

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/17/2025
NAME OF PROVIDER OR SUPPLIER Legacy Transitional Care & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 460 Auburn Avenue N.E. Atlanta, GA 30312	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observations, staff interviews, and review of the facility's policy titled Facility Maintenance Policy, the facility failed to ensure that three of 14 shared bedrooms on the 400 hall (rooms [ROOM NUMBER]) were maintained in good repair. Specifically, rooms [ROOM NUMBER] were not free from chipped and peeling paint, scuffed sheetrock, and damaged or broken electrical outlet. Findings include: Review of the policy titled Facility Maintenance Policy revealed the Maintenance Policy outlines the procedures and responsibilities for ensuring the proper operation and upkeep of the nursing home's facilities. It includes guidelines for plant operations and regular checks of the call light system to ensure the safety and comfort of all residents. Standard of Practice: Plant Operations revealed the plant operations is the maintenance and functionality of all mechanical, electrical, and plumbing within the facility. This includes heating, ventilation, air conditioning (HVAC), water supply, and emergency power systems. Responsibilities include: Conducting daily inspections of all critical systems. Performing routine maintenance as per manufacturer and regulatory guidelines. Documenting all maintenance activities and inspections. Responding promptly to any system failures or malfunctions. Tels task rounds are conducted on a weekly, monthly, and annual basis per system. Resident Rooms: Patient rooms are inspected weekly for cleanliness, functionality of fixtures, and safety compliance. Repairs and maintenance issues are addressed promptly to ensure resident comfort and safety. An observation on 9/30/2025 at 11:36 am during tour and screening of residents revealed in room [ROOM NUMBER], bed two, a damaged and broken outlet. An observation on 9/30/2025 at 11:55 am during tour and screening of residents revealed in room [ROOM NUMBER], next to bed two, wall paint that was peeled and scraped with scuffed sheetrock. An observation on 9/30/2025 at 12:19 pm during tour and screening of residents revealed in room [ROOM NUMBER], bed one, wall paint that was peeled and scraped with scuffed sheetrock, holes in the wall, and an overbed light that was inoperable. An observation on 10/1/2025 at 1:03 pm during tour and screening of residents revealed in room [ROOM NUMBER], bed two, a damaged and broken outlet. An observation on 10/1/2025 at 1:30 pm revealed in room [ROOM NUMBER], next to bed two, wall paint that was peeled and scraped with scuffed sheetrock. An observation on 10/1/2025 at 1:42pm during tour and screening of residents revealed in room [ROOM NUMBER], bed one, wall paint that was peeled and scraped with scuffed sheetrock, holes in the wall, and an overbed light that was inoperable. An interview on 10/1/2025 at 4:05 pm during walking rounds with the Maintenance Director confirmed damaged walls with peeled paint and chipped, scuffed sheetrock, a damaged and broken outlet, and the overbed light to be inoperable. An interview on 10/2/2025 at 2:09 pm with the Administrator revealed that she was aware of the environmental concerns and stated that three Maintenance Personnel would be assigned to round the facility, each responsible for a designated floor. She further indicated that additional tools would be implemented to support daily checks.		

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
--	-------	-----------

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 11/17/2025
NAME OF PROVIDER OR SUPPLIER Legacy Transitional Care & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 460 Auburn Avenue N.E. Atlanta, GA 30312	
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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of Facility policy titled, Preadmission Screening and Annual Review Policy (PASARR), the facility failed to ensure PASARR Level II was submitted for one of five residents (R) (R8). This failure had the potential to prevent R8 from attaining or maintaining the highest practicable level of mental and psychosocial well-being. Findings include: A review of the facility policy titled, Preadmission screening & Annual Resident Review (PASARR) revised 5/15/2025 revealed under Policy statement: It is the policy of the facility to screen all potential admissions on an individualized basis for PASARR. Under Policy Purpose: The Purpose of this policy is to define and set expectations regarding the appropriate preadmission assessment of all individuals with a mental disorder and individuals with intellectual disability. This includes incorporating the recommendations from the PASARR level II determination and evaluation in the residents' assessment, care plan and transition of care, and referring to all level II residents and all residents with new or evident conditions related to Level II review upon significant change in status assessment. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] Section C (Cognitive Patterns) revealed the Resident had a Brief interview for Mental Status (BIMS) score of 8 indicating moderate cognitive impairment. Section E (Behavior) revealed R8 had delusions, Section I (Active Diagnoses) revealed that R8 had a diagnosis of Schizophrenia, Section N (Medications) revealed that R8 was on an antipsychotic medication. Review of R8's care plan dated 7/23/2025 revealed R8 has impaired cognitive function/ impaired thought processes r/t dx of Schizophrenia with interventions including administer medication as ordered. Review of care plan revealed R8 has a risk for behaviors secondary to diagnosis of Schizophrenia. Interventions including Monitoring and documenting behaviors. Review of Physician orders dated 10/1/2025 revealed medications that included: Divalproex Sodium ER Oral Tablet Extended Release 24 Hour 500 mg (Divalproex Sodium) Give 1 tablet by mouth at bedtime related to Schizophrenia. Aripiprazole oral tablet 10 mg, give one tablet at bedtime related to Schizophrenia, unspecified dated 3/16/2024. Interview on 10/1/2025 at 2:20 pm with Social Service Director revealed this resident has not had an application submitted for PASARR Level II. Interview on 10/1/2025 at 10:25 am with Social Worker (BB) revealed that when a resident is admitted they verify the PASARR by approximately the end of the week they are admitted, the package is checked by the Director of Nursing and MDS. BB confirmed that resident R8 did not have a PASARR Level II submission. Interview with MDS Director on 10/2/2025 at 12:45 pm revealed that they check the diagnosis and put the diagnosis into the care plan upon admission, they do not check for PASSAR status. MDS Director revealed that R8 was admitted to the facility with a diagnosis of Schizophrenia.		

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 11/17/2025
NAME OF PROVIDER OR SUPPLIER Legacy Transitional Care & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 460 Auburn Avenue N.E. Atlanta, GA 30312	
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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and review of the facility policies titled, Call light system/Light Policy, and Facility Maintenance Policy, the facility failed to ensure that the call light communication system was functioning adequately to allow residents to call for staff assistance in two out of seven restrooms (200 hall) and two of 14 rooms (301,305) on 300 hall. Findings include: Review of the facility policy titled, Call System/Light Policy, revise date of May 15, 2025, revealed under Policy Statement: The purpose of the Resident Call System shall allow residents to call for staff assistance through a communication system that relays the call directly to a staff member or to a centralized staff work area. Under Standard of Practice: Equipment: 1. Bedside call light in functioning order 2. Emergency call light in working order. Review of the facilities policy titled, Facility Maintenance Policy, dated July 2025, revealed under Standard of Practice: Plant Operations; Responsibilities included: conducting daily inspections of all critical systems. Resident monitoring systems are a critical component for resident safety and communication. Regular checks are necessary to ensure these monitoring systems are always operational. 1. Observation on 9/30/2025 at 11:05 am during tour of resident's rooms revealed in room [ROOM NUMBER] the call light system was hanging off the wall and wires were exposed. The button on call system for the room was not functioning. Call light was tested by pushing the button and there was no sound or indicator light illuminating over the doorway. In room [ROOM NUMBER] the call light system was pulled out from the wall and hanging and was not functioning. Call light was tested by pushing the red button and there was no sound or indicator light illuminating over the doorway. Observation on 9/30/2025 at 11:15 am on the 200 hall two bathrooms connecting rooms [ROOM NUMBERS], 203 and 204 revealed the call light system was hanging from the wall and wires were exposed, and the system was not functioning. Walking rounds on 9/30/2025 at 1:24 pm with Maintenance Director verified rooms 301, 305 and bathrooms on 200 hallway had non-functioning call lights. 2. During an observation on 9/30/2025 at 11:12 am in the shared bathroom for 201 and 202 revealed the emergency call device was detached from the wall. During an observation on 9/30/2025 at 11:14 am in the shared bathroom for 203 and 204 revealed the emergency call device was detached from the wall. During an observation and interview on 10/1/2025 at 4:07 pm with Maintenance Director confirmed the call devices in the shared bathrooms were detached from the wall. Continued interview also revealed that he does conduct audits for the call devices to ensure they work.		