

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/31/2025
NAME OF PROVIDER OR SUPPLIER  Legacy Heights Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  900 West 12th St Russellville, AR 72801	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on facility policy review, record review, observations and interviews, it was determined that the facility failed to ensure ice machines were maintained in a clean condition to minimize the risk for food borne illness in one of two ice machines observed. Based on facility policy review, record review, observations and interviews, it was determined that the facility failed to ensure ice machines were maintained in a clean condition to minimize the risk for food borne illness in one of two ice machines observed.</p> <p>The findings include:</p> <p>During an observation on 07/31/2025 at 12:15 PM, Dietary Aide (DA) #1 used a white paper towel to wipe the interior of the ice machine. An unknown tan and gray substance transferred to the paper towel.</p> <p>During an interview on 07/31/2025 at 12:15 PM, DA #1 stated the substance should not be there. DA #1 indicated that it looked like dirt, and that the ice machine should be cleaned with vinegar.</p> <p>During an interview on 07/31/2025 at 12:20 PM, the Administrator reported Housekeeping/Laundry #2 was responsible for cleaning the ice machine.</p> <p>During an interview on 07/31/2025 at 12:22 PM, Housekeeping/Laundry #2 indicated that the ice machine was cleaned two times a week, sometimes more, and that the ice machine was last cleaned two days ago. They also indicated that the ice machine was deep cleaned every week. The Housekeeping and Laundry Supervisor observed the white paper towel with the tan and gray debris and reported that the substance looked like mold.</p> <p>During an interview on 07/31/2025 at 12:58 PM, the Maintenance Director (MD) indicated the ice machine was cleaned once a month, when they cleaned and checked the mechanical components on top of the ice machine. The MD indicated that he also looked for dust and build up.</p> <p>During an interview on 07/31/2025 at 1:15 PM, the Administrator indicated that the ice machine should be cleaned immediately and disinfected. The Administrator also indicated that the Housekeeping and Laundry Supervisor was trained on how to clean the ice machine but did not know what the training entailed. The Administrator indicated that the ice from this ice machine was used to distribute ice to the residents in the facility and that all of the ice used on the halls had been disposed of.</p> <p>Review of a document titled Ice Machine Cleaning Log, dated July 2025, revealed the following dates: 7/1/2025, 7/4/2025, 7/8/2025, 7/11/2025, 7/15/2025, 7/18/2025, 7/22/2025, 7/25/2025 and 7/29/2025</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 045410	If continuation sheet Page 1 of 2

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>which had a comment of Cleaned and showed a check mark with initials of the Housekeeping and Laundry Supervisor.</p> <p>A review of a facility policy titled, Infection Prevention and Control Program, ?dated? ?11/22/2017?, indicated the facility would have a system of surveillance designed to identify possible communicable diseases or infection before they can spread to other persons in the facility.</p>		