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	10/12/2022

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

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)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37145 Based on record review and interview the facility failed to ensure pain management consistent with professional standards of practice was provided for one resident (resident #1) of six (R#1, R#2, R#3, R#4, R#5, R#6) residents reviewed who were admitted with Physician Orders for pain medication. This failed practice had the potential to affect 1 resident who was at risk of pain due to fracture and resulted in past immediate jeopardy that caused or was likely to cause serious harm, injury, or death to Resident #1. The Administrator, Director of Nursing (DON) and the Consultant were notified of the Past Immediate Jeopardy (IJ) on 10/12/22 at 9:38 AM. The Immediate Jeopardy began on 09/28/22 at 6:30 pm and ended on 09/29/22 at 9:25 pm. The facility corrected the noncompliance prior to this current survey by obtaining and administering Resident #1's pain medication as ordered by the physician. This failed practice resulted in R #1 having 8 out of 10 post surgical pain for twenty seven hours which could have impaired wound healing and caused physical or pyschological suffering to the resident. 1.R#1 was admitted to the facility on [DATE] at 6:30 pm with Diagnoses of closed three (3) part fracture of proximal end of right Humerus post repair for aftercare. Acute midline back pain, and frequent falls. A 5-day Medicare Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/04/22 documented a scored 15(13-15: Cognitively Intact) on the brief interview of mental status (BIMS), required extensive one-person physical assistance for bed mobility, toileting, dressing, two-person extensive physical assistance for transfer, and limited one person assistance for eating. Section J documented received as needed (PRN) pain medication per resident interview. J0400 frequency 2. Frequent. J0500B limited daily activities J0600 verbal descriptor scale 2. Moderate and Received Antidepressant and Opioids 5 of the 7-day look back period. a. On 10/11/22 at 8:42 am, Record Review of resident # 1's Physician Order dated 09/28/22 documented . Percocet 7.5/325 MG (milligram) tablet give one tablet by mouth every four hours as needed. (Do not exceed more than 3 grams of Acetaminophen in 24-hour period. Dx [Diagnosis] pain . b. On 10/11/22 at 8:42 am, Record Review of resident # 1's September 2022 Medication Administration Record (MAR) documented .Percocet 7.5/325 mg tablet give one tablet by mouth every 4 hours as needed. Order date 09/28/22 . The MAR documented the first dose of pain medication was given on 09/29/22 at 9:28 pm. 27 hours after admission to facility. (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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. On 10/11/22 at 8:42 am, Record Review of resident # 1's progress note dated 09/29/22 at 3:15 pm .called Omnicare pharmacy to follow up on Percocet Pharmacy did not fill, unable to read signed script faxed when resident arrived 09/28/22, had called and spoke with staff earlier that day and was refaxed to backup pharmacy in town and driver would deliver at 7 pm. At 10:39 pm it had not arrived; driver had gone to back up pharmacy to pick up medication and it was not filled because only one tablet on hand. Medication arrived at 9:25 pm, resident medicated at 9:28 pm for pain . d. On 10/11/22 at 8:42 am, Record Review of resident # 1's Physical Therapy Treatment Encounter Note dated 09/29/22 at 12:51 pm documented . Pt.[patient] in bed. The Pt was unable to tolerate sitting up fully or transferring out of bed due to no pain meds given since hospital discharge and she was in excruciating pain. Nursing was working on getting pain meds for patient and is aware of issue . e. On 10/11/22 at 2:20 pm, OT # 1 was interviewed and asked to tell surveyor about OT (Occupational Therapy) services provided for R # 1 on 09/29/22. OT # 1 stated, I did the evaluation, resident # 1 came in with a total shoulder repair. She was very pain affected, had a terrible night, for the first 24 hours. She didn't want to get out of bed. f. On 10/11/22 at 2:30 pm, a phone interview was completed with PT #1. The Surveyor asked PT # 1 to tell about PT (Physical Therapy) services provided for R# 1 on 09/29/22. She stated, R#1 couldn't tolerate anything much at all that day. I would say pain level was an 8 out of 10. Resident # 1's facial expression was so that you could see the pain in her face, tired, and kept verbalizing how bad she was hurting. I went to the nurse, she said they were waiting on the pharmacy. That seems to happen quite a bit, more than once. Once she got the pain meds, she worked with me fine. g. On 10/11/22 at 2:40 pm, The Surveyor interviewed and asked Licensed Practical Nurse (LPN) # 1 if resident # 1 had any pain on 09/29/22 and if any pain medication or Sertraline was given that day. LPN#1 said yes, I didn't give any pain medication or Sertraline. h. On 10/11/22 at 3:30 pm, The Surveyor interviewed and asked Registered Nurse (RN)#1, What the facility admission process was and if she completed R#1's admission? She stated, yes, I did. Resident # 1 came with a hard script for Percocet from the hospital. I got all the orders sent to the Pharmacy before 10:00 pm. I worked until 1:00 am that day. The next day I worked the 3:00 pm to 11:00 pm shift as medication nurse. When the narcotic count was done, I asked if we hadn't received Resident # 1's pain medication and I called the Pharmacy, Medical Records had refaxed to backup pharmacy, they only had one pill and didn't fill it. I contacted the pharmacy, as soon as it came in, I logged it in the narcotic log and gave it immediately. The Surveyor asked, if the order sent to the pharmacy on admission on 09/28/22 had been confirmed as received by fax or phone call to the pharmacy? She stated, I usually should but they usually call within thirty (30) minutes if they can't read it, or allergy information isn't listed. i. On 10/11/22 at 4:00 pm, an interview with the Administrator and RN # 2 was completed. Both were asked for the policy and procedure for Admission medication ordering and if it was acceptable for a post-surgical resident to not have pain medications available until 27 hours after admission. RN# 2 stated there was a policy and would look for it. Both stated it was not acceptable. The facility should have medications for new admissions in the building within four hours of admission. (continued on next page)

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