STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Transitional Care & Rehabilitation	460 Auburn Avenue N.E. Atlanta, GA 30312

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49138 Based on observations, resident and staff interviews, the facility failed to provide a safe/clean/comfortable/homelike environment for 11 of 84 resident rooms and 10 of 48 bathrooms and for two of 66 sampled residents (R) (R128 and R428), R128 who had mobility issues from loose handrailing and R428 who had food splattered on their tube feeding pump. Specifically, resident bathrooms contained gaps behind the toilet, stopped up sinks, sinks loose from the wall, damaged faucet, ceiling damage, holes in the floor, and leaks around base of toilet and broken paper toilet paper dispenser with a sharp edge, Additionally, resident rooms and hallways contained stains on the ceiling, broken lighting behind the bed, dim lighting, wall scratches behind the bed, broken bedside table, damaged base boards, damaged packaged terminal air conditioner (PTAC) unit, drawer to dresser missing, loose handrails, door frame damage, privacy curtain off hooks, call light not working, several floor tiles missing, damaged ceiling, missing baseboard, cracked window, window that would not close, gnats in room, beeping smoke detectors, and one shower room out of order. The deficient practice had the potential to impede residents reaching their highest practicable level of functioning to support their quality of life. The facility census was 179 residents. Findings include: 1. Observation on 3/14/2024 at 11:23 am revealed in room [ROOM NUMBER]B the overbed light was dim and water spots were observed on the ceiling. Observation on 3/15/2024 at 10:15 am revealed a cracked window in room [ROOM NUMBER]B that would not lock. The bathroom was noted to have chipped paint and holes behind the toilet. Observation on 3/16/2024 at 10:27 am revealed in room [ROOM NUMBER] bathroom to have peeling paint and holes behind toilet, the base of the sink was pulling away from the wall, and patches of rough paint were noted behind and on the side of the toilet. Observation on 3/16/2024 at 10:47 am revealed room [ROOM NUMBER]B bedside lighting was dim and needed a cover over the light. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview during walking rounds on 5/16/2024 at 10:25 am with the Maintenance Manager (MM) and the Administrator on floor 200, 10:40 am on floor 300. At 10:50 am the Administrator and MM confirmed damaged walls, peeling paint, cracked window, window that would not close, holes in the floor, baseboard needing repair, sink loose from wall, damaged faucet, several damaged ceiling tiles, hand rail damaged, damaged privacy curtains, holes in the wall, gap behind the toilet, leaking toilet, and PTAC unit damage. The MM stated cubicle privacy curtain has been ordered. MM stated that he will move forward making the repairs immediately. No policy was provided in regard to the environment. 45811 2. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for R128 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating little or no cognitive deficit. Observation and interview on 5/14/2024 at 10:15 am in room [ROOM NUMBER] revealed the door and door frame had peeling paint, the PTAC casing needs to be replaced due to peeling paint and loose casing, base boards in room [ROOM NUMBER]-2 were peeling and need painting. R128 in 401-2-stated it was difficult to get the wheelchair in the bathroom due to the size of the room and the placement of the handrails. Observation on 5/14/2024 at 10:20 am in room [ROOM NUMBER] revealed the hall vent in front of the room was dusty and there were black flying bugs or gnats. Observation on 5/14/2024 at 10:30 am on the fourth floor revealed the baseboard near the Soiled Utility Room was peeling, the side rails were loose in the hallway near the bath area, there was torn tile, and the paint was peeling from the base boards. Observation on 5/14/2024 at 10:45 am in room [ROOM NUMBER] revealed the feeding pump had old tube feeding particles on the front of the pump, the wall behind bed B needed patching, the hand rail in the hallway near room [ROOM NUMBER] was loose, the drawer to the dresser was missing on the 209-2 side, and the bedside table was broken in 209-1. 46431 3. Observation on 5/14/2024 at 10:23 am in room [ROOM NUMBER] revealed the window would not close. Observation on 5/15/2024 at 9:34 am in room [ROOM NUMBER] revealed the window would not close and the sink was slow to drain water. Observation on 5/16/2024 at 11:38 am in room [ROOM NUMBER] revealed the window would not close and the sink was slow to drain water. 49394 4. Observation on 5/14/2024 at 10:41 am in room [ROOM NUMBER] revealed the smoke detector was beeping, and ceiling damage in the room. There was no privacy curtain on the left side of the bed nearest to the door. There was damage to the ceiling in the bathroom, a gap behind the toilet, and the PTAC unit was damaged. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 5/14/2024 at 10:50 am in room [ROOM NUMBER] revealed the smoke detector was beeping. Observation on 5/14/2024 at 11:03 am in room [ROOM NUMBER] revealed the smoke detector was beeping, there was a gap behind toilet in the bathroom, and the bathroom sink was stopped up. Observation on 5/14/2024 at 11:07 am in the second-floor bath/shower room revealed it had an out of order sign on the door. Observation on 5/14/2024 at 11:12 am in room [ROOM NUMBER] revealed the sink was very loose from the wall. Observation on 5/15/2024 at 11:19 am in room [ROOM NUMBER] revealed damage to the faucet in the bathroom, the pipe was leaking under the sink with a grey colored basin on the floor catching water, and a gap around the toilet base. Observation on 5/14/2024 at 11:31 am of the second-floor revealed several ceiling tiles damaged in the hallway near room [ROOM NUMBER]. Observation on 5/14/2024 at 11:38 am in room [ROOM NUMBER] revealed a medium-sized hole in the bathroom floor, which is a shared bathroom, and large hole in the wall of the resident room near the bed and scuffed and damaged wall behind resident's bed. Also noted was a broken light fixture at the head of the bed, when touched, it partially fell . 49811 5. Observation on 5/14/2024 at 10:37 am in room [ROOM NUMBER] revealed a missing baseboard along the wall behind the bathroom. Observation on 5/15/2024 at 4:22 pm in room [ROOM NUMBER] revealed the resident dresser was covering the portion of the missing baseboard. Observation on 5/14/2024 at 10:42 am in the bathroom of room [ROOM NUMBER] revealing a large hole the size of a grapefruit located near the bathroom door, a broken toilet paper dispenser with a sharp edge, and exposed plumbing under the bathroom sink. Observation on 5/15/2024 at 4:14 pm in the bathroom of room [ROOM NUMBER] revealed a large hole in the wall, a broken toilet paper dispenser with a sharp edge, and exposed plumbing under the bathroom sink. Observation on 5/14/2024 at 11:00 am revealed spilled food splattered on R428's feeding pump. Observation on 5/15/2024 at 4:15 pm revealed spilled food splattered on R428's feeding pump.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 46431 Based on record review, staff interviews, and review of the facility policy titled, Abuse Prevention Policy, the facility failed to ensure pre-employment screening, specifically fingerprints for two of 10 staff reviewed. Findings include: Review of the facility policy titled Abuse Prevention Policy last reviewed May 2024 revealed Background, reference and credential's checks should be conducted on employees prior to or at the time of employment by the facility administration, in accordance with applicable person having knowledge that an employee's license or certification is in question should report such information to the administrator. Review of the facility employee files revealed the following: 1. Certified Nursing Assistant (CNA) NN was hired on 2/1/2024 with no fingerprint process completed. 2. Certified Medical Assistant (CMA) OO was hired on 1/16/2024 with no fingerprint process completed. CNA NN and CMA OO had active, unencumbered CNA certifications. There were no concerns identified related to abuse or neglect within the facility. Interview on 5/15/2024 at 12:40 pm with the Human Resource Director revealed she must have missed the needed GCheck (Georgia Criminal History Check System). She expressed the need for all CNA's or CMA's need for a fingerprint background check. She stated she would get those completed as soon as possible. Interview on 5/16/2024 at 3:31 pm with the Administrator revealed the facility's standard was for all employees to have the appropriate background checks and fingerprints. She stated background checks were normally performed prior to hire and fingerprints were performed within a thirty-day window after hire. She expressed the two employees that were missed for a GCheck have now being processed.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49394 Based on record review and interviews the facility failed to develop a baseline care plan for one resident (R) (R172) that included goals and interventions to meet the immediate care needs present upon admission. The deficient practice had the potential for R172 not to have care needs met. Findings include: Review of the electronic medical record (EMR) for R172 revealed he was admitted to the facility with diagnoses including but not limited to pressure ulcer to left heel, unspecified stage, pressure ulcer of sacral area. Review of R172's admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Section GG-Functional Abilities and Goals revealed resident required limited assistance with all care. Section M-Skin Conditions did not indicate that the resident had a surgical wound. Review of the baseline care plan dated 5/3/2024 revealed there was not a completed plan of care that included the goals and interventions needed to provide effective and person-centered care to address care for pressure ulcers/wounds. The only problem areas identified were the resident's personal preferences, code status, and risk of infections. Review on 5/15/2024 and 5/16/2024 of the Licensed Weekly Skin Assessment from 5/10/2024 revealed no new areas. There was no indication of any documentation of present pressure ulcers/wounds. The Skin Assessment was not completed. Interview on 5/16/2024 at 10:19 am with the Minimum Data Set (MDS) Director revealed that care plans are completed and reviewed quarterly, annually, upon admission, or as needed. She further stated that upon admission baseline care plans are done within 48 to 72 hours. When asked regarding R172's care plan being incomplete and not addressing the pressure ulcers, the MDS Director stated that she knew the resident had pressure ulcers and was recently admitted and should have had a care plan addressing what care R172 required during their stay at the facility. She revealed that they were still working on the comprehensive care plan as of 5/16/2024. When shown that the resident's baseline care plan did not address his pressure ulcers/wounds, she verbally confirmed that the care plan did not address his pressure ulcer(s), she then stated that the facility has 21 days to complete. She also stated that there was no policy for care plans but stated that they follow the guidelines of Centers for Medicare and Medicaid Services (CMS). (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/16/2024 at 11:35 am with the Director of Nursing (DON), the MDS Director, and treatment nurse Licensed Practical Nurse (LPN) PP revealed that initial assessments and care plans are to be completed and once completed they are formulized by MDS within 21 days. She also revealed that all residents being admitted should include being at risk for potential related to skin breakdown and residents with ulcers/wounds should be included in the actual wound care plan. She and the MDS Director stated that the current practice of the facility was that if the resident had a pressure ulcer/wound, that they should have an actual care plan. When asked about R172 not having his pressure wounds addressed on the care plan, she pulled up the resident's care plan and showed surveyor that it was addressed, however it was dated 5/16/2024. She was made aware that the care plan did not include these items when reviewed by surveyor on 5/14/2024, 5/15/2024 and 5/16/2024, prior to making the MDS Director aware. The DON stated moving forward they will have actual and potential care plans for each resident. She voiced that it would be beneficial for other nursing staff to be vigilant of resident's needs. No policy was given regarding the care planning and admission assessments of skin prior to end of the survey.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46431 Based on observations, resident and staff interviews, record review, and review of the facility policy titled, Oxygen (O2) Therapy, the facility failed to provide respiratory care consistent with professional standards of practice for two of fourteen Residents (R) (R1 and R281) receiving O2 therapy, related to ensuring O2 filters were cleaned and the O2 nasal cannula (NC) was stored in a plastic bag when not in use, and failing to obtain a physician's order for O2. The deficient practice had the potential to cause respiratory distress. Finding include: 1. Review of the facility policy titled Oxygen Therapy stated under the section titled Policy Statement that Oxygen (O2) is administered to promote adequate oxygenation and provide relief of symptoms of respiratory distress. Under the section titled Standard of Practice it stated the following but not limited to 1. Oxygen therapy is to be used with a written order by a physician. A physician's order for O2 therapy is to contain liter flow per minute (LPM) via mask or cannula. 5. Check that the equipment is functioning properly and ensure that mask or cannula is securely and comfortably in place. 8. Change oxygen tubing weekly. 9. Date tube when changed (weekly). Review of the electronic medical record (EMR) revealed R281 was admitted to the facility with diagnoses that included, but not limited to unspecified asthma, chronic pulmonary edema, mixed disorder of acid-base balance, unspecified diastolic (congestive) heart failure, chronic obstructive pulmonary disease (COPD). Review of the most recent quarterly Minimum Data Set (MDS) dated [DATE] documented R281 having a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident had intact cognition. Further review revealed R281 had no behaviors, required limited assistance with one-person physical assistance for dressing, required one-person physical assistance for hygiene. Observation and interview on 5/14/2024 at 9:43 revealed R281 was sitting up in the bed on 2 liters LPM via NC. R281 stated she used O2 all the time and did not feel comfortable getting up without it. Observation on 05/14/2024 at 10:15 am of R281 in their room revealed the resident using O2 at 2 LPM via NC with no distress. Interview on 5/14/2024 at 10:34 am with the Director of Nursing (DON), she confirmed R281 did not have an order for O2 but had been receiving O2 since admission. She expressed her expectations to include anyone receiving O2 treatments needed an order, and if they do not, the nurse should contact the doctor. The nursing staff manage O2 therapy. The facility does not have a Respiratory Therapist on staff. Interview on 5/15/2024 at 9:50 am with Licensed Practical Nurse (LPN) AA confirmed R281 had been on O2 since admission. LPN AA revealed the nurses take care of managing O2 therapy, maintain the flow rate, change it as needed, and that they change the tubing. It was confirmed that R281 had O2 on at 2 LPM via NC. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49394 2. Review of the electronic medical record (EMR) for R1 revealed they were admitted to the facility with diagnoses including but not limited to dependence on supplemental O2, chronic obstructive pulmonary disease (COPD) with (acute) exacerbation. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated little or no cognitive impairment. Review of a physician's order with a start date of 8/18/2019 for R1 revealed to change and date all respiratory supplies and tubing weekly. If oxygen concentrator is present, clean filter. Observation on 5/14/2024 at 1:26 pm during initial screening, R172 was noted sitting on side of the bed with O2 tubing and NC lying on the floor. The O2 concentrator (machine to supply oxygen) was on with the settings at 2 LPM. The filter cover on the O2 concentrator had a white, fuzzy substance and the entire concentrator was covered with dust. The tubing was labeled with white medical tape dated 5/6/2024. Interview on 5/14/2024 at 1:26 pm with R1, R1 stated that he does not wear his O2 all the time, and that his O2 machine had not been cleaned in a long time. Observation on 5/15/2024 at 9:32 am with R1 revealed the resident sitting up on the side of the bed, O2 NC not on and O2 concentrator not on. The O2 NC was hanging from the resident's bedside table, uncovered. No distress was noted. The O2 concentrator tubing remained dated 5/6/2024. R1 stated that he often runs out of water bottles, so he turns his machine off to conserve the water. The filter cover was opened to get a better observation of the filter. It revealed a very dirty filter that appeared to have spore looking substances on the outside of the filter casing which was dated 2/7/2023. R1 stated that he can taste dust sometimes while using his O2. Observation on 5/15/2024 at 2:15 pm of R1 sleeping in bed. The O2 concentrator was not on, and the NC was on the floor. The filter cover had not been cleaned and the filter had not been changed. Observation on 5/16/2024 at 10:00 am of R1 in bed resting. The O2 concentrator was at the bedside, not in use. The NC was hanging from the bedside table, uncovered. The O2 concentrator remained dusty as well as the filter cover. The dirty filter and casing remained in the concentrator. During an Interview/walking rounds on 5/15/2024 at 10:04 am with Unit Manager (UM) BB revealed that all staff were responsible for cleaning and maintaining O2concentrators by using germicidal wipes and report any issues with the concentrators. She also stated that she delegated tasks to staff. An order should be in place for changing tubing and labeling tubing with the date. UM BB confirmed that there was no current order for cleaning the O2 concentrator when shown resident orders in the EMR. UM BB was shown tubing and confirmed a date of 5/6/2024 was written on a white piece of tape that was affixed to the tubing and water bottle, and that there was not a bag to keep the NC in when not in use, the humidifier bottle which was almost empty, and confirmed the dirty filter and that it was dated 2/7/2023. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview at 5/16/2024 at 9:45 am with UM BB stated asked about R1 having access to O2, she replied that there was portable O2 readily available on the floor. Bulk O2 tanks were kept on 4th floor and some O2 tanks were currently on 2nd floor where R1 lives. Interview on 5/16/2024 at 10:55 am with the Director of Nursing (DON) revealed that her expectations from staff when caring for residents with O2 were that staff were to follow orders, change O2 tubing weekly, date the tubing, and change and clean filter weekly. She also stated that maintenance was responsible for checking the concentrators and reporting any damage or malfunctions. The facility does use an outside vendor for the concentrators. She did confirm that she was aware of the dirty concentrator and filter and confirmed that the outside casing was dated 2/7/2023. She stated that she was not sure why the outside casing was dated because the filter was removable from the casing. When asked if the date could have been the date the filter was changed, she said that that could be possible.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45811 Based on observations, record review, staff interviews, and review of the facility policy titled, Administration of Medications, the facility failed to ensure the medication error rate was less than five percent (%). There were two medication errors with a total of 28 opportunities observed for two of four Residents (R) (R27 and R91) for a medication error rate of 7.14%. Findings include: Review of the policy titled Administration of Medications revision date 11/15/2022 revealed under the Standards section, Medications shall be administered in a safe and timely manner, and as prescribed. Review of the electronic medical record (EMR) for R27 revealed diagnosis including, but not limited to spinal stenosis, alcohol abuse, esophagitis, and muscle weakness. Review of the care plan dated 4/11/2024 included R27 has nutritional problems and is at risk for malnutrition related to alcohol abuse. Review of the Physician Orders for R27 included thiamine 100 mg (milligrams), senna tablet 8.6 mg, multivitamin oral tablet (multiple vitamin), and folic acid 1 mg. Review of the EMR for R91 revealed diagnosis including, but not limited to alcohol abuse withdrawal, cerebral infarction, and anemia. Review of the care plan dated 5/14/2024 included R91 is at risk for nutrition/hydration due to therapeutic diet and DX (diagnosis) of HTN (hypertension) and heart failure. Review of the Physician Orders for R91 included Docusate Sodium Tablet 100 MG one tablet, Vitamin C Tablet (Ascorbic Acid) 500 MG, Zinc Tablet 50 MG Give 1 tablet by mouth, Ferrous Sulfate Tablet 325 (65 Fe (iron) MG Give 1 tablet by mouth, and Multivitamin Tablet (Multiple Vitamin) Give 1 tablet by mouth. During observation of medication administration on 5/15/2024 at 9:20 am, Licensed Practical Nurse (LPN) AA administered multivitamin tablet with minerals to R27. The order indicated multivitamin oral tablet (multiple vitamin). During observation of medication administration on 5/15/2024 at 9:45 am, LPN AA administered multivitamin tablet with minerals to R91. The order indicated multivitamin tablet (multiple vitamin). Interview on 5/15/2024 at 1:00 pm with LPN AA, he confirmed the multivitamin order for R27 and R91. He confirmed he gave multivitamin with minerals to both R27 and R91. Interview on 5/15/2024 at 2:00 pm with LPN Unit Manager (UM) BB confirmed that medications should be given as ordered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/15/2024 at 3:00 pm with the Director of Nursing (DON) revealed that medications should be given per the six rights, including the right patient, right medication, make sure take medication, remove meds refused, documentation, what occurred, and try to go back later if refused.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45811 Based on observations, staff interviews, record review, and review of the facility policy titled, Storage of Medications and Biologicals, the facility failed to properly store medication for two of 66 sampled Residents (R) (R27 and R32). This failure placed residents, staff, and visitors at risk of having unauthorized access to residents' medications. Findings include: 1. Review of the policy titled, Storage of Medications and Biologicals revision date 3/11/2024 revealed under Practice Guidelines, Facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding. Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible to residents and visitors. During observation of medication administration on 5/15/2024 at 9:20 am revealed a container of 'brand name' nasal saline on a bedside table in room [ROOM NUMBER]-2. There is no Resident assigned to that area. There is a Resident in 201-1, R27, who stated the Resident that was in 201-2 went home. Licensed Practical Nurse (LPN) AA was present during this discovery as he was passing medications to R27 in room [ROOM NUMBER]-1. He confirmed the saline was in the room on the bedside table. LPN AA stated that for Residents who are no longer in the facility, medications should be placed in the medication room. The Nurse Manager or Director of Nursing (DON) would destroy the medication; it should not be left at the bedside. Interview on 5/15/2024 at 9:30 am with Certified Nursing Assistant (CNA) UU revealed the Resident that was in 201-2 was discharged from the facility about three weeks ago. Interview on 5/15/2024 at 9:40 am with LPN Unit Manager (UM) BB revealed the nasal spray should not have been at the bedside, they should have double backed and checked to make sure there was not medication there. 49138 2. Interview on 5/14/2024 at 11:40 am with R32 revealed that R32 was not feeling well. Medication from the 9:00 am medication pass was observed on R32's bedside table. Interview on 5/14/2024 at 11:45 am with LPN UM KK revealed and confirmed that the medication pass was at 9:00 am. The medicine was no longer on the R32's bedside table. Interview on 5/14/2024 at 11:55 am with R32 in the presence of LPN UM KK revealed that R32 was nauseated and was afraid to take medication, so LPN JJ gave her the pills to take later. LPN UM KK confirmed that LPN JJ did the medication pass at 9:00 am and was not an employee at the facility as she works for an agency. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Legacy Transitional Care & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 460 Auburn Avenue N.E. Atlanta, GA 30312	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/15/2024 at 10:32 am revealed that R32 was still not feeling well. R32 stated that she did take her medicine that the surveyor observed on her bedside table yesterday. Interview on 5/15/2024 at 11:39 am with LPN MM, R32 was described as alert, oriented and independent. LPN MM stated that R32 does not self-administer her medication. On 5/16/2024 at 12:30 pm surveyor attempted to speak with LPN JJ via phone. LPN JJ was busy and could not speak with the surveyor. LPN JJ ended the call. Interview on 5/16/2024 at 12:35 pm with the DON confirmed that LPN JJ worked for an agency. The surveyor discussed the concern of JJ leaving medication with the resident. The DON's expectations of nurses during medication pass included verifying resident, stand there and ensure that the resident takes the medication, if resident refuses, document refusal and notify the Nurse Practitioner or Physician. On 5/16/2024 at 3:11 pm the DON provided surveyor with documentation of a report filed with the agency regarding LPN JJ leaving medication with R32. LPN JJ will not be allowed to work at the facility right now.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49394 Based on observations, staff interviews, and review of the facility's policies titled, Receiving and Storage and Service Line Refrigerated Leftover Storage, the facility failed to ensure food items were properly labeled, discard expired foods, and to ensure the inside of the ice machine was clean and free from residue. Specifically, the facility failed to ensure opened and frozen food items were properly labeled and dated and leftover food was properly covered and to ensure that kitchen equipment used for food preparation and storage was kept clean and sanitary. The deficient practice had the potential to affect 179 of 179 residents receiving an oral diet from the kitchen. Findings include: Review of the undated facility policy titled Receiving and Storage under the section titled Policy, Receiving revealed Receiving is the point at which foodservice operation inspects and take legal ownership and physical possession of items ordered. Its purpose is to ensure that the food and supplies delivered match the established quantity and quality specifications. The section titled Storage revealed Proper storage of Date and Labeling food immediately after it has been received and checked is an important factor in the prevention and control of loss and waste. It also revealed that food should be stored in an orderly and systematic arrangement (FIFO-first in, first out). Food should be protected from pests, rodents, and insects. Review of the undated facility policy titled Service Line Refrigerated Leftover Storage under Policy revealed Leftover foods should not be saved and re-used for human consumption if there is any doubt of wholesome quality. Under the section titled Procedure revealed under 1. Cover with non-absorbent lid or material. 2. Date container with use by date (lids may be misplaced). There was not a policy presented by the facility regarding cleaning of kitchen equipment and food storage areas, however there was a typed Dietary Aide duties list hung on a wall in the facility's kitchen that included specific duties and responsibilities that included cleaning. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations on [DATE] at 8:50 am during the initial walk through with the Dietary Manager (DM) revealed that the kitchen had three large freezers. Upon inspection of all three freezers revealed that none of the items (boxes containing foods) were labeled or dated, but during the inspection the DM proceeded to start dating the boxes with a black marker. There was loose food noted at the bottom in two of three of the freezers. There were unidentified food items wrapped in plastic wrap, unlabeled and undated. Other items included corn dogs in plastic, not labeled/dated, with small holes in the plastic, approximately 10 chicken patties in plastic, not labeled or dated, one bag of approximately 30 shrimp poppers, unlabeled and undated, 20 crab cakes, not labeled or dated, and expired brownie mix. The DM discarded all the items. There were also dry items such as flour and sugar in large white containers that were not dated or labeled. There was an open bag of cereal taped closed with clear tape, not dated. Upon inspection of the two ice machines, one was a dispenser located outside of the kitchen which had dust build up on the filter cover and was dirty all over. The second larger sized ice machine, which was mainly used for the residents, was located inside of the kitchen. It also had a dirty and dusty filter cover. The dispenser was wiped with a white paper towel under where the ice was dispensed and it revealed a pink, jelly-like substance. The DM confirmed the findings. The Maintenance Supervisor (MS) was made aware, and he acknowledged and confirmed the findings and immediately stopped the use of the ice machine. He cleaned and changed the filters and covers on the machine. Follow-up observations on [DATE] at 8:22 am with the DM revealed that some of the previously identified concerns were still observed. She stated, I thought my assistant had taken care of the things I pointed out to him. The DM acknowledged that the two white containers with dry food items were not dated or labeled on the container. The DM acknowledged that the toaster, blender and large sized can opener were dirty. Interview on [DATE] at 8:22 am with the DM revealed that expected dietary staff to label and date all food items and include when to discard the food items. She revealed that she expected dietary staff to clean the kitchen equipment right after use. She stated that she interacts with staff every day about cleaning equipment after use and to date and label food items. Interview on [DATE] at 11:01 am with the MS revealed when asked who was responsible for cleaning the ice machines that he was responsible for cleaning and maintenance of the two ice machines in the facility. He confirmed that the facility uses 'company name' for pest control and presented a log which revealed the last service was dated [DATE]. He denied any pest control issues. Regarding the trash/refuse, he stated that the facility utilizes 'waste removal company name' and that they have daily scheduled trash pick-up. There was currently a large contractor roll off container in place for dumping large items such as furniture in, as the facility was changing out furniture. Interview on [DATE] at 1:00 pm with the Administrator revealed that her expectations are that the kitchen staff maintain a clean, orderly kitchen by proper labeling, dating, getting rid of expired items per policy, report any concerns with food and equipment, maintain ordering so that there was enough food for residents, and honor and adhere to specific dietary needs of the residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49811 Based on observations, staff interviews, and review of a facility document titled, Preventing Infections While Providing Personal Care and the facility policy titled, Infection Prevention and Control, Cleaning, and Disinfection of Resident-Care Items and Equipment, the facility failed to ensure staff implemented appropriate hand hygiene during the passing of trays at mealtime, before and after each resident's meal consumption for one of 66 sampled Residents (R) (R425), and failed to sanitize point of care equipment after use for two of 66 sampled Residents (R27 and R114). The deficient practice had the potential to expose residents to infection. The census was 179 residents. Findings include: Review of a document titled Preventing Infections While Providing Personal Care, not dated, revealed Proper handwashing is essential to making sure that the skin is free of contamination by potentially infectious microorganisms. When soap and water are not available, an alcohol-based hand cleanser can be used, and you must rub hands thoroughly until they are dry. Your facility will have guidelines in place for when an antimicrobial agent or a waterless antiseptic agent should be used. Review of the facility policy titled Infection Prevention and Control, Cleaning and Disinfection of Resident-Care Items and Equipment last reviewed on November 29, 2022 under Policy Statement revealed that Resident-care equipment, including reusable items and durable medical equipment, will be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard. A review of the section titled Standard of Practice number three revealed durable medical equipment must be cleaned and disinfected before being reused by another resident. 1. Observation on 5/15/2024 from 12:20 pm to 12:59 pm in the fourth-floor dining room revealed that staff were inconsistent with hand hygiene between passing trays. They were observed shaking hands to dry them after alcohol-based hand cleanser. Observation on 05/15/2024 at 12:55 pm during the fourth-floor dining revealed that R425 was provided lunch while in bed. However, R425 was not offered hand hygiene before or after meal consumption. Interview on 5/15/2024 at 1:12 pm with Certified Nursing Assistant (CNA) HH revealed that all staff must complete hand hygiene before serving meals. CNA HH revealed that hand hygiene was offered and provided to all residents before meals to prevent the spread of communicable diseases. CNA HH was unaware if hand hygiene was provided to R425 before serving the recommended lunch selection. CNA HH stated she did not offer hand hygiene to R425. 45811 2. Observation on 5/15/2024 at 9:30 am of medication administration by Licensed Practical Nurse (LPN) AA revealed he used the blood pressure cuff from the medication cart on R27 and put it in the bottom of the cart without sanitizing the cuff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 5/15/2024 at 9:45 am of medication administration by LPN AA revealed he took the blood pressure cuff out of the bottom drawer of the medication cart, he did not sanitize it, then used the cuff on R114 and put it on top of the medication cart. He did not sanitize the cuff. LPN AA confirmed he did not sanitize the blood pressure cuff after using it. Observation on 5/15/2024 11:30 am of the fingerstick blood sugar procedure completed by Med (medication) Tech (technician) CC revealed she gathered supplies for the procedure, put supplies on a barrier on the bedside table, except the container for the glucose. She then cleaned the resident's finger. After the stick she put the meter on the bedside table without a barrier. When she left the room, she put the meter on the cart without a barrier, cleaned the meter without gloves on, and put it back on the cart. Med Tech CC confirmed she did not always use a barrier during this process. Interview on 5/16/2024 at 4:00 pm with the Infection Control Nurse revealed when performing a fingerstick procedure, the staff will use a barrier to put supplies on in the room and on the medication cart. This includes the glucose meter. Interview on 5/15/2024 at 1:21 pm with the 4th-floor Unit Manager GG confirmed all staff was expected to complete hand hygiene in preparation for serving meals. Unit Manager GG revealed that hand hygiene, such as hand sanitizer, was expected to be used between tray distribution. Staff was expected to use hand sanitizer three times before washing their hands with soap and water. Interview with the Director of Nursing (DON) on 5/15/2024 at 2:05 pm revealed the facility did not have a hand hygiene policy. The DON revealed that all staff must assist with meal service to ensure meals are hot when served. The DON stated that staff should wash their hands after every third use of hand sanitizer. The DON revealed that the facility does not have a hand hygiene policy, but they provide education to all staff and follow the CDC guidelines related to hand hygiene. The DON provided a document titled Preventing Infections While Providing Personal Care, which stated these are the guidelines used by the facility.