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	06/27/2024

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 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 46613 Based on personnel record review and staff interviews, the facility failed to ensure the activities program was directed by a qualified professional. This had the potential to affect all 79 residents residing in the facility. The facility census was 79. Findings include: Review of the personnel record for Activity Director (AD) #250 revealed a hire date of 06/20/23 as a housekeeper. The personnel record indicated AD #250 was promoted to Activity Director on 02/05/24. Review of AD #250's personnel record revealed no documentation to verify AD #250 had the appropriate training and/or education to hold the position of Activity Director. Interview on 06/24/24 at 4:09 P.M. with AD #250 confirmed she had been promoted from a housekeeper position to the Activity Director in February 2024. AD #250 stated worked as a nurse aide at an Assisted Living facility prior to her employment at the facility and assisted the residents at that facility with activities. AD #250 confirmed she had not received any education and/or training to be a qualified Activity Director. AD #250 stated she worked full time and completed resident assessments, care plans, attended care conferences, conducted Resident Council meetings, and completed monthly activity calendar. Interview on 06/25/24 at 2:54 P.M. with Senior Social Worker (SSW) #278 stated she was a regional employee who assisted AD #250. SSW #278 stated she had monthly calls with AD #250 to discuss the monthly activity calendar expectations, completed random audits of resident activity documentation to ensure the facility had captured activity participation, and completed random audits of resident charts to ensure admission and quarterly assessments were accurate. SSW #278 stated AD #250 would call her for guidance or suggestions for activities at the facility. SSW #278 stated she had worked as an Activity Assistant for two years in the past five years. SSW #278 stated AD #250 completed all resident activity assessments, MDS assessments, and updated the care plans. SSW #278 confirmed AD #250 was not a qualified Activity Director. This deficiency was based on incidental findings discovered during the course of this complaint investigation.

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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(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 - Actual harm Residents Affected - Few	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** 46613 Based on medical record review, review of hospital documentation, review of written statements, staff interviews, and policy review, the facility failed to provide adequate staff assistance during a bed bath resulting in an avoidable fall. This resulted in Actual Harm on 05/31/24 when State tested Nursing Assistant (STNA) #275 rolled Resident #70 away from her during a bed bath and the resident rolled out of bed onto the floor. Subsequently, Resident #70 was transferred to the Emergency Department (ED) for evaluation and treatment and required a suture to close a forehead laceration. This affected one (#70) of three residents reviewed for falls. The facility census was 79. Findings include: Review of the medical record for Resident #70 revealed an admitted [DATE]. Diagnoses included diabetes mellitus, malignant neoplasm of the brain, left hemiplegia, depression, and obesity. Review of a significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #70 was cognitively intact. Resident #70 was dependent upon staff for bathing, toileting, hygiene, and transfers and required substantial staff assistance for bed mobility. No falls were indicated on the MDS. Review of the quarterly Fall Risk assessment completed 05/02/24 indicated Resident #70 was at high risk for falls. Review of a nurse progress note dated 05/31/24 at 9:01 A.M. documented STNA #275 notified Licensed Practical Nurse (LPN) #205 that Resident #70 had rolled out of bed during a bed bath. The note further documented LPN #205 entered Resident #70's room and he was lying prone with his head turned towards the left and a puddle of bright red drainage was pooling under his face and head. The note indicated Resident #70 had a laceration to the left eyebrow and ice was applied. Staff called nine-one-one (911) and Resident #70 was transported out of the facility. Further review of the nurses' progress notes revealed an Interdisciplinary Team (IDT) note dated 06/03/24 at 11:43 A.M. indicated the IDT met to review Resident #70's fall on 05/31/24. The IDT note indicated the STNA alerted the nurse that Resident #70 had rolled out of bed during a bed bath, nurse entered Resident #70's room to see that he was lying prone on left side of bed with face towards the window. The note documented Resident #70 had no clothing on and no undergarment. Resident #70 was noted to have a nosebleed and small laceration to his forehead. Vital signs were assessed and neurological checks were initiated. The note stated the environment was well lit, and floor clean, dry, and free from debris prior to fall. The note continued to document Resident #70 reported he reached his arm around to scratch his back and accidentally rolled himself out of bed. Resident #70 was immobilized at bedside and 911 called. Resident #70 was transported to the ED for treatment. The physician and family were notified. The IDT note stated all scans completed in ED were negative for additional fall related injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record for Resident #70 revealed an ED note dated 05/31/24 which indicated Resident #70 was seen in the ED for a fall with closed head injury and facial laceration. Further review of Resident #70's medical record revealed the resident required a suture for the head laceration. Review of a written statement by STNA #275 dated 05/31/24 stated she had rolled Resident #70 onto his left side to wash his back. STNA #275's statement indicated Resident #70 attempted to scratch his back while on his left side and he started to move forward. STNA #275's statement stated she tried to roll Resident #70 on his back, but she was unable to prevent the fall from the bed. Interview on 06/25/24 at 11:10 A.M. with the Director of Nursing (DON) stated Resident #70 informed her he was scratching his back during a bed bath, and he lost his balance and rolled off the bed onto the floor. The DON confirmed one STNA (#275) had completed Resident #70's bed bath. The DON stated Resident #70 had brain cancer and the level of care he required for bathing, transfers, and toileting would vary from day to day. The DON confirmed Resident #70 was sent to the ED for a laceration to his forehead and received one suture. Interview on 06/25/24 at 2:45 P.M. with STNA #275 confirmed she was the STNA who gave Resident #70 a bed bath on 05/31/24 when he fell out of bed. STNA #275 stated Resident #70 was rolled onto his left side in the bed, and she was standing on the opposite side of the bed to wash his back. STNA #275 confirmed Resident #70 was facing away from her and that she was the only STNA who completed the bed bath. STNA #275 stated Resident #70's bed did not have grab bars. STNA #275 stated Resident #70 used his right hand to hold onto the mattress and bedframe while she washed his back. STNA #275 stated Resident #70 let go of the mattress and used his right hand to scratch an area on his back which caused Resident #70 to lose his balance and his shoulders fell off the bed. STNA #275 confirmed Resident #70 had left hemiplegia and was not able to use his left upper extremity to assist with bed mobility. STNA #275 stated she attempted to grab Resident #70's shoulders to prevent him from falling but she was not able to do so, and Resident #70 fell off the bed onto the floor. STNA #275 stated she immediately went to get nursing assistance for Resident #70 after the fall. STNA #275 stated she believed Resident #70 required two-person assistance for his bathing due to balance difficulties, confusion at times, and recent decline in health. STNA #275 stated she resigned and was no longer employed by the facility. Review of the facility policy titled, Fall-Clinical Protocol, review date of 06/08/22, revealed the facility would attempt to identify individuals with history of falls and risk factors for subsequent falls. The policy also stated based on the assessment, the staff and physician would identify pertinent interventions to try to prevent subsequent falls and address risks of serious consequences of falling. This deficiency represents non-compliance investigated under Complaint Numbers OH00154867 and OH00154371.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on medical record review, observations, staff and resident interviews, and policy review, the facility failed to ensure staff observed resident consume medications. This affected one (#20) out of four residents reviewed for medication administration. The facility census was 79. Findings include: Review of the medical record for Resident #20 revealed an admitted [DATE] with medical diagnoses of urinary tract infection, sepsis, diabetes mellitus, diabetes mellitus, hypothyroidism, and congestive heart failure. Review of the medical record for Resident #20 revealed an admission Minimum Data Set (MDS) assessment dated [DATE] which indicated Resident #20 was cognitively intact. The MDS indicated Resident #20 was dependent upon staff for toilet hygiene and bathing and required substantial staff assistance with bed mobility. Review of the medical record for Resident #20 revealed physician orders dated 06/19/24 for hydralazine 50 milligram (mg) one tablet by mouth three times per day and levothyroxine 200 microgram one tablet daily. Further review of Resident #20's medical record revealed there were no orders, assessment or further instructions allowing the resident to self-administer medications. Observation with interview on 06/25/24 at 8:16 A.M. of Resident #20 revealed a medication cup with two medication tablets inside sitting on Resident #20's bedside table. Resident #20 stated the nurse brought the medications in his room earlier that morning and he hadn't taken them yet. Resident #20 stated he did not know what medications were in the cup. Observation with interview on 06/25/24 at 8:20 A.M. with Assistant Director of Nursing (ADON) #268 confirmed there were two medication tablets sitting in a medication cup on Resident #20's bedside table. ADON #268 brought the medication cup to the medication cart and reviewed Resident #20's list of medications. ADON #268 stated the medications in the cup were levothyroxine and hydralazine which were to be administered at 6:00 A.M. Review of the facility policy titled, Preparation and Guidelines for Medication Administration, revised November 2021, stated medications are to be administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The policy also stated the resident is always observed after the administration of medication to ensure that the dose was completely ingested. This deficiency was based on incidental findings discovered during the course of this complaint investigation.