

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365576	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/18/2024
NAME OF PROVIDER OR SUPPLIER  Legacy Chillicothe		STREET ADDRESS, CITY, STATE, ZIP CODE  1058 Columbus St Chillicothe, OH 45601	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>42728</p> <p>Based on observations, resident interview and staff interview, the facility failed to ensure resident dignity was maintained during dining experiences. This affected two (#36 and #242) of two residents observed for dining. The facility census was 87.</p> <p>Findings include:</p> <p>1. Observation on 07/15/24 at 11:59 A.M. revealed State tested Nursing Assistant (STNA) #54 entered the room of Resident #41, carrying the resident's lunch meal tray. STNA #54 set up the resident's tray and began to feed the resident while standing at the side of the resident's bed. Resident #242, Resident #41's roommate, was sitting in his wheelchair in the room and had not received a lunch meal tray.</p> <p>Interview on 07/15/24 at 12:08 P.M. with Resident #242 confirmed the lunch meal Resident #41 was being fed smelled good. Resident #242 additionally confirmed he was hungry and was still waiting for his lunch meal to be delivered to the room</p> <p>Interview on 07/15/24 at 12:10 P.M. with STNA #54 confirmed residents who required assistance consuming meals received their meal trays first so staff could assist them. While Resident #242 was in the same room as Resident #41, STNA #54 stated Resident #242 would receive his lunch meal tray once it was brought to the hallway by kitchen staff.</p> <p>Additional observation on 07/17/24 at 11:20 A.M. revealed STNA #60 entered the room of Resident #41, carrying the resident's lunch meal tray. STNA #60 set up the resident's tray and squatted down beside the resident's bed and began feeding the resident. Resident #242 was sitting in his wheelchair in the room and had not received a lunch meal tray.</p> <p>Interview on 07/17/24 at 11:26 A.M. with Resident #242 revealed the lunch meal tray Resident #41 was being fed smelled good, as he was hungry. Resident #242 confirmed Resident #41 always received his lunch meal tray first, while he received his meal approximately 30 minutes later. Resident #242 stated he preferred to receive his meal tray at the same time as Resident #41.</p> <p>Observation on 07/17/24 at 11:43 A.M. revealed the lunch meal for Resident #242 was served to the resident in his room, approximately 23 minutes after Resident #41 had been served his meal.</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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>33023</p> <p>2. Observation on 07/15/24 at 12:00 P.M. revealed Resident #31 was being fed by facility staff. Resident #36 was also observed in the room, without a meal tray. Concurrent interview with Resident #36 revealed she was hungry and always received her meal tray after her roommate, Resident #31, had already been fed. Resident #36 stated she always had to watch while Resident #31 was fed.</p> <p>Interview on 07/17/24 at 11:00 A.M. with Dietary Manager (DM) #500 verified meal trays for residents who required assistance were sent out to the floor first and fed by staff before the rest of the residents received meal trays.</p> <p>Additional observation on 07/17/24 at 11:46 A.M. revealed Resident #31 was being fed the lunch meal by facility staff. Resident #36 was also observed in the room, without a lunch meal.</p> <p>Interview on 07/17/24 at 11:56 A.M. with Resident #36 revealed her roommate, Resident #31, always received her meal tray first. Resident #36 stated she had to watch her roommate eat while she had to wait.</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</b></p> <p>Based on medical record review, resident interview, staff interview and review of facility policy, the facility failed to ensure residents were invited to care conferences. This affected one (#23) of one residents reviewed for care conferences. The facility census was 87.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #23 revealed an admitted [DATE]. Diagnoses included diabetes, schizoaffective disorder bipolar type, chronic obstructive pulmonary disease, cerebral ischemic attack, restlessness and agitation and impulsive behavior.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 was cognitively intact.</p> <p>Review of the care conferences dated 12/16/23, 03/08/24 and 05/20/24 revealed no evidence Resident #23 was invited to or attended the care conferences.</p> <p>Interview on 07/16/24 at 9:24 A.M. with Resident #23 revealed she was unaware of any care conferences and had not been invited to any. Resident #23 stated she would have attended had she been invited.</p> <p>Interview on 07/17/24 at 9:40 A.M. with the Director of Nursing (DON) and Social Services (SS) #52 confirmed the facility had no evidence of who attended Resident #23's care conferences, including any documentation of Resident #23 being invited, attending, or declining to participate.</p> <p>Review of the facility policy titled IDT Care Conference Documentation, dated 11/20/23, revealed interdisciplinary care conferences would be held and residents would be invited to attend. The conferences would be scheduled quarterly and invitations would be sent to residents to attend. Each discipline would report on current status and revise goals. Resident questions would be answered and documentation would be kept in the electronic medical record.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728</b></p> <p>Based on observation, resident interview, staff interview and review of facility policy, the facility failed to ensure bathroom flooring and resident room doors were maintained in a clean and safe condition. Additionally, the facility failed to ensure linens were changed upon being soiled in a timely manner. This affected eight (#20, #23, #35, #75, #235, #236, and #238) of eight residents reviewed for environment. The facility census was 87.</p> <p>Findings include:</p> <p>1. Observation on 07/15/24 at 9:40 A.M. revealed the linoleum in the bathroom of Resident #235 and Resident #236 was taped down across the doorway with duct tape, which was dirty and tattered. There was a gap between the edge of the linoleum and the walls which went around the bathroom. Dirt and debris were observed in the gap between the linoleum and walls.</p> <p>2. Observation on 07/15/24 at 9:50 A.M. revealed the linoleum in the bathroom of Resident #238 and Resident #75 was taped down across the doorway with duct tape which was dirty, tattered, and had a mold-like substance on it. There was a gap between the edge of the linoleum and the walls which went around the bathroom. Dirt and debris were observed in the gap between the linoleum and walls. The linoleum was loose from the floor and had formed wave like patterns across most of the bathroom floor.</p> <p>Interview on 07/16/24 at 4:10 P.M. with Resident #238 confirmed the bathroom floor was in poor repair, causing it to be difficult and unsafe to wheel across in a wheelchair.</p> <p>Observation and concurrent interview on 07/16/24 at 4:15 P.M. with Maintenance Director (MD) #55 confirmed Resident #75, Resident #235, Resident #236, and Resident #238 resided in rooms with bathroom flooring which was in poor repair, dirty, duct taped down across the doorways and in need of being replaced.</p> <p>44070</p> <p>3. Observation on 07/15/24 at 12:09 P.M. revealed the flooring in Resident #20 and Resident #35's bathroom was peeling, torn, and curling up at the doorway. The flooring under the sink also appeared wavy. Interview of Residents #20 and #35 at the time of the observation revealed the flooring had been in disrepair for several months.</p> <p>4. Observation on 07/16/24 at 9:24 A.M. revealed Resident #23's bathroom flooring was peeling and had been secured with duct tape, which was also beginning to peel and curl up. Additionally, the room and bathroom doors had gouges in the wood along the edges. Concurrent interview with Resident #23 revealed the bathroom flooring had been in disrepair for some time and the resident was fearful of getting splinters from the gouges in the room and bathroom doors.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 07/16/24 at 3:40 P.M. with MD #55 revealed he was aware of the flooring concerns in resident bathrooms. MD #55 stated the facility had obtained several quotes in November 2023 to replace the flooring, but they were waiting for approval from the corporate office. MD #55 verified the findings in Residents #20, #35 and #23's bathrooms. Additionally, MD #55 verified the large gouges to the room and bathroom doors in Resident #23's room and stated he should sand the doors to prevent injury.</p> <p>5. Review of the medical record for Resident #20 revealed an admitted [DATE]. Diagnoses included heart disease, anemia, muscle weakness, dysphasia and repeated falls.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was cognitively intact.</p> <p>Observation on 07/15/24 at 12:09 P.M. revealed an approximately six by six inch area on Resident #20's fitted bed sheet with dried blood spots. The area was uncovered, making it visible upon entering the room. Concurrent interview with Resident #20 revealed the blood on his sheets was from a skin tear to his elbow. Resident #20 had a bandage on his left elbow. Resident #20 stated he would like his sheets changed due to the dried blood, but staff had not done it yet.</p> <p>Observation on 07/16/24 at 3:27 P.M. revealed Resident #20's bed linens had blood spots in the same area as observed the previous day. Concurrent interview with Resident #20 confirmed his linens had not been changed.</p> <p>Interview on 07/16/24 at 3:40 P.M. with MD #55, and concurrent observation, confirmed Resident #20's bed linen had spots of dried blood. MD #55 stated he would request the sheets be changed.</p> <p>Review of facility policy titled, ADL Care, dated 11/30/23 revealed Resident linen should be changed on shower days and as needed.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00154488.</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42728</b></p> <p>Based on medical record review and staff interview, the facility failed to ensure the appropriate records and documentation were completed and sent with the resident upon transfer to the hospital. This affected one (#13) of the three residents reviewed for hospitalization s. The facility census was 87.</p> <p>Findings include:</p> <p>Record review for Resident #13 revealed an admitted [DATE] with diagnoses including chronic respiratory failure, pulmonary disease, and dementia.</p> <p>Review of the admission Minimum Data Set (MDS) assessment, dated 04/23/24, revealed Resident #13 was assessed to have mildly impaired cognition.</p> <p>Review of the nurses progress note, dated 03/24/24 and timed 1:34 A.M., revealed Resident #13 experienced a change in condition and was transferred to the hospital.</p> <p>Further review of Resident #13's medical record revealed the facility SNF/NF to Hospital Transfer Form was not completed until 03/25/24, the day after the resident was sent to the hospital.</p> <p>Interview on 07/18/24 at 8:46 A.M. with the Director of Nursing (DON) confirmed the SNF/NF to Hospital Transfer Form, medication list, and bed hold notice were not sent to the hospital at the time Resident #13 was transferred. The DON confirmed the SNF/NF to Hospital Transfer form was completed on 03/25/24 and was faxed to the hospital, along with the residents medication list and bed hold notice, after the hospital called and requested them.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31404</p> <p>Based on medical record review and staff interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded. This affected one (#82) of three residents reviewed for resident assessments. The facility census was 87.</p> <p>Findings include:</p> <p>Review of Resident #82's medical record revealed an admitted [DATE] and discharged on [DATE]. Diagnoses included congestive heart failure, hypertensive heart disease, endocarditis, primary pulmonary hypertension, monothematic aortic valve stenosis, anemia, thrombocytopenia, hyperlipidemia, obesity, benign prostatic hyperplasia, hyperglycemia and anxiety disorder.</p> <p>Review of the Medicare Five-Day Minimum Data Set (MDS) assessment, dated 04/27/24, revealed Resident #82 discharged to a short term general hospital.</p> <p>Review of a progress note, dated 04/27/24 at 1:26 P.M., revealed Resident #82 was transferring to an inpatient hospice facility.</p> <p>Interview on 07/18/24 at 1:17 P.M. with Registered Nurse (RN) #66 confirmed Resident #82 was transferred to an inpatient hospice facility and did not go to the hospital from the facility. RN #66 verified the MDS was coded incorrectly.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</b></p> <p>Based on observation, resident interview, staff interview and review of the medical record, the facility failed to ensure a new skin impairment was assessed and monitored to promote healing. This affected one (#20) of four residents reviewed for skin assessments. The facility census was 87.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #20 revealed an admitted [DATE]. Diagnoses included heart disease, anemia, muscle weakness, dysphasia and repeated falls.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was cognitively intact.</p> <p>Observation on 07/15/24 at 12:08 P.M. of Resident #20 revealed the resident had a bandage to his left elbow. Concurrent interview with Resident #20 stated, during his shower, he bumped his elbow on the wall and had a small scrape. Resident #20 stated the nurse put a bandage on the area.</p> <p>Further review of Resident #20's medical record, including progress notes and skin/wound assessments, revealed no evidence of an assessment of the area noted to the Resident's left elbow.</p> <p>Interviews on 07/17/24 from 11:10 A.M. to 11:30 A.M. with the Director of Nursing (DON), Licensed Practical Nurse (LPN) #40, Assistant Director of Nursing (ADON) #99 and Unit Manager (UM) #63 revealed they were each unaware of any skin impairment on Resident #20. LPN #40 stated he had been Resident #20's nurse on 07/15/24 and ADON #99 and UM #63 revealed they had been on Resident #20's unit the last few days. Each staff confirmed they had no knowledge of the skin impairment.</p> <p>Interview on 07/18/24 at 1:16 P.M. with State tested Nursing Aide (STNA) #53 revealed she assisted Resident #20 with a shower over the weekend. STNA #53 stated the resident bumped his arm and got a small skin tear to his left elbow. STNA #53 stated she she informed Registered Nurse (RN) #88, who gave Resident #20 a bandage.</p> <p>Interview on 07/18/24 at 2:30 P.M. with the DON confirmed the facility had no documentation related to assessment, monitoring, or treatment of Resident #20's skin tear.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33023</p> <p>Based on medical record review and staff interview, the facility failed to ensure a resident with Post Traumatic Stress Disorder (PTSD) was appropriately assessed to identify the source of the resident's PTSD and minimize triggers and/or re-traumatization. This affected one (#48) of one residents identified by the facility as having a diagnosis of PTSD/trauma. The facility census was 87.</p> <p>Findings include:</p> <p>Record review for Resident #48 revealed an admitted [DATE]. Diagnoses included PTSD, chronic respiratory failure, chronic osteomyelitis, diabetes mellitus type II, chronic obstructive pulmonary disease, cerebrovascular insufficiency, protein-calorie malnutrition, apraxia, hypotension, myocardial infarction, anxiety, pulmonary embolism, spinal stenosis, restless leg syndrome, epilepsy, chronic pain, pseudobulbar affect (causes uncontrollable crying and/or laughing), insomnia, gastroesophageal reflux disease and hypertension.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 06/05/24, revealed Resident #48 was cognitively intact. Resident #48 had an active diagnosis of PTSD.</p> <p>Review of the active plan of care revealed Resident #48 had no care plan in place addressing the resident's PTSD, including cause, triggers which may lead to re-traumatization, interventions to reduce the risk of re-traumatization, or care provided for PTSD.</p> <p>Further review of Resident #48's medical record revealed no evidence an assessment had been completed to identify the cause of the resident's PTSD or to identify potential triggers, which may cause re-traumatization.</p> <p>Interview on 07/18/24 at 8:47 A.M. with the Director of Nursing (DON) verified an assessment of the source of Resident #48's PTSD and possible triggers had not been completed. Additionally, the DON verified there was no plan of care implemented to address Resident #48's diagnosis of PTSD to minimize the risk of re-traumatization.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>31404</p> <p>Based on review of pharmacy recommendations, medical record review and staff interview, the facility failed to timely act upon pharmacy recommendations for laboratory values to be drawn. This affected one (#25) of five residents reviewed for unnecessary medications. The facility census was 87.</p> <p>Findings include:</p> <p>Review of Resident #25's medical record revealed an admitted of 12/29/22. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, type two diabetes mellitus, chronic kidney disease, myocardial infarction, epilepsy, atherosclerotic heart disease of native coronary artery, hypertension, chronic pain syndrome, , major depressive disorder, gastroesophageal reflux disease, fracture of right upper end of humerus and localized edema.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment, dated 06/18/24, revealed Resident #25 was cognitively intact, used a walker to aid in ambulation and was always continent of bowel and bladder.</p> <p>Review of a physician order dated 04/18/23 revealed to give Keppra (anti-seizure medication) oral tablet 500 milligrams (mg), one tablet by mouth two times a day for epilepsy.</p> <p>Review of a pharmacy recommendation, dated 04/22/24, revealed a recommendation for Keppra laboratory level to be drawn every six months. The Certified Nurse Practitioner (CNP) accepted the recommendation on 04/24/24 and ordered Keppra level every six months.</p> <p>Review of laboratory results revealed Resident #25 had a Keppra level drawn on 06/21/24. Further review of the medical record revealed no previous laboratory draws had been completed for a Keppra level.</p> <p>Interview on 07/18/24 at 1:14 P.M. with the Director of Nursing (DON) verified Resident #25's Keppra laboratory value was not drawn until 06/21/24, approximately two months after the pharmacy had made the recommendation and the CNP ordered the level to be completed.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31404</p> <p>Based on observation, medical record review and staff interview, the facility failed to ensure medication error rates were not greater than 5% when staff crushed extended release medications for Residents #27 and #46. This affected two (#27 and #46) of five residents reviewed for medication administration. The facility had two errors out of 30 opportunities, for a medication error rate of 6.67%. The facility census was 87.</p> <p>Findings include:</p> <p>1. Review of Resident #27's medical record revealed an admitted [DATE]. Diagnoses included carotid artery syndrome, heart failure, type two diabetes mellitus, atherosclerotic heart disease, atrial fibrillation, hypertensive heart disease with heart failure, anemia and vascular dementia.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 04/19/24, revealed Resident #27 was severely cognitively impaired, used a wheelchair, had an ostomy and was always incontinent of bladder.</p> <p>Review of a physician order dated 04/20/22 revealed to give metoprolol succinate extended release tablet 24 Hour 50 milligram (mg), one tablet by mouth one time a day for hypertension and do not crush.</p> <p>Observation on 07/16/24 at 7:45 A.M. of medication administration pass for Resident #27 revealed Registered Nurse (RN) #11 passed all scheduled medications, including metoprolol succinate extended release 50 mg. RN #11 crushed all of Resident #27's medications prior to administration, including the metoprolol succinate extended release.</p> <p>Interview on 07/16/24 at 9:00 A.M. with RN #11 verified she crushed Resident #27's medications and the metoprolol succinate extended release should not of been crushed.</p> <p>2. Review of Resident #46's medical record revealed an admitted [DATE]. Diagnoses included cerebrovascular disease, parkinsonism, encounter for palliative care, generalized anxiety disorder, vitamin D deficiency, hypertension, personal history of transient ischemia attack and cerebral infarction, multiple sclerosis and disorder of bone.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/06/24, revealed Resident #46 was cognitively intact, used a wheelchair to aid in mobility and was infrequently incontinent of bladder and always continent of bowels.</p> <p>Review of a physician order, dated 12/09/23, revealed to give Myrbetriq (Mirabegron) oral tablet Extended Release 24 Hour 50 mg, one tablet by mouth one time a day for overactive bladder.</p> <p>Observation on 07/16/24 at 8:00 A.M. of medication administration pass for Resident #46 revealed RN #11 passed all scheduled medications, including Myrbetriq 50 mg. RN #11 crushed all of Resident #46's medications, including the Myrbetriq Extended Release.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Legacy Chillicothe		STREET ADDRESS, CITY, STATE, ZIP CODE  1058 Columbus St Chillicothe, OH 45601	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/16/24 at 9:00 A.M. with RN #11 verified she crushed Resident #46's medications and the Myrbetriq Extended Release should not of been crushed.</p> <p>Interview on 07/16/24 at 9:13 A.M. with the Director of Nursing (DON) verified she confirmed with the pharmacy that Myrbetriq Extended Release should not be crushed.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</b></p> <p>Based on medical record review, review of dental notes, resident interview and staff interview, the facility failed to ensure dental recommendations were followed-up on timely. This affected one (#23) of one residents reviewed for dental services. The facility census was 87.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #23 revealed an admitted [DATE]. Diagnoses included diabetes, schizoaffective disorder bipolar type, chronic obstructive pulmonary disease, cerebral ischemic attack, restlessness and agitation and impulsive behavior.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 was cognitively intact. The dental section indicated Resident #23 had no broken teeth.</p> <p>Review of the plan of care dated 05/08/24 revealed Resident #23 was at risk for oral and dental problems. Interventions included to monitor, document and report any problems needing attention.</p> <p>Review of dental notes dated 09/27/23 revealed Resident #23 was seen by the dentist for discomfort. Extraction was recommended for probable broken tooth. Further review of the medical record revealed a referral was not sent until 07/12/24 for the extraction of 10 lower teeth.</p> <p>Interview on 07/16/24 at 9:29 A.M. with Resident #23 revealed she was seen by the dentist a while ago for broken teeth, but there had been no follow-up after that appointment for the extractions. Resident #23 stated the broken teeth caused her discomfort and she had several teeth that needed pulled.</p> <p>Interview on 07/17/24 at 9:40 A.M. with the Director of Nursing (DON) verified the facility had not followed-up on getting needed dental services for Resident #23 from the time the recommendation for extraction was received on 09/27/23 until the referral was made on 07/12/24.</p>		

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NAME OF PROVIDER OR SUPPLIER  Legacy Chillicothe		STREET ADDRESS, CITY, STATE, ZIP CODE  1058 Columbus St Chillicothe, OH 45601	
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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>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>42728</p> <p>Based on observation, staff interview and review of facility policy, the facility failed to ensure food was prepared in a manner to prevent food-borne illness. This had the potential to affect all residents residing in the facility, with the exception of two residents (#48 and #237) identified by the facility as having no food by mouth (NPO). The facility census was 87.</p> <p>Findings include:</p> <p>Observation on 07/15/24 at 9:00 A.M. revealed two large, uncooked pork loins in plastic packaging, lying in the sink. The two raw pork loins were submerged in water with the drain plug in place, keeping the water from draining. No water was running into the sink. Dietary Manager (DM) #500 obtained the temperature of the water the pork loins were submerged in with a facility thermometer. The water temperature was 62 degrees Fahrenheit (F).</p> <p>Interview with DM #500 on 07/15/24 at 9:02 A.M. confirmed the two raw pork loins were submerged in standing water, which had a temperature of 62 degrees F. DM #500 confirmed raw meats were only to be thawed under cold running water.</p> <p>Review of the facility policy titled Time and Temperature Control and Recording, undated, revealed during thawing, the surface of foods can warm up enough to allow dangerous bacteria to grow. Since it can take more than four hours to thaw most foods, it is imperative to do so in a safe manner to discourage the growth of bacteria. For cold water thawing, thaw frozen food, in its leak-proof packaging, completely submerged under clean, cold, running water. This method is not appropriate for large roasts/cuts of meat that will not thaw within the four hour timeframe of exposure to temperatures above 41 degrees F.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070</b></p> <p>Based on medical record review, staff interview and review of the Centers for Disease Control and Prevention (CDC) guidance, the facility failed to ensure residents were timely offered, provided, and educated on pneumococcal vaccinations. This affected three (#23, #25, and #58) of five residents reviewed for vaccination status. The facility census was 87.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of the medical record for Resident #23 revealed an admitted [DATE]. Diagnoses included diabetes, schizoaffective disorder bipolar type, chronic obstructive pulmonary disease, cerebral ischemic attack, restlessness and agitation and impulsive behavior.</li> <li>Review of the pneumococcal consent dated 09/15/23 revealed Resident #23 consented to the pneumonia vaccine. Further review revealed the vaccine was not administered until 10/02/23.</li> <li>Review of the medical record for Resident #25 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis, cerebral infarct, diabetes and epilepsy.</li> </ol> <p>Further review of Resident #25's medical record revealed the resident's family declined the pneumococcal vaccine. The medical record contained no evidence Resident #25 or the resident's responsible party were provided education on the vaccination, including the risks and benefits.</p> <ol style="list-style-type: none"> <li>Review of the medical record for Resident #58 revealed an admitted [DATE]. Diagnoses included heart disease, hemiplegia and hemiparesis, atrial fibrillation, heart disease, spinal stenosis and cerebral attack.</li> </ol> <p>Review of the immunization record revealed Resident #58 received the Prevnar 13 pneumococcal vaccine on 12/21/15. Further review revealed no evidence Resident #58 was offered or provided any additional doses of pneumococcal vaccinations.</p> <p>Review of the CDC guidelines for pneumococcal vaccination revealed a dose of pneumococcal 20-valent conjugate vaccine (PCV20) or pneumococcal polysaccharide vaccine (PPSV23), at least one year after the previous dose of Prevnar 13, was recommended for Resident #58.</p> <p>Interview on 07/18/24 at 11:20 A.M. with Infection Preventionist (IP) #78 and Minimum Data Set Nurse (MDSN) #66 confirmed there was a delay in Resident #23 receiving the pneumococcal vaccination following consent. IP #78 and MDSN #66 stated vaccines should be provided within one week of getting consent from the resident or the resident's responsible party. Additionally, IP #78 and MDSN #66 verified there was no evidence Resident #25 was provided education related to pneumococcal vaccination and no evidence Resident #58 had been offered or provided the CDC recommended dose of either PCV20 or PPSV23.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Pneumococcal Vaccination of Residents, undated, revealed each resident would be asked about the pneumococcal vaccination as well as previous records reviewed to determine vaccination status. Recommendations were available from the CDC on specific situations in which vaccination is indicated, as well as direction on additional booster doses that may be recommended.</p>		