STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365616	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Kettering	3313 Wilmington Pike Kettering, OH 45429

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, staff interview, and review of the facility policy, the facility failed to address a resident's representative concerns regarding care concerns. This affected one (#105) out of the three residents reviewed for timely response to resident and/or resident representative concerns. The facility census was 93. Findings include: Review of the medical record for Resident #105 revealed an admitted [DATE] with medical diagnoses of diabetes mellitus, metabolic encephalopathy, hypertensive heart disease, congestive heart failure, and dysphagia oropharyngeal. The medical record indicated Resident #105 discharged from the facility on 12/29/24. Review of the medical record for Resident #105 revealed an admission Minimum Data Set (MDS) assessment, dated 11/19/24, which indicated Resident #105 had moderate cognitive impairment and required staff supervision with eating, bed mobility, and transfers, and required partial/moderate staff assistance for toilet hygiene and bathing. Review of the medical record for Resident #105 revealed a nurse's note dated 12/29/24 at 12:25 P.M. which stated Resident #105's daughter stated she felt her concerns were being dismissed. Interview on 01/06/25 at 8:45 A.M. with Director of Nursing (DON) stated she spoke with Resident #105's daughter on 12/22/24 about care/service concerns, staff not answering phone calls, and staff not returning her phone calls. DON stated she agreed with everything Resident #105's daughter said because she did not want to argue with the daughter. DON confirmed on 12/29/24 Resident #105's daughter left her a voicemail message which stated she had concerns about Resident #105's care and wanted a return call. DON stated she did not return Resident #105's daughter's call because Resident #105 daughter used foul language in the message and Resident #105 discharged to the hospital on 12/29/24 and the facility was notified Resident #105 would not be returning to the facility. Review of the facility policy titled, Resident Rights, revised December 2016, the resident has the right to voice grievances to the facility and the right to have the facility respond to the grievances. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00161119 and Complaint Number OH00159866.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record reviews, staff interview, and policy review, the facility failed to conduct quarterly care conferences. This affected two (#08 and #38) out of the three residents reviewed for care conferences. The facility census was 93. Findings include: 1. Review of the medical record for Resident #08 revealed an admitted [DATE] with medical diagnoses of dementia, chronic obstruction pulmonary disease (COPD), hypertensive heart and chronic kidney disease, anxiety, congestive heart failure (CHF), and atrial fibrillation. Review of the medical record for Resident #08 revealed a quarterly Minimum Data Set (MDS) assessment, dated 11/07/24, which indicated Resident #08 was cognitively intact and was dependent upon staff for toilet hygiene and transfers, required partial/moderate staff assistance for bathing, and substantial/maximum staff assistance for bed mobility. Review of the medical record for Resident #08 revealed a quarterly care conference note on 09/11/24. Review of the medical record for Resident #08 revealed no documentation to support the facility had conducted or offered to conduct a care conference since 09/11/24. 2. Review of the medical record for Resident #38 revealed an admitted [DATE] with medical diagnoses of COPD, CHF, chronic respiratory failure, morbid obesity, and hypertensive heart disease. Review of the medical record for Resident #38 revealed a quarterly MDS assessment, dated 11/14/24, which indicated Resident #38 was cognitively intact and was independent with all her activities of daily living. Review of the medical record for Resident #38 revealed a care conference note dated 05/14/24. Review of the medical record for Resident #38 revealed no documentation to support the facility had conducted or offered to conduct a care conference since 05/14/24. Interview on 01/07/25 at 4:08 P.M. with Regional Nurse #310 confirmed the medical records for Residents #08 and #38 did not contain documentation to support the care conferences were conducted with quarterly MDS assessments. Review of the facility policy titled, Care Planning-Interdisciplinary Team, revised September 2013, stated the resident, resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. This deficiency represents non-compliance investigated under Complaint Number OH00161119.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, staff interviews, and policy review, the facility failed to timely provide a therapeutic diet as per speech therapy recommendations. This affected one (#105) out of the three residents reviewed for diets. The facility census was 93. Findings include: Review of the medical record for Resident #105 revealed an admitted [DATE] with medical diagnoses of diabetes mellitus, metabolic encephalopathy, hypertensive heart disease, congestive heart failure, and dysphagia oropharyngeal. The medical record indicated Resident #105 discharged from the facility on 12/29/24. Review of the medical record for Resident #105 revealed an admission Minimum Data Set (MDS) assessment, dated 11/19/24, which indicated Resident #105 had moderate cognitive impairment and required staff supervision with eating, bed mobility, and transfers, and required partial/moderate staff assistance for toilet hygiene and bathing. Review of the MDS revealed Resident #105 received a mechanically altered diet, had no swallowing or chewing problems, and no weight loss. Review of the medical record for Resident #105 revealed a physician order dated 11/27/24 for regular diet, dysphagia pureed texture and thin liquids. Review of the medical record revealed an order dated 12/12/24 for regular diet, dysphagia texture and thin liquids. Review of the medical record for Resident #105 revealed a speech therapy note dated 12/06/24 which stated Resident #105 had a request for diet upgrade. The note stated Resident #105 received a trial tray of dysphagia advanced diet and tolerated the meal well. The note stated a diet order was given to upgrade Resident #105's diet to dysphagia advanced. Further review of the medical record for Resident #105 revealed a speech therapy note dated 12/11/24 which stated Resident #105's diet had not been changed from pureed to dysphagia advanced and that nursing and the director of rehab were notified. Interview on 01/07/25 at 3:35 P.M. with Speech Therapist (ST) #320 stated the facility offered a dysphagia pureed diet which had all foods pureed and a dysphagia advanced diet which had all meat ground but all other food on the tray were regular texture. ST #320 confirmed Resident #105 requested a diet upgrade because she did not like the consistency of the food. ST #320 stated she explained to Resident #105 that her diet had to be updated by levels and the resident would have to complete trial trays to determine if diet was safe for resident to consume. ST #320 confirmed on 12/06/24, Resident #105 had a trial tray of dysphagia advanced diet and tolerated the tray well. ST #320 stated she wrote a dietary order change for Resident #105 and gave to the facility rehabilitation director. ST #320 stated the nursing staff are responsible for getting an order from the physician to upgrade the diet. ST #320 confirmed on 12/11/24 she notified nursing and the director of rehabilitation that Resident #105's diet had not been updated to advanced dysphagia on 12/06/24. Interview on 01/07/25 at 2:06 P.M. with Regional Nurse #310 confirmed the medical record did not have documentation to support Resident #105's physician was notified of the speech therapy recommendation on 12/06/24 to upgrade Resident #105's diet from dysphagia pureed to advanced dysphagia. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Therapeutic Diets, revised October 2017 stated therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. The policy stated a therapeutic diet is considered a diet ordered by the physician, practitioner, or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of the diet. This deficiency represents non-compliance investigated under Complaint Number OH00161119.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record reviews, staff interviews, and policy review, the facility failed to ensure medications were administered as ordered resulting in significant medication errors. This affected three (#08, #95, and #100) out of the five residents reviewed for medication administration. The facility census was 93. Findings include: 1. Review of the medical record for Resident #08 revealed an admitted [DATE] with medical diagnoses of dementia, chronic obstruction pulmonary disease (COPD), hypertensive heart and chronic kidney disease, anxiety, congestive heart failure (CHF), and atrial fibrillation. Review of the medical record for Resident #08 revealed a quarterly Minimum Data Set (MDS) assessment, dated 11/07/24, which indicated Resident #08 was cognitively intact and was dependent upon staff for toilet hygiene and transfers, required partial/moderate staff assistance for bathing, and substantial/maximum staff assistance for bed mobility. Review of the medical record for Resident #08 revealed a physician order dated 08/05/24 for oxycodone 5 milligram (mg) one tablet by mouth every six hours as needed. Review of the medical record for Resident #08 revealed a nurse's note dated 10/02/24 at 8:48 A.M. which indicated Resident #08 received oxycodone 5 mg one tablet by mouth, a note dated 10/02/24 at 1:41 P.M. which indicated Resident #08 received oxycodone 5 mg one tablet by mouth and a note dated 10/02/24 at 3:54 P.M. which stated Resident #08 was given an extra dose of oxycodone by mistake and daughter and on call doctor were notified. Review of the medical record for Resident #08 revealed the October 2024 Medication Administration Record (MAR) which indicated Resident #08 received one oxycodone at 8:48 A.M. Review of the MAR revealed no documentation to support Resident #08 received another dose of oxycodone on 10/02/24. Review of the facility investigation report, dated 10/02/24, stated Licensed Practical Nurse (LPN) #240 received a verbal warning for not following physician orders and on the Five Rights of Medication Pass which was signed by LPN #240 on 10/07/24. The investigation report stated LPN #240 administered Resident #08 an oxycodone tablet instead of a Lyrica. The investigation indicated an assessment was completed on Resident #08 and no injuries were reported post incident. 2. Review of the medical record for Resident #95 revealed an admitted [DATE] with medical diagnoses of right tibia fracture, chronic osteomyelitis of right tibia and fibula, diabetes mellitus with polyneuropathy, and epilepsy. Review of the medical record for Resident #08 revealed Resident #08 discharged home on 11/19/24. Review of the medical record for Resident #95 revealed a quarterly MDS assessment, dated 10/29/24 which indicated Resident #95 was cognitively intact and required partial/moderate staff assistance with toileting hygiene, substantial/maximum staff assistance with bathing, and was dependent upon staff for transfers. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #95 revealed a physician order dated 10/30/24 for doxycycline 100 mg one tablet by mouth two times per day for wound infection and had not stop date. Review of the medical record for Resident #95 revealed the October and November 2024 MAR's which contained no documentation to support Resident #95 received doxycycline as ordered on 10/30/24 to 11/04/24. Review of the medical record for Resident #95 revealed a Nurse Practitioner (NP) note, dated 11/05/24 which stated there was an issue with the pharmacy discontinuing the previous order for doxycycline and the new order was cued but not active and was restarted today for her chronic prophylactic doxycycline 100 mg two times per day. The NP note stated Resident #95 missed six days of doxycycline. Review of the facility medication error investigation report, dated 11/07/24, indicated the DON educated all nursing regarding pending medication orders. The report indicated the facility staff audited the medical records for residents who were ordered antibiotics to ensure the medication was administered as ordered. 3. Review of the medical record for Resident #100 revealed an admitted [DATE] with medical diagnoses of COPD, myasthenia gravis, attention to gastrostomy, hypertensive chronic kidney disease, and restless leg syndrome. The medical record indicated a discharge date of [DATE]. Review of the medical record for Resident #100 revealed an admission MDS assessment, dated 11/06/24, which indicated Resident #100 was cognitively intact and required substantial/maximum staff assistance with toilet hygiene, bathing, supervision with bed mobility, and set-up assistance with eating. Review of the medical record for Resident #100 revealed physician orders dated 10/31/24 for fluticasone propionate nasal suspension 50 micrograms (mcg) per activation (act) one spray in both nostrils daily, for mirtazapine 15 mg one tablet via gastrostomy tube (g-tube) daily at bedtime (QHS), for ropinirole 1 mg tablet via g-tube) QHS, for azelastine nasal solution 137 mcg per spray one spray in both nostrils daily, for budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg per activation two puffs orally two times per day, for calcium carbonate 1250 mg one tablet via g-tube two times per day, for glycopyrrolate 2 mg one tablet via g-tube three times per day, for pyridostigmine bromide 60 mg one tablet via g-tube three times per day, lisinopril 40 mg one tablet via g-tube daily to hold if systolic blood pressure (SBP) was less than 120 per millimeter of mercury (mm/Hg) and for scopolamine transdermal patch 72 hour 1 mg per 3 days to apply one patch transdermal every 72 hours. Further review of the medical record revealed physician orders dated 11/04/24 for melatonin 5 mg one tablet via g-tube QHS, for montelukast sodium 5 mg two tablets via g-tube daily, and for gabapentin 250 mg per five milliliter (ml) give 8 ml via g-tube three times per day. The medical record for Resident #100 revealed physician order dated 11/08/24 for sodium chloride 1 gram one tablet via g-tube two times per day, an order dated 11/12/24 for acetaminophen 160 mg per 5 ml to give 32.5 ml via g-tube three times per day, orders dated 11/19/24 for Flomax 0.4 mg one tablet via g-tube daily and methocarbamol 500 mg one tablet via g-tube four times per day, an order dated 11/21/24 for prevacid 30 mg one tablet via g-tube every 12 hours and an order dated 11/23/24 for sertraline 50 mg one tablet via g-tube daily. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #100 revealed the November 2024 MAR which had no documentation to support Resident #100 received the following medications as ordered on 11/24/24: Flomax, fluticasone propionate nasal suspension, melatonin, mirtazapine, montelukast sodium, ropinirole, sertraline, azelastine, nasal solution, budesonide-formoterol fumarate inhalation aerosol, calcium carbonate, prevacid, sodium chloride, acetaminophen, gabapentin, glycopyrrolate, pyridostigmine, methocarbamol, and scopolamine transdermal patch. Review of the November 2024 MAR revealed no documentation to support Resident #100 received gabapentin as ordered on 11/07/24 through 11/11/24. Further review of the November 2024 MAR revealed documentation Resident #100 received lisinopril 40 mg one tablet via g-tube on 11/09/24 with a SBP of 108, on 11/13/24 with a SBP of 110, on 11/21/24 with a SBP of 119, on 11/22/24 with a SBP of 118 and on 11/27/24 with a SBP of 118. Interview on 01/02/25 at 11:40 A.M. with Regional Nurse #310 confirmed the medical record for Resident #100 did not contain documentation to support the facility administered her medications as ordered on 11/24/24 or the gabapentin as ordered from 11/07/24 to 11/11/24. Regional Nurse #310 also confirmed the medical record revealed documentation to support the facility staff administered Lisinopril 40 mg to Resident #100 on 11/09/24, 11/23/24, 11/21/24, 11/22/24, and 11/27/24 even though her blood pressure was outside of the order parameter for administration. Interview on 01/02/25 at 1:30 P.M. with Regional Nurse #310 confirmed the medical record for Resident #95 did not have documentation to support Resident #95 received doxycycline as ordered from 10/30/24 through 11/04/24. Interview on 01/02/25 at 3:00 P.M. with Regional Nurse #310 stated LPN #240 accidentally pulled the oxycodone from Resident #08's roommate, Resident #76's medications, and signed for the oxycodone on Resident #76's controlled substance record. Regional Nurse #310 stated Resident #08 was scheduled to receive her Lyrica on 10/02/24 at 10:00 A.M. but LPN #240 administered an oxycodone instead. Review of the facility policy titled, Medication Administration, revised April 2019, stated medications are administered in a safe and timely manner, and as prescribed. The policy stated medications are to be administered within one hour of their prescribed time, unless otherwise specified. The policy stated the individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. The policy stated the individual administering the medication initials the resident's MAR on the appropriate line after giving the medication and before administering the next ones. This deficiency represents non-compliance investigated under Complaint Number OH00159866.