

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365616	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Legacy Kettering		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>49044</p> <p>Based on record review, interview and policy review, the facility failed to ensure the posted staffing document included the total number and the actual hours worked for each discipline and failed to ensure the staffing document reflected any staff absences due to call-offs or illness. This had the potential to affect all residents residing in the facility.</p> <p>Findings include:</p> <p>The facility's document titled Report of Nursing Staff Directly Responsible for Resident Care, for the time frame from 05/13/2024 through 06/13/2024, used by the facility to post the daily staffing, did not reflect the actual hours worked for each discipline nor did it reflect any staff absences or changes due to call-outs or illness. The Report of Nursing Staff Directly Responsible for Resident Care document did not include any RN hours for 05/31/2024 and 06/10/2024.</p> <p>A document titled, Daily Coverage Report, for 05/31/2024 and 06/10/2024 revealed there was RN coverage that was not reflected on the facility's Report of Nursing Staff Directly Responsible for Resident Care forms for 05/31/2024 and 06/10/2024.</p> <p>During an interview on 06/14/2024 at 12:55 PM, the Scheduler stated she had been told to include how many nurses, RNs, LPNs, and state tested nurse aides (STNAs) that were working on the form. She said no one told her she needed to include the total number of actual hours worked on the form. The Scheduler stated she only updated the form at the beginning of the day when she completed it and did not make any changes to the posted forms to reflect any call-ins.</p> <p>During an interview on 06/14/2024 at 3:30 PM, the Director of Nursing (DON) stated she thought the staff postings in the lobby only had to include the number of RNs, LPNs, and STNAs for the day, but she did not know the actual hours worked also needed to be posted. The DON said she was unaware the numbers needed to be updated per shift; she thought it was just at the beginning of the day. The DON stated she expected the information to be posted accurately.</p> <p>During an interview on 06/14/2024 at 1:05 PM, the Administrator stated the forms should include the census, the number of staff from each discipline, the DON, and the Administrator on the top as well as the total census. The Administrator said the form should be updated with each shift if they had any call ins, however, she was unaware it needed to include the total number and actual hours worked per shift for each discipline.</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 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Review of the policy titled Staffing & Scheduling, last reviewed on 06/08/22, revealed, Facility will follow CMS [Centers for Medicare and Medicaid Services] Staffing requirements, maintain staffing schedule, and posting of staffing. 1. Facility will comply with CMS and state staffing requirements 2. Facility will provide a schedule for employees 3. Posting of facility staff daily at the beginning of each shift. Posting will be in a prominent place, readily accessible to residents and visitors.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>49044</p> <p>Based on record review and interview, the facility failed to ensure routine medication was available for administration. This affected one (Resident #67) of 24 sampled residents.</p> <p>Findings include:</p> <p>A review of Resident #67's Admission Record revealed the facility admitted the resident on 06/30/22, with diagnoses that included legal blindness, cataract extraction status right and left eyes, and bipolar disorder.</p> <p>Resident #67's Order Summary Report, revealed an order dated 08/14/2023, for Rocklatan Ophthalmic Solution 0.02-0.005%, instill one drop in both eyes at bedtime related to cataract extraction status right eye.</p> <p>Resident #67's medication administration record (MAR) for May 24 revealed staff initialed the MAR on 05/07/24, 05/08/24, 05/11/24, 05/13/24 - 05/18/24, 05/20/24, and 05/22/24 - 05/24/24 to indicate the Rocklatan Ophthalmic Solution was not available for administration.</p> <p>During an interview on 06/11/24 at 8:30 AM, Resident #67 stated they did have eye drops that sometimes did not get reordered on time, so the eye drops were not available for the staff to administer to them.</p> <p>During an interview on 06/12/24 at 11:28 AM, Resident #67's family member stated the staff had not been administering the resident's eye drops because they did not reorder the medication.</p> <p>During a telephone interview on 06/13/24 at 8:26 PM, Licensed Practical Nurse (LPN) #5 stated she recalled Resident #67 and that sometimes the resident did not receive their medications because they were not found.</p> <p>During an interview on 06/13/24 at 8:32 PM, LPN #6 stated she reordered Resident #67's eye drop medication as it was not available for administration when she worked. LPN #6 stated she worked part time and could reorder the medication, but was not present in the facility when the medication was received.</p> <p>During a telephone interview on 06/14/24 at 9:54 AM, the Pharmacy Representative stated their documentation showed the medication was ordered and dispensed on 05/04/24 and 05/25/24.</p> <p>During an interview on 06/14/24 at 11:32 AM, the Nurse Practitioner (NP) stated Resident #67 was seen by an eye specialist for a retinal detachment who ordered the eye medication. The NP stated Resident #67 should receive their eye medications as the medication is used for eye pressure and the resident should not miss any doses.</p> <p>During a telephone interview on 06/14/24 at 2:41 PM, Registered Nurse #1 stated she remembered Resident #67 and that there was a time when their eye drops were not available.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/14/24 at 3:30 PM, the Director of Nursing (DON) stated most medications were on automatic refill. When their contracted pharmacy took over initially, they had to reorder all the residents' medications but since then they were automatic unless the medication was a new prescription. She stated there had been times when they had to call the pharmacy numerous times. The pharmacy would tell them the medication was coming on the next run and then it did not come. The DON said the nurses should call the pharmacy to find out why the medication had not been refilled and let the physician know the medication had not been given. The DON stated she was unaware Resident #67 had gone days without their eye drops.</p> <p>During an interview on 06/14/24 at 3:51 PM, the Administrator stated she expected staff to reorder the medications timely so they were at the facility on time to administer to the residents.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153981.</p>		