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	12/30/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44412 Based on observation, medical record review, staff interviews, resident interview, and review of facility policy, the facility failed to administer medications in a timely manner. This affected four (Residents #29, #73, #10, and #44) of four residents reviewed for medication administration. The facility census was 73. Findings include: 1. Review of the medical record for Resident #29 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, Chronic Obstructive Pulmonary Disease (COPD), and DM II. Review of the admission MDS assessment dated [DATE] revealed Resident #29 had intact cognition as evidenced by a BIMS score of 13. The resident was assessed to require supervision with eating, partial assistance with toileting, bathing, dressing, and transfers. Review of the Medication Administration Record (MAR) revealed medications ordered for the morning. Observation on 12/23/24 at 12:14 P.M. revealed Registered Nurse (RN) #30 administered morning medications to Resident #29. Interview on 12/23/24 at 12:20 P.M. with Registered Nurse (RN) #30 revealed she was administering Resident #29's morning medications after 12:00 P.M. 2. Review of the medical record for Resident #73 revealed an admitted [DATE] with a readmission on 10/24/24. Diagnoses included DM II, Congestive Heart Failure (CHF), and chronic kidney disease stage four. Review of the MDS assessment dated [DATE] revealed Resident #73 had intact cognition as evidenced by a BIMS score of 14. This resident was assessed to require setup with eating, partial assistance with toileting and transfers, dependent with bathing, and substantial assistance with dressing. Review of the MAR revealed medications ordered for the morning. Interview on 12/24/24 at 11:37 A.M. with Resident #73 revealed he had not received his morning medications yet. (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/24/24 at 12:03 P.M. with Assistant Director of Nursing (ADON) verified she was still administering morning medications related to staffing issues and had not administered morning medications to Resident #73. Observation on 12/24/24 at 12:07 P.M. revealed ADON administered medications to Resident #73. 3. Review of the medical record for Resident #10 revealed an admitted [DATE]. Diagnoses included Chronic Obstructive Pulmonary Disease (COPD), generalized anxiety disorder, major depressive disorder, and convulsions. Review of the annual MDS assessment dated [DATE] revealed Resident #10 had intact cognition as evidenced by a BIMS score of 13. The resident was assessed to require setup with eating, dependent with toileting and dressing, and substantial assistance with bathing. Review of the physician order dated 07/13/24 revealed Resident #10 was ordered Morphine Sulfate Extended-Release (ER) Oral tablet 30 milligrams (mg), give one tablet by mouth two times a day for pain. Review of the MAR dated December 2024 revealed Resident #10 was not given Morphine Sulfate 30 mg as ordered per physician orders on 12/14/24 through 12/16/24. Review of the controlled drug record dated December 2024 revealed Resident #10 was not given the following doses of Morphine ER 30 mg per physician orders: evening dose on 12/14/24, morning dose on 12/15/24, and morning and evening dose on 12/16/24. Interview on 12/24/24 with Resident #10 revealed she was not getting her medications as ordered. Resident #10 reported they are always out of one of her medications. Interview on 12/30/24 with Regional Nurse (RN) #80 verified Resident #10 was not given Morphine ER 30 mg from 12/14/24 through 12/16/24 as ordered. 4. Review of the medical record for Resident #44 revealed an admitted [DATE]. Diagnoses included bipolar disorder, Attention Deficit Hyperactivity Disorder (ADHD), and peripheral vascular disease. Review of the quarterly MDS assessment dated [DATE] revealed Resident #44 had intact cognition as evidenced by a BIMS score of 13. The resident was assessed to be independent with eating and required supervision with toileting, bathing, dressing, and transfers. Review of the physician order dated 08/22/24 revealed Resident #44 was ordered Oxycodone oral tablet 10 mg, give one tablet by mouth every six hours as needed. Review of the MAR dated November and December 2024 revealed Resident #44 did not receive Oxycodone from 11/28/24 through 12/06/24. Review of the controlled drug record dated November and December 2024 revealed Resident #44 received a dose of Oxycodone 11/28/24 at 9:30 P.M. and did not receive another dose until 12/07/24 at 9:30 P.M. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/23/24 at 11:51 A.M. with Resident #44 reported the facility did not have her Oxycodone available for about a week about three weeks ago. Interview on 12/30/24 with RN #80 verified Resident #44 did not receive any Oxycodone from the pharmacy from 11/28/24 through 12/06/24. RN #80 verified Oxycodone was not pulled from the Pyxis (facility supply of medication) to be given to Resident #44 during that time frame. Review of the facility policy titled, Administering Medications, revised April 2019 revealed medications were administered in a safe and timely manner, and as prescribed. Medications were administered in accordance with the prescriber orders, including any required time frame. This deficiency represents non-compliance investigated under Complaint Number OH00160232.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on review of the medical record, observations, interviews, and policy review, the facility failed to ensure medications were administered per physician orders. There were two medication errors out of 37 opportunities resulting in a 5.4 percent medication error rate. This affected one (Resident #14) of three residents observed for medication administration. The facility census was 73. Findings include: 1. Review of the medical record for Resident #14 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, type two Diabetes Mellitus (DM II), and atrial fibrillation. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of three. The resident was assessed to require setup with eating, toileting, bathing, dressing, and independent with transfers. Review of the physician order dated 09/13/24 revealed Resident #14 was ordered K-Phos Oral tablet 500 milligrams (mg), give 250 mg by mouth three times a day for supplement. Review of the physician order dated 09/13/24 revealed Resident #14 was ordered Potassium Chloride 20 milliequivalents (mEq) Extended-Release (ER), give 20 mEq by mouth one time a day for hypokalemia. Observation on 12/23/24 at 9:20 A.M. revealed Licensed Practical Nurse (LPN) #21 crushed Potassium Chloride ER 20 mEq and administered to Resident #14. Observation also revealed K-phosphate was not administered because the packaging did not have a dose present. Interview on 12/23/24 at 9:25 A.M. with Licensed Practical Nurse (LPN) #21 verified she crushed Potassium Chloride ER for medication administration to Resident #14. LPN #21 also verified she did not administer K-Phosphate because there was not a dose present on the packaging. Interview on 12/30/24 at 9:30 A.M. with the Regional Nurse (RN) #80 verified potassium extended release should not be crushed. Review of Medscape revealed do not crush or chew extended release capsules or tablets due to release of all the drug at once, which increases the risk of side effects. This deficiency represents non-compliance investigated under Complaint Number OH00160232.