

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365640	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Legacy Miamisburg		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303</p> <p>Based on medical record review, staff interview, and review of facility policy, the facility failed to ensure a resident was free from unnecessary psychotropic medications by ensuring the resident was on the lowest ordered dose of an antipsychotic. This affected one (#4) of three residents reviewed for psychoactive medications. The census was 82.</p> <p>Findings include:</p> <p>Review of Resident #4's medical record revealed an admitted [DATE]. Diagnoses listed included cerebral palsy, schizoid disorder, anxiety disorder, depression, and pseudobulbar affect.</p> <p>Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 was cognitively intact.</p> <p>Review of physician orders revealed an order dated 07/25/24 for Olanzapine (antipsychotic) 10 milligrams (mg) give one tablet by mouth at bedtime for Schizoaffective disorder. An order dated 09/05/24 was for Olanzapine 10 mg give one tablet by mouth at bedtime.</p> <p>Review of outpatient psychiatry notes revealed Olanzapine was increased to 20 mg at bedtime for auditory verbal hallucinations.</p> <p>Review of written physician orders revealed and order transcribed dated 09/04/24 for Olanzapine 20 mg give one tablet by mouth at bedtime.</p> <p>Review of medication administration records (MAR) revealed Resident #4 had received both Olanzapine 10 mg and Olanzapine 20 mg at bedtime since 09/05/24 for a total of 30 mg dose.</p> <p>Interview with Clinical Services Manager (CSM) #220 on 09/26/24 at 11:03 A.M. confirmed Olanzapine was ordered to be increased to 20 mg on 09/04/24 for Resident #4. CSM #220 confirmed Resident #4 had received Olanzapine 10 mg and Olanzapine 20 mg for a total of 30 mg at bedtime since 09/05/24. CSM #220 confirmed Olanzapine 10 mg should have been discontinued when Olanzapine 20 mg was ordered.</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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled Chemical Restraint Use dated 11/30/23 revealed psychotropic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157578.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303</p> <p>Based on medical record review, observation, resident and staff interviews, and review of facility policy, the facility failed to ensure medications were observed taken by residents and not left at the bedside. This affected one (#3) of three residents reviewed for medication administration. The census was 82.</p> <p>Findings include:</p> <p>Review of Resident #3's medical record reviewed an admitted [DATE]. Diagnoses listed included displaced comminuted fracture of the left tibia, injury of the popliteal artery, comminuted fracture of the left fibula, and asthma.</p> <p>Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was cognitively intact.</p> <p>Observation on 09/25/24 at 1:58 P.M. revealed five pills in a medication cup sitting on a bedside table. Interview with Resident #3 during the observation revealed his nurse had left them for home to take.</p> <p>Interview with Registered Nurse (RN) #100 on 09/25/24 at 2:01 P.M. confirmed she had left pills at Resident #3 bedside to take. RN #100 confirmed she did not observe Resident #3 take the medications. RN #100 identified the medications as Tylenol (two tablets), gabapentin, Clindamycin (antibiotic), and Oxycodone (narcotic pain medication).</p> <p>Review of medication administration records (MAR) revealed Tylenol 500 milligrams (mg) two tablets, gabapentin 300 mg on tablet, Clindamycin 300 mg one tablet, and Oxycodone 10 mg one tablet were documented as being administered by RN #100 on 09/25/24. Further review of Resident #3's medical record revealed there was no physician order, care plan, or other documentation permitting the resident to self administer medications.</p> <p>Interview with Clinical Services Manager (CSM) #220 and CSM #200 on 09/25/24 at 2:35 P.M. confirmed that RN #100 left medications including Oxycodone. CSM #220 and CSM #200 confirmed nurse should watch residents take there medications and not leave them at the bedside.</p> <p>Review of the facility policy dated Medication Administration-General Guidelines dated revised December 2019 revealed medications are administered without unnecessary interruptions. The resident is always observed after administration to ensure the dose completely ingested. If a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157578.</p>		