The resident required supervision or touching assistance for meals. Review of an email from the regional ombudsman, dated 12/17/2024, indicated staff reported Resident #68 ingested a liquid cleaning agent. Review of the facility's internal investigation report confirmed Resident #68 was found by Certified Nursing Assistant (CNA) #14 in the resident's room with an open bottle of cleaning agent up to their mouth and appeared to be drinking from it. CNA #14 intervened and took the bottle of cleaner from resident #68's hand and then reported the incident to Registered Nurse (RN) #13. Resident #68 was assessed and transferred to the hospital emergency department for evaluation and treatment. The facility initiated an in-service to all staff titled, Any cleaning liquid or cleaning product labelled Keep out of Reach of Children must be kept locked and out of resident's reach for their safety. A review of the hospital records dated 12/16/2024 indicated Resident #68 was seen at the hospital because staff believed the resident may have ingested a cleaning agent left in the resident's room by family. A physical exam was performed, which indicated the resident did not have any coughing, choking, shortness of breath, abdominal pain, nausea, or vomiting. Resident #68 was transferred back to the facility and monitored by staff; anti-nausea medication was prescribed if the resident began showing symptoms. Review of Resident #68's progress notes indicated, the resident did not develop gastrointestinal pain or discomfort from ingesting the cleaning agent. During an interview on 01/28/2025 at 2:39 PM Licensed Practical Nurse (LPN) #16 confirmed, Resident #68 was found drinking from an open bottle of cleaning agent in their room. LPN #16 wasn't sure what the date was but stated it was about a month or so ago. LPN #16 was not sure who left the cleaning agent in the resident's room. LPN #16 stated Resident #68 had a family member that visited often, and they could have left it. During an interview on 01/29/2025 at 1:29 PM, the Housekeeping Supervisor (HS) acknowledged the incident and indicated that the housekeeping staff used a similar type of cleaner in the mop buckets as (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the one found in the resident's room. The HS did not believe the housekeepers left chemicals in the resident's room, because the one found was much smaller than what was kept in the supply closet. The HS gave this surveyor a tour of the cleaning closets and only a very large bottle of the cleaning agent was observed in the closet. During an interview on 01/29/2025 at 2:51 PM, Licensed Practical Nurse (LPN) #8 acknowledged the incident occurred but was not working when it happened. LPN #8 remembered the in-service that instructed to keep chemicals locked up and away from residents. LPN #8 did not know how the cleaning agent got left in the resident's room but stated, Anybody that knows the resident knows not to leave liquids laying around because [resident] will try to drink it. During an interview on 01/29/2025 at 3:01 PM, Registered Nurse (RN) #13 confirmed, a CNA had intervened and reported the incident. RN #13 assessed the resident and called for an ambulance to transport the resident to the hospital emergency department for evaluation and treatment. Resident #68 did not show any signs or symptoms of ingestion, and the bottle of cleaning agent had a very small amount missing. RN #13 also confirmed the resident was known for behaviors of taking beverages and attempting to drink them. During an interview on 01/30/25 at 8:59 AM, Housekeeping Technician (HT) #20 indicated housekeepers use the same type of cleaning chemical in the mop buckets which was found in the Resident #68's room. HT #20 confirmed leaving a cleaning agent in a resident's room or unlocked would be considered an accident and hazard. During an interview on 01/30/25 at 9:37 AM, Resident #68's family representative confirmed notification had been given of the incident and the resident had been transferred to the hospital for ingesting a cleaning agent but did not get ill from the ingestion. Resident #68's representative denied bringing cleaning agents to the facility and stated, Lord no. Anybody that knows [resident] knows that [pronoun] will pick anything up and try to drink it. During an interview with CNA #22 on 01/31/2025 at 2:50 PM, the CNA indicated that the cleaner was most likely left by staff on the evening shift because the staff on that shift had mentioned that resident rooms were cleaned on the evening shifts and supplies were brought from home (by staff). A review of the facility's staff in-service dated 12/17/2024 indicated, Do not keep or place any of your personal belongings in resident's rooms.