STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365640	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Miamisburg	450 Oak Ridge Boulevard Miamisburg, OH 45342

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on record review and staff interviews, the facility failed to update resident care plan to include a resident's possession and suspected use of illegal substances. This affected one (#54) of three residents reviewed for care planning. The facility census was 80. Findings include: Review of medical record for Resident #54 revealed admitted [DATE] admitted to hospice on 11/22/23. Diagnoses including cirrhosis of the liver, chronic obstructive pulmonary disease, anemia, depression and history of cocaine abuse. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #54 required extensive one person assistance for toileting and supervision for bed mobility, eating and transfers. A brief Interview Mental Status (BIMS) score of 15 indicating intact cognition. Review of the progress note dated 03/10/24 revealed staff had found a plastic baggie with an unknown substance lying on the floor next to the bed. The Director of Nursing (DON) was informed. Review of the progress notes revealed on 04/05/24, Resident #54 was found unresponsive with periods of apnea and agonal breathing. Narcan was given and Resident #54 became alert and oriented within 15 minutes. Further review of Resident #54's care plan revealed there was no care plan related to illegal drug use and/or interventions staff should implement. Interview on 05/16/24 at 12:16 P.M. with Clinical Registered Nurse (CRN) #121 revealed the police were called after the substance was found in Resident #54's room on 03/10/24. CRN #121 stated the facility was not informed until 05/05/24 the substance found in Resident #54's room tested positive for fentanyl. A second interview with CRN #121 at 4:42 P.M. verified there was not a care plan regarding possession of and/or risk of substance abuse. This deficiency represents non-compliance investigated under Complaint Number OH00153893.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on record review, observation, staff and resident interviews, the facility failed to ensure treatments orders were completed as ordered. This affected one (#55) of three residents reviewed for implementation of treatments. The facility census was 80. Findings include: Review of medical record for Resident #55 revealed admitted [DATE]. Diagnoses include congestive heart failure, type two diabetes mellitus, and depression. Additional diagnosis added on 04/25/24 of aftercare following surgical amputation, left below the knee amputation and history of Methicillin Resistant Staphylococcus Aureus. The resident remained in the facility. Review of Resident #55's admission Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition. Resident #55 required extensive two-person assistance for bed mobility, transfers, toileting and supervision for eating. A care plan for an alteration in skin integrity to the left below knee surgical site documented interventions which included to provide treatments as ordered. Review of the physician orders revealed an order to cleanse left below knee amputation site with wound cleanser, pat dry, apply hydrogel moistened collagen to wound bed, cover with abdominal pad (ABD), secure with kerlix and compress with wrap. Treatment was ordered daily with a start date of 05/01/24. Interview on 05/13/24 at 9:28 A.M. with Resident #55 revealed a concern his dressing was not changed the day prior. Observation on 05/13/24 at 10:19 A.M. of the dressing change for Resident #55 by Assistant Director of Nursing (ADON) #100 revealed when she removed the kerlix and exposed the Abdominal (ABD) Pad, it was dated 05/11/24. ADON #100 confirmed Resident #55's dressing was not changed daily as ordered. This deficiency represents non-compliance investigated under Complaint Numbers OH00153893 and OH00153743.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on medical record review, observations and resident and staff interviews, the facility failed to provide adequate intervention and/or supervision to ensure residents did not possess illegal drugs and/or drugs not prescribed to the resident. Additionally, the facility failed to implement a resident's care plan to ensure adequate supervision was provided during a meal. This affected three (#54, #47 and #74) of three residents reviewed for supervision related to illegal drug usage and one (#27) of three residents reviewed for supervision with meals. The facility census was 80. Findings include: 1. Review of medical record for Resident #54 revealed admitted [DATE] admitted to hospice on 11/22/23. Diagnoses include cirrhosis of the liver, chronic obstructive pulmonary disease, anemia, depression and history of cocaine abuse. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #54 required extensive one person assistance for toileting and supervision for bed mobility, eating and transfers. A brief Interview Mental Status (BIMS) score of 15 indicating intact cognition. Review of Resident #54's progress notes dated 01/01/24 revealed an unnamed State tested Nursing Assistant (STNA) alerted the nurse that Resident #54's behavior was not normal. An assessment revealed extreme lethargy, and the bed was urine soaked. A vape pen was discovered and given to the Director of Nursing (DON), hospice was contacted, and hospice was notified. A second note revealed hospice staff instructed to hold narcotic medication and obtain a urine sample for drug screen. Results of the 01/02/24 drug screen revealed a positive result for Benzodiazepine (resident had an order for Ativan). Amphetamines, Barbiturates, Cocaine, Cannabinoids, Opiates, Phencyclidine, Propoxyphene, Methadone and Methaqualone were all negative. Review of Resident #54's progress note dated 03/10/24 revealed staff found a plastic baggie with an unknown substance lying on the floor next to the bed. The DON was informed. Review of the drug screening for 03/11/24 and 04/05/24 were negative for Amphetamines, Barbiturates, Cocaine, Cannabinoids, Opiates, Benzodiazepine, Oxycodone and Methadone were all negative. Further review of the progress notes revealed on 04/05/24 revealed Resident #54 was found unresponsive with periods of apnea and agonal breathing. Narcan was given and Resident #54 became alert and oriented within 15 minutes. Resident #27 refused three times to have his room checked. Resident #27 was educated on the facility policy that no illicit substances could brought into the facility and he was educated on the importance of refraining from using illegal drugs. The physician was notified and updated. Further review of Resident #54's care plan revealed there was no care plan related to illegal drug use and/or interventions staff should implement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/16/24 at 12:16 P.M. with Clinical Registered Nurse (CRN) #121 revealed the police were contacted on 03/10/24 when the baggie was found in Resident #54's room. CRN #121 stated it was almost two months later on 05/04/24 the police returned to the facility and confirmed the substance found in Resident #54's room was fentanyl. CRN #121 shared Resident #54 had the right to refuse to have his room and person searched and to leave the facility. CRN #121 stated the facility was looking at alternative placement for Resident #54 but was unaware if the Ombudsman had been contacted for assistance for interventions and/or alternative placement. A joint interview on 05/16/24 at 1:54 P.M. with the Administrator and DON revealed Resident #54 had the right to refuse a room search and they were unable to restrict his right to leave the facility. It was shared referrals had been sent but all had been refused, they were unsure of the Ombudsman had been contacted for assistance. A second interview with CRN #121 at 4:42 P.M. verified there was not a care plan regarding Resident #54's possession of and/or risk of substance abuse. 2. Review of medical record for Resident #47 revealed admitted [DATE]. Diagnoses include Bipolar Disorder, anxiety and post-traumatic stress disorder. The resident remained. The quarterly MDS dated [DATE] revealed Resident #47 had a BIMS score of 13 indicating intact cognition. Resident #47 required one person assistance for toileting and supervision for eating. Review of medical record for Resident #74 revealed admitted [DATE]. Diagnoses include COPD and encephalopathy. The resident was discharged to the hospital on 05/12/24 and did not return to the facility. Review of Resident #47's progress notes dated 05/07/24 revealed the resident was placed on two hour vital checks after self-administering medication given by another resident. Interview on 05/16/24 at 9:39 A.M. with Resident #47 revealed he had been offered a breath mint by another resident (Resident #74) and he did take it. Resident #47 stated later the staff came into his room and informed him it was not breath mint, it was a pain pill. Resident #47 denied any effects or outcome from taking the medication. Resident #47 further shared staff came in and checked his vitals often for one day following the incident. A joint interview on 05/16/24 at 1:54 P.M. with the Administrator and DON revealed staff had informed the DON that Resident #74 had passed out medication to residents during a smoke break. They shared they confronted Resident #74 who consented to a search of her purse. The DON shared Percocet (pain) five milligram (mg) tablets were found along with other loose pills in the bottom of her purse. The Administrator and DON verified Percocet five mg that was found in Resident #74's purse were not prescribed by the facility. The police were contacted, and the medication was confiscated from Resident #74. The Administrator and DON confirmed Resident #47 was identified by Resident #74 as receiving the medication. The physician was notified, and orders were received to monitor him for effects and monitor his vitals every two hours for 24 hours. No outcome was noted. 3. Review of medical record for Resident #27 revealed admitted [DATE]. Diagnoses include epilepsy, dystonia, anxiety, and dementia. The resident remained in the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #27's quarterly Minimum Data Set (MDS) dated [DATE] revealed she/he required extensive two person assistance for bed mobility, transfers, and supervision for eating. A brief Interview Mental Status (BIMS) score of seven indicating severely impaired cognition. A care plan for risk of aspiration/pneumonia initiated 05/06/24 revealed interventions which included to monitor for signs and symptoms of aspiration: coughing, drooling, pocketing of food, food residual in mouth after meals, trouble chewing and or swallowing. Observation on 05/14/24 at 8:19 A.M. revealed Resident #27 was in bed with his breakfast tray in front of him. He was observed feeding himself, staff was observed passing trays at the opposite end of the hall. Observation on 05/14/24 at 12:24 P.M. revealed Resident #27 in his room, in bed with his lunch tray in front of him on the bedside table. Resident #27 was feeding himself, no spillage observed on his clothes. No staff were present in his room or in the hall. Interview on 05/14/24 at 2:26 P.M. with Therapy Director #111 revealed Resident #27 was able to feed himself but required supervision for safety due to dystonia (movement disorder causing muscles to involuntarily contract). Interview on 05/14/24 at 4:12 P.M. with State tested Nursing Assistant (STNA) #103 revealed there was miscommunication for room assignment on 05/14/24. Each of the two aids on the hall providing care for Resident #27 thought the other had been assigned to him. This deficiency represents non-compliance investigated under Complaint Numbers OH00153893, OH00153382 and OH00153743.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076 Based on record review, staff, physician and pharmacy staff interviews, the facility failed to ensure medications were administered as physician ordered. This affected two (#134 and #55) of three residents reviewed for medication administration. The facility census was 80. Findings include: 1. Review of medical record for Resident #134 revealed admitted [DATE]. Diagnoses include paraplegia and schizophrenia, depression and anxiety. Resident #134 remains in the facility. Review of Resident #134's annual Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition. Resident #134 required extensive two-person assistance for bed mobility, transfers and supervision for eating. Review of the physician orders revealed an order for Estrogens Conjugated Vaginal Cream 0.625 Milligrams/Gram. Insert 0.5 Grams vaginally one time a day for vaginal dryness. Review of medication administration record (MAR) and the progress note dated 04/14/24, 04/23/24, 04/25/24 and 05/13/24 documented Estrogens Conjugated Vaginal Cream was not given/administered to Resident #134 because it was unavailable. Interview on 05/16/24 at 12:42 P.M. with Pharmacy Staff #120 revealed a 30 day supply of Estrogens Conjugated Vaginal Cream was delivered to the facility on [DATE], 04/16/24 and 05/13/24. Interview on 05/16/24 at 1:54 P.M. with the Director of Nursing (DON) revealed Resident #134's Estrogen Conjugated Vaginal Cream was on the treatment cart and acknowledged agency staff may be unaware of its location so it was not administered as ordered. 2. Review of medical record for Resident #55 revealed admitted [DATE]. The resident was admitted with diagnoses including congestive heart failure, type two diabetes mellitus, and depression. Additional diagnosis added on 04/25/24 of aftercare following surgical amputation, left below the knee amputation and history of Methicillin Resistant Staphylococcus Aureus. Resident #55 remains in the facility. Review of Resident #55's admission MDS dated [DATE] revealed the resident had a BIMS score of 15 indicating intact cognition. Resident #55 required extensive two-person assistance for bed mobility, transfers, toileting and supervision for eating. Review of the progress note dated 02/26/24 at 1:02 P.M. revealed the visiting Nurse Practitioner was in during the morning and prescribed a new order for Doxycycline (antibiotic) 100 milligrams (mg) one capsule by mouth two times a day for left heel wound with foul odor, necrotic tissue for ten days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #55's February Medication Administration Record (MAR) revealed the Doxycycline was not given on 02/26/24 until the evening shift. Review of Resident #55's physician orders revealed an order for Doxycycline (antibiotic) 100 milligrams (mg) one capsule by mouth two times a day for left heel wound with foul odor, necrotic tissue for ten days. The documentation revealed the medication was listed as on hand. Interview on 05/15/24 at 9:51 A.M. Physician #117 acknowledged an antibiotic (Doxycycline 100 mg) had been ordered on 02/26/24. Physician #117 stated it would be his expectation the medication would be given if it was readily available at the facility or as soon as it came from the pharmacy. Interview on 05/15/24 at 12:38 P.M. with Pharmacist #118 revealed Doxycycline was readily available in the pyxis on 02/26/24 when it was ordered for Resident #55. Interview on 05/14/24 at approximately 3:12 P.M. with Clinical Registered Nurse (CRN) #121 revealed the evening time slot on the MAR for Resident #55 on 02/26/24 encompassed a 7:00 P.M. to 11:00 P.M. time block. CRN #121 further shared when reviewing Resident #55's MAR, the Doxycycline was given at 12:08 A.M. on 02/27/24. CRN #121 confirmed the Doxycycline was available in the facilities pyxis and could have been administered to Resident #55 sooner. This deficiency represents non-compliance investigated under Complaint Numbers OH00153893 and OH00153743. This deficiency represents ongoing noncompliance from the survey dated 04/25/24.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44076 Based on record review, observations and staff and resident interviews, the facility failed to provide meals per resident choice and per the facility planned menu. This affected three (#33, #55 and #70) out of three residents reviewed for meals and had the potential to affected 78 residents residing in the facility who receive their meals from the facility, the facility identified two residents (#47, #65) who receive nothing by mouth (NPO). Facility census was 80. Findings include: Review of the May 2024 Menu revealed the posted breakfast for 05/13/24 was cold cereal, hard boiled egg, bagel, fruit cup and two percent milk. Observation on 05/13/24 from 9:06 A.M. to 9:28 A.M. of three residents (#33, #55 and #70) breakfast trays revealed their tickets did not match what was served. Observation and interview on 05/13/24 at 9:06 A.M. revealed the breakfast ticket for Resident #70 was cold cereal, two hard boiled eggs, half bagel and half cup of fruit. Observation of the breakfast meal served was bacon, toast, two hard boiled eggs and a fruit cup. Observation and interview on 05/13/24 at 9:11 A.M. revealed the breakfast ticket for Resident #33 was for two cold cereals, two hard boiled eggs, a half of a bagel and a half cup of fruit. Observation of the breakfast served was bacon, two hard boiled eggs and toast. Resident #33 voiced concern she did not receive her cereal for breakfast and voiced frustration to the staff. Interview on 05/13/24 at 9:17 A.M. with State tested Nursing Assistant (STNA) #102 revealed a concern the meals provided often did not match the menus. STNA #102 stated the facility was out of milk that morning so the menu had to be changed. Observation and interview on 05/13/24 at 9:28 A.M. revealed the breakfast ticket for Resident #55 was for cold cereal, yogurt, cottage cheese, two hard boiled eggs, 1/2 bagel and a fruit cup. Observation of the breakfast served was two hard boiled eggs, bacon, oatmeal, yogurt and a fruit cup. Resident #33 voiced concern he often did not get what was on the menu or what he ordered. Interview on 05/14/24 at 10:24 A.M. with the Dietary Manager (DM) #108 verified the facility was out of milk on the morning of 05/13/24. DM #108 stated there was a delay with the delivery which was scheduled that morning. Observation and interview on 05/14/23 at 12:34 P.M. of the lunch tray for Resident #55 revealed a cheeseburger, extra lemonade and vegetable soup on the meal ticket had not been delivered. Resident #55 also acknowledged she did not contact the dietician prior to the substitutions of the breakfast meal. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview was made with DM #108 on 05/14/34 at 12:34 P.M. of the lunch ticket and meal of Resident #55. DM #108 shared the kitchen was out of vegetable soup and acknowledged staff did not inform her that Resident #55 wanted an alternative. DM #108 also verified the cheeseburger and extra lemonade was not provided as Resident #55 requested. The facility confirmed there are 78 residents residing in the facility that receive their meals from the facility, the facility identified two residents (#47, #65) who are NPO. This deficiency represents non-compliance investigated under Complaint Number OH00153743.