STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365780	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Marietta	5001 State Route 60 Marietta, OH 45750

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 07316 Based on resident interview, staff interview, and policy review, the facility failed to ensure residents were treated with respect and dignity. This affected four of 50 records reviewed (Residents #13, #25, #37, and #54). The facility census was 65. Findings include: 1. Interview with Resident #13 on 03/27/24 at 9:40 A.M. revealed she hears staff arguing in the hallway. She heard a nursing assistant say you need to get your ass back there and do your job. She stated staff use the F word in the hall and staff are always on their cell phones. She stated she hears staff being reprimanded in the halls and stated residents should not have to hear these kinds of things. 2. Interview with Resident #54 on 03/27/24 at 10:50 A.M. revealed he hears nursing assistants arguing in the halls. He stated it has happened at different times and was disturbing to him. 3. Interview with Resident #37 on 03/27/24 at 11:00 A.M. revealed she has heard staff yelling in the hall things like that's your job. She stated she does not like hearing that. 4. Interview with Resident #25 on 03/27/24 at 10:33 A.M. revealed nursing assistants will say to him that they are stressed out and have a lot of work to do. He said then they will quit. 5. Interview with Nursing Assistant #117 on 03/28/24 at 11:00 P.M. confirmed he/she had heard staff argue in the resident hallways. Review of the facility policy titled Resident Rights and Facility Responsibilities (dated 10/24/23) revealed residents have the right to be treated at all times with courtesy, respect, and full recognition of dignity and individuality. This deficiency represents non-compliance investigated under Complaint Number OH00151794.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observation, resident interview, staff interview, policy review, and record review, the facility failed to ensure residents had the right to choose bathing schedules consistent with their interests. This affected two of 50 records reviewed (Residents #1 and #41). The facility census was 65. Findings include: 1. Review of the medical record for Resident #1 revealed an admitted [DATE]. Review of a Minimum Data Set (MDS) assessment completed 01/16/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Review of the plan of care dated 01/30/24 revealed the resident preferred staff help with set up for bathing and then help with certain parts. The resident preferred a shower on Wednesday and Saturday. Interview with Certified Nurse Practitioner (CNP) #104 on 04/01/24 at 8:15 A.M. revealed Resident #1 had voiced concerns to her about not getting timely showers. She stated he was ready at 6:30 A.M. and still had not gotten a shower at 11:00 A.M. a week or so ago. Interview with Resident #1 on 04/03/24 at 7:15 A.M. revealed he has issues with getting timely showers. He said staff will say they will be right back and then do not come back. He said you may be supposed to get one on a certain day then it may be the next day before you actually get it. 2. Review of the medical record for Resident #41 revealed an admitted [DATE]. Review of a MDS assessment completed 01/25/24 revealed a BIMS score of 13, indicating intact cognition. It further stated the resident was dependent upon staff for showers. During observation of Resident #41's dressing changes with the wound nurse practitioner on 03/27/24 at 2:00 P.M., Resident #41 stated that staff had came to his room at 4:30 A.M. to give him a bed bath. On 03/28/24 at 8:28 A.M. Resident #41 stated he preferred to be bathed later in the morning, not 4:30 A.M. like they did the other day. Review of bathing records for Resident #41 revealed on 03/13/24 a bed bath was documented as completed at 4:19 A.M. Interview with Nursing Assistant #117 on 03/28/24 at 11:00 P.M. revealed there are not enough staff to get showers done at the scheduled times. He/she stated for the 7:00 P.M. to 7:00 A.M. shift staff do not have a chance to even do showers until 11:00 P.M. to 12:00 A.M. He/she stated residents do not like it. Interview with Nursing Assistant #201 on 03/29/24 at 12:15 A.M. revealed there are not enough staff to get showers done at the scheduled times. He/she stated he/she has had to do showers at times residents don't want them but the residents know if they don't take them at that time, they won't get one. (continued on next page)

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Legacy Marietta	5001 State Route 60 Marietta, OH 45750

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on 04/01/24 at 10:25 A.M. revealed Resident #41's shower/bathing was scheduled on Tuesday and Friday on the 7:00 P.M. to 7:00 A.M. shift. She confirmed a bed bath was documented on 03/13/24 at 4:19 A.M. When asked by the surveyor if staff should be bathing residents at 4:19 A.M. if that is not their preference, the Director of Nursing refused to answer the question. Review of the facility policy titled Resident Rights and Facility Responsibilities (dated 10/24/23) revealed residents have the right to choose activities and schedules. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295 and Complaint Number OH00151794.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on medical record review, staff interview, and policy review, the facility failed to develop policies and procedures regarding advance directives and failed to ensure a procedure was in place to effectively implement a resident's advance directives. This affected one (Resident #80) of 50 residents records reviewed but had the potential to affect all 65 residents. Findings include: Review of the closed medical record for Resident #80 revealed an admitted [DATE] with diagnoses including diabetes mellitus, acute kidney failure, acute respiratory failure, pulmonary embolism, and cellulitis. Review of an acute care hospital discharge summary dated [DATE] revealed the resident had been admitted to the hospital on [DATE]. She presented to the emergency department with complaints of generalized weakness and a fall on [DATE]. During her stay she had low blood pressure which improved with intravenous fluids and holding of all antihypertensive therapy. It stated her blood pressure was then stable on discharge. Review of an admission nursing assessment dated [DATE] revealed Resident #80 was admitted to the facility at 5:05 P.M. A baseline care plan on admission stated the primary medical reason for admission was diabetes and atrial fibrillation. The goal was to manage or improve medical status. The resident had a physician's order dated [DATE] for DNRCC-Arrest (Do not resuscitate Comfort Care-Arrest). (This is an order given by the physician that has allowed a resident to make their choice regarding resuscitation in the event of an emergency. DNRCC-Arrest means the resident chose not to be resuscitated in the event of cardiac or respiratory arrest). Review of a Minimum Data Set assessment completed [DATE] revealed Resident #80 had a brief interview for mental status score of 13, indicating intact cognition. Review of a progress note dated [DATE] by Certified Nurse Practitioner (CNP) #104 revealed the resident had hypotension during her hospitalization and was not able to be on beta-blockers and all blood pressure medications were stopped. She is alert and oriented. Blood pressure was ,d+[DATE] on last check. We will check blood pressure and heart rate every shift (facility has two shifts: 7:00 A.M. to 7:00 P.M. and 7:00 P.M. to 7:00 A.M.) and then we will do orthostatic lying, sitting, and standing blood pressure and heart rate every morning for five days and notify providers if systolic drops more than 10 mmHg. (Orthostatic blood pressures check for drops in blood pressure when going from lying or sitting to standing). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a nursing progress note for Resident #80 by Registered Nurse (RN) #131 on [DATE] at 12:50 A.M. revealed the nursing assistant came to the nurse and stated she did not think the resident was breathing. RN #131 went to the room and listened to her heart. No respirations or heart beat was noted. The note stated that, even though Point Click Care (PCC) (the electronic medical record system) stated the resident was a DNRCC-A, there were no signed papers to indicate such once the chart was checked. The physician was notified, Cardiopulmonary resuscitation (CPR) was initiated, and 911 was called. The responders took over CPR when they arrived but CPR was stopped at 1:15 A.M. upon orders from the hospital emergency physician. Resident #80 expired at that time at the facility. The noted stated the resident's power of attorney arrived at 1:25 A.M. after CPR had been stopped and provided copies of a living will which was now on the chart. Interview with RN #131 on [DATE] at 5:18 P.M. revealed she did not know a lot about Resident #80 on the night of [DATE]. She stated, when the nursing assistant came to her and said she did not think the resident was breathing, she was not sure what the resident's code status was. (Resuscitate or do not resuscitate). She stated she did see the physician's order for DNRCC-Arrest but there was no paper available with the written order by the physician. She stated she always checks for the written paper and makes sure it matches the order that is in the electronic medical record. She stated the paper with the written order should have been in the chart. She stated she texted the physician and asked her what to do. The physician stated if there was no paper with a signed order for DNRCC-Arrest, then start CPR. She stated CPR was started and 911 was called. When the emergency personnel arrived, they took over CPR. She stated facility staff called the resident's family and they stated the resident was not to be resuscitated and they would bring in copies of her living will. (A living will is a legal document that lets a competent adult specify what health care they want or do not want when he or she becomes terminally ill or permanently unconscious and can no longer make their wishes known). The emergency personnel stopped CPR at the facility and the resident expired. She stated the family then brought in copies of her living will. Upon record review on [DATE], the facility now had copies of a living will and durable power of attorney for health care form signed by Resident #80 on [DATE]. Interview with Certified Nurse Practitioner (CNP) #104 on [DATE] at 2:00 P.M. revealed if a resident has a DNRCC-Arrest order in the electronic medical record, then there should be a paper signed by the physician to verify the order. She stated staff should not do CPR if a resident wished to be a DNRCC-Arrest. Interview with Director of Nursing (DON) #147 on [DATE] at 7:20 A.M. revealed when a resident is admitted , they or their family are asked what advance directives they wish, including code status. She stated if the resident wishes to be a DNR (do not resuscitate) then the physician fills out a DNR form and signs it. There is also a physician's order for DNR added to the electronic medical record under physician's orders. She stated the form signed by the physician should be scanned into the medical record so the nurses have access to it in the case of an emergency. She confirmed Resident #80 had a physician's order for DNRCC-Arrest in the electronic medical record but she did not know where the written paper for DNR by the physician was located and it had not been scanned into the record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Director of Nursing #147 on [DATE] at 8:25 A.M. revealed the facility did not have a policy or procedure on advance directives to include items such as determining on admission whether a resident has an advance directive and, if not, determining whether the resident wishes to formulate an advance directive; establishing mechanisms for documenting and communicating the resident's choice to the interdisciplinary team and to staff responsible for the resident's care; and obtaining copies of advance directive documents and maintaining them in the resident's medical record readily retrievable by any facility staff. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, interview, and policy review the facility failed to ensure resident/responsibility parties were notified timely of changes in resident treatment and changes in condition. This affected four residents (Resident #4, #24, #31, and #44) of 36 records reviewed for quality of care. Findings included: 1. Record review revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus, heart disease, malignant neoplasm of part of the lung, acquired absence of the lung, age-related physical disability, and neuropathy. Review of Resident #44's Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed the resident BIMS was 15 out of 15 (cognition intact). Review of Resident #44 paper orders dated 03/25/24 revealed new orders for discharge planning for this Friday, hemoglobin, and hematocrit (H/H) daily for four days, Carafate (prevent/treat ulcers) 1 gram twice daily for 14 days, and Gabapentin 100 milligram (mg) three times a day for neuropathy. The order was signed off by a nurse on 03/26/24 at 12:45 A.M., however there was no documented evidence the resident and family were notified. Review of Resident #44's medical record revealed no evidence the resident/family was notified of new orders written on 03/25/24. Interview on 03/26/24 at 1:06 P.M. and 03/27/24 at 4:14 P.M., with Resident #44 and his wife revealed they were not notified the Certified Nurse Practitioner (CNP) had written orders on 03/25/24. The resident wife reported one of her concerns with the facility was staff didn't update them on new orders or test results. Interview on 03/27/24 at 4:18 P.M. with Licensed Practical Nurse (LPN) #129 confirmed there was no evidence Resident #44, or his wife was notified of the new orders written on 03/25/24. LPN #129 reported she was unaware the resident was not updated on new orders written on 03/25/24 and she spoke to them today regarding the orders and they were understanding. Interview on 03/28/24 at 8:15 A.M., with Resident #44's wife and review of Resident #44's orders written 03/11/24 to 03/28/24 with the Resident #44's wife revealed she was not notified of orders for neurology consult, cardiologist consult, electromyography (EMG), or kidney, ureter, and bladder (KUB) x-ray. The Resident's wife reported they don't tell her anything and she stays at the facility almost all day except for a few hours and she has been staying all night with her husband. 07316 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the medical record for Resident #24 revealed an admitted [DATE]. Review of a physician history and physical on 03/22/24 revealed the resident was admitted from the hospital. He had complications of pneumonia suspected to be aspiration in nature. He is at the facility for rehab. Review of a physician progress note on 03/28/24 revealed the resident was being seen because he wanted to go outside and smoke. Is on oxygen. He understands the risks of smoking yet still wants to. He has completed his antibiotics. Will do a follow up chest xray on the pneumonia as well as the congestive heart failure. Record review revealed a chest xray was completed on 03/29/24 which showed acute right posterior basilar pneumonia. There was no evidence the physician was notified of the results until 04/01/24 (3 days later). Review of a physician progress note on 04/01/24 revealed the chest xray on 03/29/24 for follow up did show acute pneumonia in the right lower lobe, which is consistent with what he had. The note indicated it might be residual from previous pneumonia but will do a follow up chest xray in another five days. Will continue to monitor his temperature as well as do some additional blood work. Review of the facility policy titled Change in Resident Condition (dated 11/30/23) revealed the nurse will notify the resident's physician when there has been a change in resident condition. (The policy did not specify what constituted a change in condition). Interview with Director of Nursing (DON) #147 on 04/08/24 at 1:40 P.M. confirmed there was no evidence the physician was notified of the chest xray results of 03/29/24 showing pneumonia until 04/01/24. 3. Review of the medical record for Resident #4 revealed an admitted [DATE]. Review of a nursing progress note dated 01/30/24 at 11:30 A.M. revealed the nurse was called to the dining room. Upon arrival, another nurse was giving Resident #4 the Heimlich maneuver. The resident had been eating lunch right before. After the successful Heimlich, the resident spit up food and a large amount of phelgm. On 01/30/24 at 1:51 P.M. it was noted the resident's diet was changed to pureed. It was documented that all respective parties were notified (but did not specify who was notified). Review of the facility policy titled Change in Resident Condition (dated 11/30/23) revealed the nurse will notify the resident's physician when there has been a change in resident condition. (The policy did not specify what constituted a change in condition). The policy further stated, unless otherwise instructed, the nurse will notify the resident's family or representative. Interview with Assistant Director of Nursing (ADON) #128 on 03/27/24 at 9:00 A.M. confirmed that documenting all respective parties notified did not given a clear indication of who was notified. 4. Review of the medical record for Resident #31 revealed an admitted [DATE]. Review of nursing progress notes revealed on 02/06/24 at 3:13 P.M. the nurse documented there were new physician's orders to obtain blood work (CBC and BMP) today if possible. The nurse documented that all respective parties were notified (but did not specify who was notified). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Change in Resident Condition (dated 11/30/23) revealed the nurse will notify the resident's physician when there has been a change in resident condition. (The policy did not specify what constituted a change in condition). The policy further stated, unless otherwise instructed, the nurse will notify the resident's family or representative. Interview with Assistant Director of Nursing (ADON) #128 on 03/27/24 at 9:00 A.M. confirmed that documenting all respective parties notified did not given a clear indication of who was notified. This deficiency represents non-compliance investigated under Complaint Number OH00151794.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 07316 Based on observations, resident interview, staff interview, and policy review, the facility failed to ensure a resident was provided with personal privacy. This affected one resident (#13) of 65 residents in the facility. Findings include: Observations on 03/27/24 at 9:40 A.M. revealed the surveyor was in Resident #13's room conducting an interview with the door shut. During the interview, Housekeeper #138 entered Resident #13's room without knocking. Resident #13 stated, at that time, that staff only knock on her closed door about half the time. She stated it bothered her as she could be sitting there with no clothes on. Interview with Housekeeping/Laundry Supervisor #162 on 03/27/24 at 10:20 A.M. confirmed staff should knock before entering a resident's room with the door closed. Interview with Housekeeper #138 on 03/27/24 at 10:22 A.M. revealed she sometimes forgets to knock before entering a resident's room where the door is closed. Review of the facility policy titled Resident Rights (dated 11/30/23) revealed the facility will take measures to ensure that each resident has the right to personal privacy. Personal privacy includes medical treatment, personal care, visits, and meetings of family and resident groups. This deficiency represents non-compliance investigated under Complaint Number OH00151794.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on family interview, staff interview, review of grievance forms, record review, and policy review, the facility failed to make prompt efforts to resolve resident grievances. This affected two residents (Residents #44 and #50) of 50 records reviewed. The facility census was 65. Findings include: 1. Review of the medical record for Resident #50 revealed an admitted [DATE]. Review of a Minimum Data Set assessment completed 03/15/24 revealed a Brief Interview for Mental Status score of 15, indicating intact cognition. The assessment further stated the resident was incontinent of bowel and bladder, required substantial/maximal assistance with toileting,and partial/moderate assistance with rolling left to right on the bed. The resident was not identified to have any pressure areas. The plan of care dated 12/28/23 stated the resident was incontinent of bowel and bladder. Interventions included check for wetness before and after meals, at bed time, and on rounds during the night. If continent, offer to assist with toileting. If incontinent, provide incontinence care. Review of a resident/family concern/grievance form dated 03/11/24 revealed Director of Nursing (DON) #147 reported a concern to Social Services #159 from Resident #50's daughter. The family member stated that Resident #50 was not checked on, changed, or rotated from 03/09/24 at 11:00 P.M. until 03/10/24 at 1:00 P. M. Family member was also concerned that wash rags were not being used during care. Family stated chux not being used. Family member also stated resident was having difficulty feeding herself. The plan of action stated that the Director of Nursing was to check in on the resident two times daily for two weeks to ensure proper care was occurring. The plan of action was signed by the Director of Nursing. Under resolution it stated the Director of Nursing to talk with staff and the family. The date of the concern resolution was 03/11/24. Family member notified on 03/11/24. The administrator had signed the form on 03/11/24. Interview with Resident #50's family member who filed the concern/grievance form on 04/01/24 at 3:30 P.M. revealed the resident had been left incontinent for 14 hours and was not changed. They don't wash the urine off after incontinence. Resident #50's brother came in on 03/11/24 and the mattress was soaked in urine. They were out of chux (incontinent pads). Resident #50 has a history of pressure ulcers and she does not want her to get another one. She stated she does not feel the issues were rectified. She stated the resident had gone 12 hours after that without being changed. She stated she had not spoken with the Director of Nursing after the initial report. Interview with Resident #50 on 04/02/24 at 7:45 A.M. revealed she goes to bed between 10:30-11:00 P.M. She stated the staff do not check her for incontinence until around 5:30 A.M. She stated she was wet right now and had not been changed since she went to bed. (The resident was observed in bed with her breakfast tray). (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reported to staff that Resident #50 indicated she had been incontinent. On 04/02/24 at 8:00 A. M. Nursing Assistant #209 came to Resident #50's room. Nursing Assistant #209 stated she did not know when the resident was changed last. She stated she had come on duty at 7:00 A.M. Incontinence care was provided. The resident's incontinent brief was observed to be wet which was confirmed by Nursing Assistant #209. Resident #50 was observed to have a small red area on the left inner buttock. Licensed Practical Nurse (LPN) #150 entered the room during the care and stated she would notify the physician of the red area and would obtain an order for a dressing to prevent pressure. Interview with LPN #150 on 04/02/24 at 8:40 A.M. revealed she came into the room during incontinence care because she had overheard an aide on night shift say that the resident's bottom was hurting so she came in to see. Review of the facility policy titled Investigating Grievances/concerns (dated 08/08/22) revealed the facility investigates all grievances/concerns filed with the facility. The Administrator will assign the responsibility of investigating grievances and concerns to appropriate department. Upon receiving a grievance/concern report, appropriate department will begin an investigation into the allegations. The resident or person acting on behalf of the resident will be informed of the findings of the investigation, as well as any corrective actions recommended, within five working days of the filing of the grievance. Interview with Director of Nursing #147 on 04/01/24 at 3:40 P.M. revealed she had checked on the resident daily (not twice per day per the grievance form) but had not documented any findings. She further confirmed she had not spoken with the resident's family since the concern was voiced. 32801 2. Record review revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus, heart disease, malignant neoplasm of part of the lung, acquired absence of the lung, age-related physical disability, and neuropathy. Review of Resident #44's Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed the resident BIMS was 15 out of 15 (cognition intact). Review of Resident #44's progress note dated 03/17/24 revealed the State tested Nurse's Aide (STNA) #108 went into change the resident and his wife was lying across the bed holding the urinal for the resident. STNA #108 left room and proceeded to pass water to 300 hall and then returned to the resident's room to change the resident. At that point, resident's wife (who had been here all night), told STNA #108 that this would be her last night working at this facility. Resident's wife then said she knows how many residents were in the facility and how many nurses and aides were working this evening. Review of the concern log dated 03/2024 revealed no evidence Resident #44's wife's concern were addressed. Interview on 03/26/24 at 1:06 P.M., with Resident #44 and his wife revealed the facility doesn't address concerns timely. They have voiced concerns regarding staffing. (continued on next page)

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	365780	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Marietta	5001 State Route 60 Marietta, OH 45750

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/01/24 at 8:53 A.M. with the Director of Nursing (DON) revealed there was no evidence the facility followed up with Resident #44's wife's concerns that were documented in the resident's medical record on 03/17/24 regarding staffing. The DON reported the social worker was calling the wife now, due the resident was discharged home on Friday. This deficiency represents non-compliance investigated under Complaint Number OH00151794.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47569 Based on observation, review of facility billing/financial information, review of the Facility Assessment, facility policy review and interview the facility neglected to operate in a manner to ensure all bills were being paid in a timely manner to prevent potential interruption in services. This had the potential to affect all 65 residents residing in the facility. Findings Include: On 03/27/24 at 1:57 PM an interview with Medical Records #157 revealed she was also responsible for paying vendors. During the interview, Medical Records #157 revealed the facility was behind on bills, however historically when they would receive a shut off notice the company would pay the bill to avoid disruption of services. No bills were paid in January 2024 due to two upper management staff having quit leaving no one to approve the bills. Currently the septic company who does the grease traps would not return due to non-payment and TCL transportation company would not provide service as the facility owed them money. The transportation company wanted paid every 30 days and the facility would only pay vendors every 90 days. On 04/03/24 at 11:45 A.M., an interview with the Administrator revealed Medical Records (MR) #157 was also the facility's accounts payable (AP) clerk. She received the various invoices and would upload them into the AP system for the administrator to approve and send on to the corporate AP office. The Administrator revealed if the facility were to receive a shut off notice or an overdue notice, it would be sent up to the corporate office using the same system. Legacy Health Services uses a third-party vendor (Engie) to pay the utility bills for the company. If there were to be a shut off notice or overdue invoice the facility may not receive those due to the third-party vendor involvement. On 04/03/24 at 3:52 P.M. an interview with Legacy Health Services Director - Accounts Payable (AP) revealed the corporate AP office receives invoices from the facility for review and approval for payment. Vendor payments were sent out weekly via paper bank checks. If the facility received a shut off notice or a delinquent account notice, the facility AP clerk would communicate with the corporate AP office and process the notice. The corporate AP office would review the account in question for any missed invoices or lack of processing the original invoice, and then would contact the vendor and make the payment immediately via a corporate credit card so there was no interruption of services to the facility. If a delinquent account required a payment plan agreement between Legacy Health Services and the vendor, the Chief Financial Officer (CFO), the Controller, and the legal department would be involved with the payment plan development with the vendor which was requesting the payment plan. Although there was no evidence of any current shut-off notices for services at the time of the investigation, the risk for notice or interruption of services was identified. The facility failed to provide evidence of fund availability and systems in place to ensure bills/invoices were paid timely and as due. Review of the following vendor/suppliers invoices/billing documentation and interviews completed as part of the State agency investigation revealed the following facility financial solvency concerns: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. Review of the facility's vendor aging report dated 03/15/24 revealed an outstanding balance of $197,872.52 owed to Dedicated Nursing Associates (staffing agency). This unpaid amount was for facility staffing needs for State tested Nursing Assistants (STNAs), Licensed Practical Nurses (LPNs), and Registered Nurses (RNs) for services dated 12/01/23 through 03/01/24. Interview on 03/28/24 at 12:08 P.M. with Dedicated Nursing Associates accounts receivable (AR) confirmed the facility owed a substantial amount of money, the facility was past due on their account and when companies owed a substantial amount of money, they would slowly start pulling their staff from services at the facility. Interview on 04/01/24 at 3:38 P.M. with Dedicated Nursing Associates accounts receivable revealed the facility had still not been paid and the corporate personnel for Legacy Health Services had not returned phone calls inquiring of payment or a payment plan. There was no timeframe provided as to when services would be pulled from the facility due to non-payment. Interview on 04/03/24 at 2:45 P.M. with the Administrator revealed as of March 2024 the facility no longer used Dedicated Nursing Associates. b. Review of the facility's vendor aging report dated 03/15/24 revealed an outstanding balance of $182,082.98 owed to [NAME] Staffing (staffing agency). This unpaid amount was for facility staffing needs for STNAs, LPNs, and RNs for services dated 12/01/23 through 03/01/24. Interview on 03/28/24 at 12:20 P.M. with [NAME] Staffing confirmed the facility owed a substantial amount of money to the company. The company and Legacy Health Services had come to an agreement for weekly payments against the outstanding balance until the balance was resolved. The facility had requested several times for [NAME] Staffing not to discontinue staffing services. There was a payment received for the week of 03/24/24 to 03/30/24 in the amount of $15,000.00. The representative from [NAME] Staffing reported the facility was at risk for termination of services if weekly payments stopped. Interview on 04/02/24 at 10:30 A.M. with Central Supply/Staff Scheduler #140 revealed the facility uses agency staffing to help fill the open shifts. The facility has approximately 30 open shifts for direct patient care staff as of this time. A follow-up interview on 04/04/24 at 11:50 A.M. with Central Supply/Staff Scheduler #140 revealed she currently does use agency staffing to fill open shifts and had been able to get the agency to send staff. However, there had been instances in the past when a staffing agency would not send staff to the facility due to the facility's lack of paying the staffing agencies bill. c. Review of the facility's utility listing revealed the facility owed [NAME] County Commissioners an outstanding balance of $9,771.27 for water and sewer services. Interview on 04/02/24 at 11:21 A.M. with [NAME] County Commissioners account receivable confirmed the amount owed by the facility is $9,771.27 due immediately. This outstanding balance would be added to the facility's property taxes to be paid in conjunction with the property taxes. If the facility failed to pay, there would be a [NAME] placed on the facility property. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 04/02/24 at 11:30 with the [NAME] County Treasurer revealed the facility owes $19,044.92 to [NAME] County for the first half of the yearly property tasks which were due on 03/08/24. There was now a 10% late fee added to the total amount due. d. Interview on 04/03/24 at 2:38 P.M. with TLC Home Care Services (transportation company) accounts receivable revealed TLC had terminated their contract with the facility in September 2023 for failure to pay timely for their services. There was a payment received from Legacy Health Services on 03/28/24 for $6,338. 28. The total amount for the facility's outstanding balance was $8,880.20. The accounts receivable representative revealed it was hard to communicate with Legacy Health Services in regard to setting up a payment plan or even getting a payment in general. Interview on 04/03/24 at 2:26 P.M. with Resident #13 revealed two appointments had to be rescheduled. Resident #13 stated, I know the facility was not paying their bills to TLC. I know the owner and she told me they were not servicing the facility anymore because of them not paying their bill. The maintenance man will use the bus to take us to appointments now, or there's another company they use but I don't like the vehicles that they use. e. Review of the facility's vendor aging report dated 03/15/24 revealed the facility owed an outstanding balance of $3,107.52 to 02 Safe Solutions for oxygen and respiratory equipment services dated 12/31/23 through 02/26/24. Interview on 04/03/24 at 11:58 A.M. with 02 Safe Solutions accounts receivable revealed the facility had an outstanding balance of $4,638.72 with the invoices dated from November 2023 to March 2024. f. Interview on 04/02/24 at 12:36 P.M. with Wound Healing Technologies accounts receivable revealed the facility had an outstanding balance of $10,773.50 for negative pressure wound vacuum machine supplies and rental services from 10/01/23 to present. The most recent invoice for services received for the month of March 2024 was $899.00. During the interview, the representative indicated the continued non-payment or lack of a payment plan with the company would result in termination of services provided to the facility. g. Interview on 04/02/24 at 12:47 P.M. with [NAME] billing specialist revealed the facility had an outstanding balance of $4,670.20 for durable equipment rentals dated from 10/01/23 to 03/01/24. The last payment received from Legacy Health Services was dated 12/28/23. There were currently four outstanding invoices which needed to be paid immediately. The representative indicated there could be a credit hold placed on the facility for non-payment. Observation on 04/03/24 at 2:30 P.M. revealed Resident #58 was using a low air loss mattress being rented from [NAME]. h. Interview on 04/02/24 at 12:58 A.M. with A1 Sprinkler Company accounts receivable revealed the facility had an outstanding balance of $8,090.32 for servicing, monitoring, and quarterly inspection of the facility's sprinkler system. The company had been trying to work with Legacy Health Services for payment of the outstanding balance, but there was no payment agreement established. i. Review of the facility's vendor aging report dated 03/15/24 revealed an outstanding balance of $59,844.05 owed to Medline Medical Supply for services dated 10/13/23 to 03/07/24 for medical supplies and incontinence products. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview 04/03/24 at 12:20 P.M. with Medline accounts receivable confirmed the outstanding balance and indicated while there was no current credit hold on the account, the account was escalating to the point of a potential credit hold if there was no payment. In addition, no payment plan had currently been agreed upon by both parties. j. Review of the facility's vendor aging report dated 03/15/24 revealed an outstanding balance of $44,205.57 owed to Blue Sky Therapy for services dated 08/31/23 to 03/01/24. Interview on 04/03/24 at 10:37 A.M. with Blue Sky Therapy Chief Operating Officer (COO) revealed the facility had entered into a payment plan to address the outstanding balance. Interview on 04/04/24 at 11:10 A.M. with the Director of Nursing (DON) revealed there were 20 residents currently receiving either/or Physical Therapy, Occupational Therapy, and Speech Therapy in the facility. k. Interview on 04/03/24 at 11:10 A.M with All Stat Portable X-ray services accounts receivable revealed the facility had an outstanding balance of $7,370.00 for service invoices dated October 2023, December 2023, January 2024, February 2024, and March 2024. Review of the Facility assessment dated [DATE] revealed the facility's residents were at a clinically complex and special high categories who oftentimes have one or more chronic or comorbid conditions including their acuity. Residents of the facility were at risk for falls, pressure ulcers, infections, incontinence, increased disability, weight loss, depression, and other potential areas of decline. Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property (dated 10/24/22) revealed, Residents have the right to be free from abuse, neglect, exploitation, and misappropriation of the resident property. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint that is not required to treat the resident's medical symptoms. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, interview, and policy review the facility failed to ensure resident medications were not misappropriated. This affected two residents (#42, #44) of four reviewed for pain management. Findings included: Record review revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus, heart disease, malignant neoplasm of part of the lung, acquired absence of the lung, age-related physical disability, and neuropathy. Review of Resident #44's Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed the resident BIMS was 15 out of 15 (cognition intact). Review of Resident #44's paper orders dated 03/25/24 revealed Gabapentin 100 milligrams (mg) three times daily for neuropathy. The order was signed off on 03/26/24 at 12:45 A.M Interview on 03/27/24 at 4:14 P.M., with Resident #44 revealed he just finally received the first dose of Gabapentin today, and his neuropathy pain was a 12 out 10. Interview on 03/27/24 from 4:18 P.M. to 4:35 P.M., with Licensed Practical Nurse (LPN) #129 and Registered Nurse (RN) #126 confirmed Resident #44 just received his first dose of Gabapentin around 2:00 P.M., and it was originally ordered on 03/25/24. RN# 126 reported she had used Resident #42's Gabapentin to give Resident #44 due to his had not arrived at this time. LPN #129 confirmed there was Gabapentin in the emergency box the RN could have administered. LPN #129 reported she called the Pharmacy, and they had the signed scripts for the Gabapentin for Resident #44 since 03/25/24 and was not sure why the Gabapentin was not sent, and they would send it out with tonight's delivery. Review of the facility policy and procedure titled Medication Administration (dated 11/2021) revealed medication supplied for one resident are never administered to another resident. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295.

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F 0622 Level of Harm - Actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, interview, and policy review, the facility failed to provide Resident #67 a safe discharge and failed to provide the resident or resident representative with required documentation upon discharge. This affected one resident (#67) of one resident reviewed for discharge. The facility census was 65 residents. Actual Harm occurred on 03/16/24 (four days after admission), when Resident #67, who was admitted with primary diagnosis of post-surgical hip repair, was immediately discharged without a safe place to be discharged to, after being observed in the facility parking lot on one occasion smoking and taking sips of alcohol. Following the resident's discharge, she did not have a safe place to go, the resident was transported to the emergency room by a friend where she was subsequently admitted to the hospital as the resident was assessed/deemed unsafe to return home and the facility refused to re-admit the resident. Findings include: Record review revealed Resident #67 was admitted to the facility on [DATE] and was discharged on [DATE]. The resident's diagnoses included orthopedic aftercare, fracture of lower end of right femur, presence of right artificial joint, asthma, pneumonia, acute kidney failure, bronchitis, dorsalis, heart disease, hypertension, gastro-esophageal reflux disease, hernia, osteoarthritis, history of falling, difficulty walking, and need for assistance with personal care. Review of Resident #67's admission progress note dated 03/12/24 revealed the resident arrived at the facility via stretcher from the hospital. The resident was in a pleasant mood, alert, and oriented times four. Resident #67 had a port to the right upper chest with a single lumen. The resident had a surgical incision to the hip extending down to the posterior knee. The resident was in severe pain, rated a 10 on a scale of one to 10 with 10 being the most severe pain. The facility was awaiting pharmacy to deliver medications. Review of Resident #67's progress notes dated 03/13/24 revealed the resident was sent to the emergency room (ER) with uncontrolled pain at 4:46 A.M., due to the facility being unable to administer the resident ordered pain medication due to the pharmacy not delivering the medication. The resident returned from theER on [DATE] at 5:10 P.M. via stretcher. The resident was in an unpleasant mood, irate, and irritable. The resident began vomiting and non-pharmacological interventions were attempted to alleviate the vomiting. (continued on next page)

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F 0622 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #67's progress note dated 03/16/24 (Saturday) at 5:54 P.M. revealed the resident was discharged from the facility after being seen earlier smoking marijuana and drinking alcohol. The resident reported she had a medical marijuana card, and it helped her calm down. The resident reported she only had a few sips of alcohol and she had hit a couple joints. The Director of Nursing (DON) contacted the Administrator to determine what the proper channel would be. The facility Medical Director/Physician #105 was notified, and all agreed that she would be immediately discharged . The resident was given all medication including narcotics. The writer went over the discharge with her and told the resident if she had any issue to call 911 or to be taken to the nearest ER. Discharge papers were sent with the resident's friend who was taking her home. The resident was sent home in a wheelchair to make sure the resident could get around safely. The police escorted the resident out. The resident did become loud with staff saying she wanted to know how and why she was being discharged and the police told her to come with them as they could not change the decision. The resident was discharged for violating facility policy. Further review of the electronic and paper medical record revealed no evidence of discharge paperwork. Review of Resident #67's hospital emergency department note dated 03/16/24 at 7:30 P.M. revealed the resident was a [AGE] year-old female who presented to the ER for evaluation of back pain and bilateral leg pain. She recently had orthopedic surgery for right femur fracture and was sent to a local skilled facility for aftercare. Today there was an incident at the facility, and she was forcibly removed. Afterwards she did not know where to go so a family member picked her up and dropped her off at the ER. She has chronic back pain and pain from surgery on her right leg. She was not able to go home because she could not care for herself. Due to the resident walking on her leg and worsening pain will obtain an x-ray of right leg. The resident would also need to be placed (for continued medical/nursing care). Review of the hospital record revealed the x-ray showed a periprosthetic fracture of the distal femur on the right which appears slightly more displaced compared to the previous x-ray. The physician called a specialist to discuss, and he stated since the fracture had already been internally fixated that there would be no interventions indicated. The writer called for admission, and the resident was accepted for placement for pain control. Review of Resident #67's hospital note date 03/16/24 revealed the resident had a right distal femur fracture repair approximately one week ago. The resident also noted she had fractured her left fifth metatarsal. She was forcibly removed from the facility by staff and law enforcement after she was found drinking alcohol (ethanol level was undetectable). The resident admitted she had a couple sips. The resident reported she was unable to return home because she was not able to care for herself nor complete her activities of daily living as she could not bear weight on either leg. Review of the hospital record revealed a call was placed to this skilled nursing home and the facility reported they would not be willing to take the resident back due to the resident threatening staff and overall behavioral issues. Case management attempted to be contacted but were not available to assist with further placement at this time. Review of hospital orthopedic note dated 03/17/24 revealed the resident had uncontrolled pain after surgery to right femur and a fractured left fifth metatarsal fracture. Order for non-weight bearing to right lower extremity and weight bearing as tolerated to left lower extremity in boot. (continued on next page)

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F 0622 Level of Harm - Actual harm Residents Affected - Few	During the onsite investigation, it was determined the resident was currently residing in her home (after receiving hospital treatment). The resident was discharged home from the hospital on 03/22/24. Interview on 03/26/24 at 1:22 P.M. and 04/08/24 at 10:00 A.M. with the Medical Director/Physician #105 confirmed Resident #67 was improperly discharged when she was found outside smoking and drinking wine. Physician #105 reported the facility had called after the decision was made discharge the resident on 03/16/24. It was her understanding they were sending the resident to the ER. Physician #105 reported she had spoken to the facility Monday (03/18/24) morning regarding her concerns with the discharge not being appropriate. Physician #105 was not aware of any concerns that would have warranted an immediate discharge such as the resident being of harm to herself or others. Interview on 04/08/24 at 10:22 A.M., with Registered Nurse (RN)/ Assistant Director of Nursing (ADON) #128 reported when a resident was discharged there was a form under the assessment tab that would be completed and a copy would be signed and given to the resident upon discharge, however there was no discharge assessment started or completed for Resident #67. The RN/ADON #128 looked through the paper medical record as well with the surveyor and was not able to locate any discharge paperwork. Interview on 04/08/24 at 11:08 A.M. and 12:05 P.M. with Clinical Service Manager (CSM) #102 reported Resident #67 was issued an immediate discharge notice for violating the facility's smoking policy. CSM #102 confirmed the facility was not able to locate any evidence of discharge paperwork for Resident #67. CSM #102 confirmed the discharge paperwork should have been documented under the assessment tab in the electronic medical record and there was no evidence it was completed. CSM #102 reported she was not able to locate any documented evidence of discharge paperwork in the resident's paper chart either. Interview on 04/08/24 at 11:32 A.M. with Assistant Administrator (AA) #137 confirmed the facility was a smoking facility. The residents had designated times and smoking areas for use. Interview on 04/08/24 at 11:58 A.M. with Resident #67 revealed she was told she was discharged from the facility for drinking alcohol, and she was only given a bag of pills upon discharge. She was not given instructions on how to take the medication, no wound supplies or instruction, and no home health services or equipment were arranged. The resident reported she had only taken a few sips of her friend's wine cooler. The resident reported she had nowhere to go upon discharge (from the facility on 03/16/24) because she could not get into her house. The resident reported she ended up going to the ER because she was non-weight bearing and had no place to go. The resident reported she was not safe to return home because she could not care for herself. At the time of the interview, the reisdent was still upset about the discharge and continued to feel that she could not provide care for herself, she still did not have supportive services arranged including equipment. (continued on next page)

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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 0622 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy and procedure titled Resident Transfer and discharge date d 06/08/22 revealed it was the facility policy to permit each resident to remain in the facility and not to transfer or discharge a resident, unless the transfer or discharge meets the criteria identified in this policy. A facility-initiated transfer or discharge was one in which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences. If a facility-initiated discharge was determined the interdisciplinary team (IDT) would determine whether one of the following conditions exist: The resident improved and no longer needs services, the facility cannot meet the resident's needs, the resident or other individuals would be endangered, or the resident failed to pay for their stay. Continued review of the policy revealed once the IDT determine a discharge was appropriate, the following would be documented in the record. The reason for discharge. If a resident's need could not be met, the documentation would include what specific needs that could not be met. If the reason for the discharge was because the resident no longer needs nursing home services or because the facility can no longer [NAME] the resident's needs, the required documentation supporting those reasons must be completed by the resident's physician. If the reason for the discharge was because the health or safety of the resident or individuals in the facility was endangered, the documentation supporting those reasons must be completed by any physician. Appropriate discharge planning, including any resident and/or family education and referrals. Once a determination was made the resident discharge was appropriate, a written discharge notice would be issued to the resident and a copy to the office of general counsel, the department of health, and the long-term care ombudsman. The notice must include the reason of discharge, the proposed date of discharge (not the date must be 30 days from the sate the notice was issued), a statement that the resident would not be discharged before the date specified in the notice, the proposed location of discharge (which must meet the resident safety needs), the statement that the resident has the right to appeal, the name, address ,and telephone number of the state long term care ombudsman. The written notice must be provided to the resident at least 30 days in advance of the proposed discharge, unless any of the following applies: resident health has improved sufficiently, the resident has resided in the facility for less than thirty days, and emergency exist where the safety of individuals in the facility was endangered or the health of the individual in the facility would otherwise be endangered or the resident has urgent medical needs that require a more immediate or discharge. If a resident was to be discharged for any of the above reasons notice should be provided as many days in advance of the proposed transfer or discharge as was practicable. The IDT would provide the resident with appropriate preparation prior to discharge to ensure a safe and orderly discharge in accordance with the facility discharge planning policy. If a resident request an appeal of the discharge, the facility will not discharge the resident while the appeal was pending, unless the failure to discharge the resident would endanger the health and safety of the resident or other residents in the facility. Review of the facility policy and procedure titled Resident Smoking, (dated 06/08/22) revealed the admission coordinator or designee will inform the resident in writing, at the time of admission, regarding the facility smoking policy and resident responsibility. If a resident was unable to adhere to the facility smoking policy, facility Administration may determine this ground for immediate discharge if it impedes the safety of this and/or other residents. (continued on next page)

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	365780	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Marietta	5001 State Route 60 Marietta, OH 45750

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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 0622 Level of Harm - Actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Master Complaint Number OH00152295.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, interview, and policy review the facility failed to ensure the resident received a copy of the baseline care plan. This affected one resident (#44) of 50 records reviewed. Findings include: Record review revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus, heart disease, malignant neoplasm of part of the lung, acquired absence of the lung, age-related physical disability, and neuropathy. Review of Resident #44's Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed the resident BIMS was 15 out of 15 (cognition intact). Review of the baseline plan of care (dated 03/11/24) revealed the resident and/or interested party was unavailable to review care plan and medication list. Printed copy left at bedside. Interview on 03/28/24 at 8:15 A.M., with Resident #44's wife confirmed they never received a copy of the baseline care plan, and it was not left in her husband's room. The resident's wife reported she only leaves the facility for a few hours a day and she spends the night at the facility as well with her husband. Interview on 03/28/24 at 9:35 A.M. with the Social Worker (SW) #159 confirmed a care conference was not held with the resident or family within 48 hours to develop a plan of care. SW #159 reported he had a care conference scheduled, but he was not able to keep the appointment. The facility had no documented evidence a copy was given to the resident, except the nurse documented a copy was left at the resident's bedside. Interview on 03/28/24 at 1:06 P.M., with Resident #44 and his wife revealed the facility has not had a care conference with them yet and she thought on admission the facility should meet with them to develop a plan of care for his needs. The wife reported she doesn't even know what medication her husband is even taking currently, and they are planning on going home this Friday. Review of the facility policy titled Baseline Person-Centered Care Planning (dated 11/30/23) revealed upon admission the baseline person-centered care plan (in the nursing admission assessment or separately) within 48 hours of admission. A copy of the baseline person centered care plan upon admission to resident/and or resident's responsible party. Review of the facility policy titled Care Conferences Documentation (dated 11/30/23) revealed a care conference would be scheduled after admission. Resident and family/responsible party question will be answered. Documentation would be in the electronic medical records. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295.

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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** 07316 Based on medical record review, observations, and staff interview, the facility failed to develop comprehensive care plans related to the prevention of and care for pressure ulcers. This affected three residents (#29, #30, and #41) of three residents reviewed for pressure ulcers. The facility census was 65. Findings include: 1. Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including Parkinsons disease and chronic pain syndrome. A Minimum Data Set (MDS) assessment completed 01/25/24 documented a brief interview for mental status (BIMS) score of 13, indicating intact cognition. It further stated the resident was dependent upon staff for toileting, showering, dressing, hygiene, rolling in bed, and transfers. The MDS indicated the resident had one Stage 3 pressure ulcer on admission. (A stage 3 pressure ulcer is a full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed). Review of the facility policy titled Pressure Ulcer Prevention Protocols/Risk Assessment (dated 11/30/23) revealed resident's level of risk for pressure ulcer development will initially be determined at the time of admission or readmission taking into consideration the nature of risk to include underlying causes. Residents are considered high risk when admitted with a pressure ulcer. Pressure ulcer preventative/supportive precautions will be implemented. The resident had physician's orders dated 1/20/24 to turn and reposition as tolerated and as needed. (not specific to how often). Review of the wound nurse practitioner (WNP) notes on 01/24/24 revealed Resident #41 had a Stage 3 pressure ulcer on the coccyx with yellow slough measuring 3.7 centimeters (cm) long by 3.5 cm wide by 0.1 cm deep. The note stated there was 90% granulation and 10 % slough. (Slough is non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed). The note stated to keep pressure off ulceration and avoid friction and shearing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/08/24 the resident went to the outside wound clinic. An Unstageable pressure ulcer to the coccyx was noted measuring 4.5 cm long by 3 cm wide by 0.1 cm deep with purulent exudate. (An Unstageable pressure ulcer is a full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed). Recommendations included Prevalon heel boots daily and turn every two hours. Interview with Resident #41 on 03/26/24 at 1:22 P.M. revealed staff do not turn him every two hours. Observations on 03/27/24 at 7:35 A.M. and 9:35 A.M. the resident was in bed on his back (no positioning pillows noted in the bed). At 11:18 A.M. and 1:50 P.M. he was noted up in the wheelchair. (all observations he would have had pressure to the ulcer on the coccyx). Observations on 03/27/24 at 2:00 P.M. of the treatments to the coccyx and right heel revealed an open area to the right heel measuring 1.8 cm by 0.8 cm by 0.1 cm deep. The resident complained of pain to the right heel during the treatment. The pressure ulcer on the sacrum measured 2.5 cm by 1.5 cm by 0.2 cm and contained yellow slough. The wound was described by the wound nurse practitioner as 75% slough and 25% red tissue. The skin around the ulcer was very red. The treatments were completed by the wound nurse practitioner and Assistant Director of Nursing #128. During the treatments, the wound nurse practitioner explained to the resident how important it was to stay off of his bottom for healing of the wound (even though the resident was dependent upon staff for transfers and repositioning). Observations on 03/28/24 at 8:28 A.M. the resident was sitting on the edge of the bed eating breakfast. At 10:40 A.M. and 12:08 P.M. he was up in the wheelchair (all observations he would have had pressure to the ulcer on the coccyx). Review of the plan of care for Resident #41 dated 02/04/24 stated the resident had a potential for alteration in skin integrity related to history of skin breakdown, immobility, and incontinence. The goal was not to develop further skin breakdown. The interventions included turn and reposition as needed using lift pad to minimize friction and shear, and educate resident as to causes of skin breakdown including frequent positioning. However, the care plan was not specific to instruct staff on how often the resident should be turned and repositioned. Interview with Assistant Director of Nursing #128 on 04/01/24 at 10:25 A.M. confirmed the plan of care was not specific regarding how often to turn and reposition Resident #41. She stated that, although the physician's orders and plan of care indicate to turn and reposition as needed, residents should be turned every two hours. 2. Review of the medical record for Resident #29 revealed an admitted [DATE] and diagnoses including diabetes and acute kidney failure. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an admission nursing assessment on 11/16/23 revealed the resident had a Stage 2 (Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present) pressure ulcer on the coccyx, a Stage 1 (Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue pressure injury) diabetic ulcer on the right heel, and an Unstageable diabetic ulcer on the left heel. Physician's orders were obtained on 11/17/23 to turn and reposition as tolerated and as needed. Review of a MDS assessment completed 11/21/23 revealed a BIMS assessment of 12 (moderate cognitive impairment). It indicated the resident required substantial/maximal assistance with rolling left to right and was dependent for dressing, bathing, and toileting. It indicated the resident had two unstageable pressure ulcers. Review of weekly wound notes by the wound nurse practitioner revealed on 11/22/23 revealed the resident was noted with moisture associated skin damage (MASD) of the sacrum measuring 3.5 cm by 4.5 cm by 0.1 cm deep. The left heel was noted to be an Unstageable pressure ulcer measuring 4.5 cm by 4.3 cm. with 100% necrosis. The right heel was noted to be an Unstageable pressure ulcer measuring 2 cm by 2.5 cm with 100% necrosis. The note stated to turn and reposition the resident every two hours. Review of wound care notes by the Wound Nurse Practitioner on 12/20/23 Resident #29 was noted to have an Unstageable pressure ulcer of the left heel measuring 4.5 cm by 4.3 cm with 100% necrotic tissue; An Unstageable pressure ulcer of the right heel measuring 2 cm by 2.5 cm with 100% necrotic tissue; A MASD wound of the sacrum measuring 6.5 cm by 2.5 cm by 0.1 cm deep; No other areas were noted. The wound status was noted to be declined. The note stated to keep heels off bed, heel protector boots, turn and reposition every two hours. The resident was seen at an outside wound clinic on 12/21/23 and was noted to have pressure ulcers on the coccyx (3 cm by 0.8 cm by 0.2 cm); right gluteus (1 cm by 0.5 cm by 0.1 cm); left heel (5 cm by 5 cm by 0.1 cm) and right heel (2 cm by 2 cm by 0.1 cm). Recommendations included Prevalon boots while in bed or float heels on pillows and turn from left to right every two hours and as needed. On 02/01/24 the outside wound clinic recommended Prevalon boots in bed or float heels on pillows and turn every two hours. A MDS assessment completed 03/18/24 documented a BIMS score of 6, severe cognitive impairment, and dependent on staff for rolling left to right, toileting, dressing, and transfers. Observations on 03/26/24 at 1:35 P.M. and 3:45 P.M. revealed Resident #29 to be in bed on her back with the head of the bed elevated. Observations on 03/27/24 at 9:38 A.M., 11:17 A.M., and 1:54 P.M. revealed Resident #29 to be in bed on her back with slippers on (no heel protector boots) and her heels were resting on a pillow. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/24 wound notes by the wound nurse practitioner stated the resident had an Unstageable pressure ulcer on the left heel measuring 4.2 cm by 4.5 cm by 0.2 cm with 75% necrotic tissue and 25% slough, an Unstageable pressure ulcer on the right heel measuring 2 cm by 2.6 cm by 0.1 cm deep with 90% slough and 10% granulation, and a stage three pressure ulcer on the sacrum measuring 8.8 cm by 2.2 cm by 0.3 cm deep with 75% slough and 25% granulation. Recommendations included keep heels off bed, heel protector boots, and turn and reposition every two hours. Observations on 03/28/24 at 8:41 A.M. and 10:38 A.M. the resident was in bed on her back with her heels resting on a pillow (no heel protector boots on). At 10:38 A.M. the resident had a flat pillow under her right side but it did not tilt her enough to relieve pressure from bottom. At 12:11 P.M. the resident was in bed on her back with staff feeding lunch. Observation of the treatments for Resident #29 on 04/03/24 at 11:20 A.M. revealed the resident to be in bed on her back. The resident had heel protector boots on but not Prevalon boots (have a cut out area near the heel to avoid any pressure at all on the heels). The resident was observed to have a 3.5 cm by 5.5 cm by 0.2 cm deep area on the left heel with 75% brown necrotic tissue covering the wound and 25% granulation. She had a 3.5 cm by 4 cm by 0.1 cm deep area on the right heel that was 75% slough and 25% granulation tissue. She had a 4 cm l by 1 cm open area on the coccyx that had 90% slough and 10% granulation described as unstageable. She also had two new areas on the buttocks: left upper buttock 2.5 cm by 4 cm Unstageable with white slough and right upper buttock 0.5 cm by 0.5 cm by 0.1 cm Stage 2 open area. Interview with Assistant Director of Nursing #128 on 04/03/24 at 11:20 A.M. confirmed Resident #29 had developed two new pressure ulcers on her buttocks since the week prior. Review of the plan of care revealed on 12/04/23 potential for alteration in skin integrity related to immobility and history of skin breakdown was added. Interventions included turn and reposition as needed, and use pillows/pads to support/position as appropriate. (The plan was not specific to how often the resident should be turned and repositioned). Interview with Assistant Director of Nursing #128 on 04/01/24 at 10:25 A.M. confirmed the plan of care was not specific regarding how often to turn and reposition Resident #29. She stated that, although the physician's orders and plan of care indicate to turn and reposition as needed, residents should be turned every two hours. 3. Review of the medical record for Resident #30 revealed an admitted [DATE] and diagnoses including diabetes and adult failure to thrive. The resident also had diagnoses of Stage 4 (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location) pressure ulcer with osteomyelitis of the vertebrae, sacral, and sacrococcygeal areas and a deep tissue injury on the left heel present upon admission. The resident was on hospice. On 07/11/23 the resident was noted to have an Unstageable pressure ulcer to the coccyx measuring 14.5 cm by 6.3 cm by 2.4 cm deep with undermining, 50% slough 10% eschar. The resident had an Unstageable pressure ulcer to the left hip measuring 7 cm by 6.5 cm by 3 cm deep with undermining with 50% slough/eschar. The resident had an Unstageable pressure ulcer to the left heel measuring 4 cm by 6 cm by 0. 1 cm deep with 25% eschar. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a quarterly MDS assessment 02/17/24 revealed the resident had a BIMS score of 7, severe cognitive impairment. It stated the resident required moderate assistance with toileting and rolling in bed. The resident was dependent for transfers. Review of wound care notes by the Wound Nurse Practitioner revealed on 09/20/23 the resident continued with the Stage 4 pressure ulcer on the coccyx (12 cm by 9 cm by 2 cm deep), Stage 3 pressure ulcer on the left heel (1.5 cm by 4 cm) and left posterior thigh (4.5 cm by 3.2 cm by 1.8 cm). The resident was now noted to have a new pressure ulcer on the right heel (Stage 2 measuring 6 cm by 10 cm described as a blister that drained) and an Unstageable pressure ulcer on the right lateral lower leg measuring 9.5 cm by 1.5 cm. On 10/09/23 the resident had physician's orders to turn and reposition as tolerated and as needed. Observations on 03/26/24 at 1:33 P.M. revealed Resident #30 to be in bed on her back (no pillows on either side). On 03/26/24 at 3:44 P.M. she remained in bed on her back. Observations on 03/27/24 at 7:52 A.M., 9:35 A.M., and 11:15 A.M. revealed Resident #30 to be in bed on her back. At 1:53 P.M. the resident was up in a wheelchair while the air mattress on her bed was changed. At 2:45 P.M. she was back in bed on her back. Observations on 03/28/24 at 8:36 A.M., 10:39 A.M., and 12:10 P.M. revealed Resident #30 to be in bed with a flat pillow under her right side which slightly tilted her to her left side. Her upper body was tilted but her bottom was still resting on the mattress. Interview with Certified Nurse Practitioner (CNP) #104 on 04/01/24 at 8:15 A.M. revealed the resident did have pain with movement but staff should attempt to turn the resident so she is off of her bottom. Review of the wound care notes by the wound nurse practitioner on 03/27/24 revealed the left heel was noted to be healed. The pressure ulcer on the coccyx was noted to be Stage 4 measuring 7 cm by 6 cm by 0. 8 cm deep (smaller in size). The left posterior thigh was 1.4 cm by 1.4 cm by 1.1 cm deep (smaller in size). The right heel was Unstageable (3.2 cm by 2.2 cm by 0.1 cm) smaller in size. The right lateral lower leg Unstageable pressure was 13 cm by 1.2 cm by 0.2 cm (larger in size since last readmission 10/09/23). Review of the plan of care dated 10/09/23 revealed the resident had potential for altered skin integrity related to a history of skin breakdown, impaired mobility, and diabetes. Interventions included encourage to turn and reposition as needed. (The plan was not specific to how often to turn and reposition). Interview with Assistant Director of Nursing #128 on 04/01/24 at 10:25 A.M. confirmed the plan of care was not specific regarding how often to turn and reposition Resident #30. She stated that, although the physician's orders and plan of care indicate to turn and reposition as needed, residents should be turned every two hours. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295 and Complaint Number OH00151794.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on medical record review, resident interview, staff interview, and policy review, the facility failed to develop and implement an effective discharge planning process that focused on the resident's discharge goals, the preparation of the resident to effectively transition the resident to post-discharge care, and the reduction of factors leading to preventable readmissions. This affected one resident (#54) of 50 resident records reviewed. The facility census was 65. Findings include: Review of the medical record for Resident #54 revealed an admitted [DATE] and diagnoses including morbid obesity, diabetes mellitus, hypertension, and schizophrenia. Review of an admission Minimum Data Set assessment 03/19/24 revealed the resident had a brief interview for mental status score of 15, indicating intact cognition. It stated the resident was occasionally incontinent of bowel and bladder and was not on a toileting program. Review of bladder tracking revealed the resident had been incontinent of bladder on 03/14/24 and 03/28/24. Review of a Social Service admission assessment dated [DATE] revealed Resident #54 was admitted from an acute hospital. It stated the resident planned to return to the community to home/community (not specified). It stated discharge planning was occurring but did not specify what type. Review of social service notes on 03/14/24 and 03/18/24 revealed that it only stated that Resident #54 planned to return to the community. It did not specify any needs the resident had or a plan on how to transition the resident back to the community. Interview with Resident #54 on 03/27/24 at 10:50 A.M. revealed he has an apartment in the community that he does not want to lose. He stated it was very difficult to complete all the paperwork to obtain an apartment so he wanted to be able to return to the apartment. He stated he needed help with learning how to maintain his blood sugar. He stated that was what led to his hospitalization . He stated the facility had acted like they did not want him to discharge home and he wants to. He stated he had asked to speak to social services but no one had come to speak with him. Interview with Social Services staff #159 on 04/01/24 at 12:45 P.M. revealed he had spoken to Resident #54 the week prior and he was planning to return home to his apartment. He stated the resident had concerns with maintaining blood sugar control at home and incontinence issues at home. He stated there had been no follow up on providing teaching for the resident on blood sugar control or incontinence. He stated that was not his job. He stated the resident was receiving physical therapy but he did not know how long the resident's stay was anticipated to be. Interview with Physical Therapist/Director of Rehab #168 on 04/01/24 at 1:00 P.M. revealed Resident #54 was receiving physical therapy and occupational therapy. She stated that, based on his type of insurance, his stay would probably only last another two weeks. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Discharge Planning (dated 06/08/22) revealed when a resident's discharge in anticipated, the facility will develop and implement a discharge plan that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The discharge plan: the discharge needs of each resident will be identified and result in the development of a discharge plan for each resident. The discharge plan will: include regular re-evaluation of residents to identify changes that require modification of the discharge plan; involve the interdisciplinary team in the ongoing process of developing the discharge plan; address the resident's goals of care and treatment preferences. Interview with Director of Nursing #147 on 04/01/24 at 1:05 P.M. revealed the nursing department was not aware of Resident #54's needs for education/training regarding blood sugar control or incontinence. Therefore, this had not been provided. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295.

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	365780	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Marietta	5001 State Route 60 Marietta, OH 45750

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, record review, resident interview, staff interview, and review of resident council meeting minutes, the facility failed to ensure residents who are unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene in the areas of bathing and incontinence care. This affected five residents (#13, #41, #50, #54, and #79) of 36 residents reviewed for quality of care . The facility census was 65. Findings include: 1. Review of the medical record for Resident #50 revealed an admitted [DATE]. Review of a Minimum Data Set (MDS) assessment completed 03/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The assessment further stated the resident was incontinent of bowel and bladder, required substantial/maximal assistance with toileting,and partial/moderate assistance with rolling left to right on the bed. The resident was not identified to have any pressure areas. The plan of care dated 12/28/23 stated the resident was incontinent of bowel and bladder. Interventions included check for wetness before and after meals, at bed time, and on rounds during the night. If continent, offer to assist with toileting. If incontinent, provide incontinence care. Review of a resident/family concern/grievance form dated 03/11/24 revealed Director of Nursing (DON) #147 reported a concern to Social Services #159 from Resident #50's daughter. The family member stated that Resident #50 was not checked on, changed, or rotated from 03/09/24 at 11:00 P.M. until 03/10/24 at 1:00 P. M. Family member was also concerned that wash rags were not being used during care. Family stated chux not being used. The plan of action stated that the Director of Nursing was to check in on the resident two times daily for two weeks to ensure proper care was occurring. The plan of action was signed by the Director of Nursing. Under resolution it stated the Director of Nursing to talk with staff and the family. The date of the concern resolution was 03/11/24. Family member notified on 03/11/24. The administrator had signed the form on 03/11/24. Interview with Resident #50's family member who filed the concern/grievance form on 04/01/24 at 3:30 P.M. revealed the resident had been left incontinent for 14 hours and was not changed. They don't wash the urine off after incontinent. Her brother came in on 03/11/24 and the mattress was soaked in urine. They were out of chux (incontinent pads). Resident #50 has a history of pressure ulcers and she does not want her to get another one. She stated she does not feel the issues were rectified. She stated the resident had gone 12 hours after that without being changed. She stated she had not spoken with the Director of Nursing after the initial report. Interview with Resident #50 on 04/02/24 at 7:45 A.M. revealed she goes to bed between 10:30-11:00 P.M. She stated the staff do not check her for incontinence until around 5:30 A.M. She stated she was wet right now and had not been changed since she went to bed. (The resident was observed in bed with her breakfast tray which would have been provided by staff). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reported to staff that Resident #50 indicated she had been incontinent. On 04/02/24 at 8:00 A. M. Nursing Assistant #209 came to Resident #50's room. Nursing Assistant #209 stated she did not know when the resident was changed last. She stated she had come on duty at 7:00 A.M. Incontinence care was provided. The resident's incontinent brief was observed to be wet which was confirmed by Nursing Assistant #209. Resident #50 was observed to have a small red area on the left inner buttock. Licensed Practical Nurse (LPN) #150 entered the room during the care and stated she would notify the physician of the red area and would obtain an order for a dressing to prevent pressure. Interview with LPN #150 on 04/02/24 at 8:40 A.M. revealed she came into the room during incontinence care because she had overheard an aide on night shift say that the resident's bottom was hurting so she came in to see. 2. Review of the medical record for Resident #54 revealed an admitted [DATE] and diagnoses including morbid obesity, diabetes, hypertension, and schizophrenia. Review of a MDS Assessment completed 03/19/24 revealed a BIMS score of 15, indicating intact cognition. Interview with Resident #54 on 03/27/24 at 10:50 A.M. revealed it was hard to get assistance with a shower at the facility. He stated you have to keep after the staff to get them to assist you with a shower. He stated he preferred two showers a week but had not received that since admitted . Review of shower records revealed only two showers had been provided to Resident #54 since admission (03/21/24 and 03/28/24). Therefore, he went eight days from 03/13/24 to 03/21/24 without a shower and seven days from 03/21/24 to 03/28/24 without a shower. Interview with Director of Nursing #147 on 04/01/24 at 1:05 P.M. revealed Resident #54 was to receive a shower on Monday and Thursday of each week. She confirmed he had only had two showers since admission. 3. Review of the closed medical record for Resident #79 revealed an admitted [DATE] and diagnoses including malignant neoplasm of the bile duct, chronic kidney disease, and heart failure. A nursing progress note on 03/13/24 stated the resident had no memory issues and required staff supervision with showers/bathing. Review of a physician history and physical on 03/14/24 revealed the resident was at the facility for a hospice respite stay. The resident is confused and cannot give any reliable history. Review of a physician's progress note on 03/18/24 revealed the resident was complaining of some pain under her right breast. The note stated the physician reviewed the shower log. It stated the resident had been at the facility for five days and had not had a shower. She is agreeable to a shower. The note stated the resident had significant yeast under the right breast. The physician documented that the resident needed to be showered on that day. A powder to treat yeast infections was ordered three times daily for 14 days. The resident was discharged home on 03/18/24. There was no evidence the resident received a shower while at the facility from 03/13/24 to 03/18/24. Interview with Assistant Administrator #137 on 04/04/24 at 11:10 A.M. confirmed there was no evidence Resident #79 received a shower/bath while at the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the medical record for Resident #13 revealed an admitted [DATE] and diagnoses including adult failure to thrive, rheumatoid arthritis, and hypertension. A MDS assessment completed 01/15/24 stated the resident had a BIMS score of 15, indicating intact cognition. It stated the resident required supervision or touching assistance with bathing. The medical record indicated the resident was scheduled for showers on Tuesday and Friday. Review of shower records for March 2024 revealed the resident was documented as receiving one shower for the month on Friday 03/29/24. The resident did have three refusals documented on Tuesday 03/05/24, Friday 03/22/24, and Tuesday 03/26/24. There was no evidence showers were provided on 03/01/24, 03/08/24, 03/12/24, 03/15/24, or 03/19/24 as scheduled. There were no refusals of showers documented in the nursing progress notes for March 2024. Interview with Resident #13 on 03/27/24 at 9:40 A.M. revealed the facility does not have enough help and she had not had a shower for three weeks. She stated her showers were supposed to be on Tuesday and Friday but the staff say they don't have enough staff to do showers as scheduled. She stated she had never refused a shower except for one time in March 2024 after a fall. 5. Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including Parkinson's disease and chronic pain syndrome. A MDS assessment completed 01/25/24 documented a BIMS score of 13, indicating intact cognition. It further stated the resident was dependent upon staff for toileting, showering, dressing, hygiene, rolling in bed, and transfers. Review of bathing records for March 2024 revealed the resident had received a bed bath two times in March 2024 (03/13/24 and 03/29/24). Interview with Assistant Director of Nursing #128 on 04/01/24 at 10:25 A.M. revealed Resident #41 was to receive a shower/bath on Tuesday and Friday of each week. She confirmed there was no documentation to indicate this was done. Review of Resident Council Meeting minutes for 03/18/24 revealed a topic discussed by residents was residents not getting their scheduled showers. Interview with Resident #37 on 03/27/24 at 11:00 A.M. (BIMS score of 15) revealed the facility is short of staff and she does not get her showers twice weekly as scheduled. Interview with Nursing Assistant #117 on 03/28/24 at 11:00 P.M. revealed there are not enough staff to be able to complete scheduled showers. Interview with Nursing Assistant #118 on 03/28/24 at 11:15 P.M. revealed there are not enough staff and showers are hit and miss for residents. He/she stated staff were not able to check and change residents who are incontinent every two hours Interview with Licensed Practical Nurse #153 on 03/28/24 at 11:25 P.M. revealed there are not enough staff to be able to complete scheduled showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Nursing Assistant #127 on 03/28/24 at 11:55 P.M. revealed there is not enough staff to meet the needs of the residents including showers. He/she stated staff can't answer call lights timely or give the care the residents need. He/she stated some residents require the assistance of two staff and there is no one to help her/him. He/she stated staff have to go look for another staff to assist them and that takes time. He/she stated residents have to wait too long if he/she is in another room with another resident providing care. He/she stated staff can't give showers to residents who require a hoyer lift with only one staff person on each hall. She confirmed staff are not able to check and change residents who are incontinent every two hours. Interview with Nursing Assistant #201 on 03/28/24 at 12:15 A.M. revealed there is not enough staff to being able to complete resident showers as scheduled. Interview with Nursing Assistant #122 on 04/01/24 at 3:05 P.M. revealed the facility is very short staffed. He/she stated most days there is only one aide per hallway (7:00 A.M. to 7:00 P.M.). He/she stated the aide would have to leave their hall to go assist another staff who needed help with a resident who required two person assistance. He/she stated call lights were then not answered timely. He/she stated it is just survival there in getting things done that need to be done. He/she confirmed showers are not completed as scheduled. Interview with Director of Nursing (DON) #147 on 04/04/24 at 10:30 A.M. confirmed she felt there was not enough staff to meet resident needs. At the time of the survey, there were 21 residents on the 200 hall, 17 residents on the 300 hall, and 21 residents on the 400 hall. The facility identified 24 residents as being dependent for bathing, dressing, and transferring. The facility identified 31 residents as requiring 1-2 staff assistance for bathing, dressing, and transferring. Interview on 04/09/24 at 12:43 PM with Assistant Administrator #137 and Director of Nursing (DON) #147 revealed they have no evidence of any quality assurance activity to ensure that resident showers are done . The DON reported the previous Administrator was to check to ensure showers were done. They both confirmed that multiple changes in Administrator and Director of Nursing in the past year and the lack of leadership was the root cause of the concerns noted at the time of this survey. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295 and Complaint Number OH00151794.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 07316 Based on medical record review, staff, certified nurse practitioner and physician interviews, hospital record review, review of literature from Centers for Disease Control (CDC), National Health Institute, and American Heart Association, and facility policy review, the facility failed to ensure Resident #80's blood pressure was adequately monitored to prevent incidents of hypotension (low blood pressure) and failed to notify the physician of the resident's hypotension resulting in a delay in care and treatment. This resulted in Immediate Jeopardy with serious life threatening harm beginning on [DATE] when Resident #80, who had a history of hypotension, had a blood pressure of ,d+[DATE] which was not reported to the physician, physician ordered blood pressure and pulse monitoring was not completed, a beta blocker medication (works to lower blood pressure) was administered with a resulting blood pressure of ,d+[DATE] on [DATE] which was not reported to the physician and no treatment was provided. Resident #80 was found two hours later, on [DATE] at 12:50 A.M. without a pulse or respiration and was declared deceased . Actual Harm (that was not Immediate Jeopardy) occurred on [DATE] when Resident #34, with a diagnosis of heart failure, had a hypotension blood pressure reading that staff failed to notify the resident's physician of and staff administered hypertensive and diuretic medication that resulted in a significant drop in the resident's already low blood pressure that required hospitalization for three days due to hypotension with dizziness and fatigue symptoms where treatment included intravenous fluids and vasopressor medication (used to treat severe low blood pressure). Actual Harm (that was not Immediate Jeopardy) occurred on [DATE] to Resident #53, with a diagnosis of congestive heart failure, when staff failed to follow physician orders for weight monitoring; the resident sustained a significant weight gain and staff failed to notify the physician with the change in condition resulting in a delay in care and treatment until the resident attended a medical appointment with the pulmonologist resulting in a direct admission to the hospital for three days for treatment of congestive heart failure requiring intravenous diuretic administration and strict fluid restriction. In addition, concerns identified which did not rise to Immediate Jeopardy or harm that was not Immediate Jeopardy occurred due to the facility's failure to complete timely and comprehensive assessment and monitoring including neurological assessment for a resident with an unwitnessed fall, failure to complete ordered consults in the areas of surgery, gynecology, and hematology for a resident with low hemoglobin with evidence of continued bleeding, and failure to complete dressing changes and monitoring of the condition of stasis ulcers. This affected five residents (#5, #31, #34, #53, #78 and #80) of 36 residents reviewed for quality of care and treatment. The facility census was 65. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:38 P.M. Licensed Nursing Home Administrator (LNHA) #200, Director of Nursing (DON) #147, [NAME] President of Clinical Services #103, Assistant Administrator #137, and Regional Clinical Service Manager (RCSM) #102 were notified Immediate Jeopardy began on [DATE] for Resident #80, with a history of low blood pressure (hypotension), when staff failed to monitor the resident's blood pressure including completion of physician ordered blood pressure checks, failed to notify the physician of hypotension thereby delaying care and treatment, and staff continued administration of a blood pressure lowering medication resulting in Resident #80 being found without pulse or respirations and declared deceased . The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 8:00 A.M. current Medical Director, Physician #5, was notified of early release from contract effective [DATE]. All current resident families notified of Medical Director Transition via phone and in person, along with notification to cognitively intact residents. On [DATE] at 8:00 A.M., Physician #206 assumed role of facility Medical Director, with initiation of [NAME] Services for Nurse Practitioner oversight. Contact information of both parties posted throughout facility. Letters to be either hand delivered or mailed certified to all current residents and/or responsible parties of the update in medical director. On [DATE] (no time identified), an Ad Hoc Policy Review was held with the Administrator #200, Assistant Administrator #137 Director of Nursing #147, Regional Clinical Services Manager #102 , [NAME] President of Nursing Operations #103, Chief Nursing Officer #207, Medical Director/Physician #206, Social Service Designee (SSD) #159, Activities Director #167, Diet Tech #160, Medical Records/Accounts Payable #157, RN/MDS #161, Director of Rehab #168, RN/ADON #128, RN Staff Development Coordinator/Infection Control #164, Admission Staff #144 , Business Office Manager #142, Maintenance Director #141, Central Supply/Scheduler #140, and NP #205 to review facility polices for Change in Resident Condition and Medication Administration, with regards to following physician's orders for blood pressure and pulse monitoring with parameters per orders from the physician/physician extender. Change in Resident Condition policy was updated to specifically address acute changes in condition including abnormal vital signs. Parameters were provided by the facility Nurse Practitioner #204 for administration of cardiac medications as follows: Ace Inhibitors- hold if SBP<90 and notify MD/NP, angiotensin 2 Receptor Blockers (ARBs)- hold of SBP<90 and notify MD/NP, Beta Blockers- hold if HR<60 and notify MD/NP, Calcium Channel Blockers- hold if HR<60 and/or SBP<90 and notify MD/NP, and Vasodilators- hold if SBP<90 and notify MD/NP. On [DATE] (no time identified), the Regional Clinical Services Managers educated the Administrator #200, Assistant Administrator #137, Director of Nursing #147, RN ADON #128, and RN SDC/IC #164 regarding updated policies and procedures for Change in Resident Condition including addressing acute changes in condition with abnormal vital signs and Medication Administration, with regards to following physician's orders for blood pressure and pulse monitoring with parameters per orders from the physician/physician extender. Parameters were provided by the facility Nurse Practitioner #204 for administration of cardiac medications as follows: Ace Inhibitors- hold if SBP<90 and notify MD/NP, angiotensin 2 Receptor Blockers (ARBs)- hold of SBP<90 and notify MD/NP, Beta Blockers- hold if HR<60 and notify MD/NP, Calcium Channel Blockers- hold if HR<60 and/or SBP<90 and notify MD/NP, and Vasodilators- hold if SBP<90 and notify MD/NP. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] (no time identified), the Administrator #200 and Director of Nursing #147 educated Administrative Staff, including Social Services Designee #159, Admissions Director #144, Business Office Manager #142, RN/MDS #161, Diet Tech #160, Maintenance Director #141, Activities Director #167, Central Supply/Scheduler #140, Medical Records #157, and Director of Rehab #168 regarding updated policies and procedures for reporting a Change in Resident Condition including addressing acute changes in condition with abnormal vital signs and Medication Administration, with regards to following physician's orders for blood pressure and pulse monitoring with parameters per orders from the physician/physician extender. Parameters were provided by the facility Nurse Practitioner#204 for administration of cardiac medications as follows: Ace Inhibitors- hold if SBP<90 and notify MD/NP, angiotensin 2 Receptor Blockers (ARBs)- hold of SBP<90 and notify MD/NP, Beta Blockers- hold if HR<60 and notify MD/NP, Calcium Channel Blockers- hold if HR<60 and/or SBP<90 and notify MD/NP, and Vasodilators- hold if SBP<90 and notify MD/NP. On [DATE], all facility staff educated on updated policies and procedures for reporting Change in Resident Condition including addressing acute changes in condition with abnormal vital signs and Medication Administration, with regards to following physician's orders, for blood pressure and pulse monitoring with parameters per orders from the physician/physician extender. Parameters were provided by the facility Nurse Practitioner #204 for administration of cardiac medications as follows: Ace Inhibitors- hold if SBP<90 and notify MD/NP, angiotensin 2 Receptor Blockers (ARBs)- hold of SBP<90 and notify MD/NP, Beta Blockers- hold if HR<60 and notify MD/NP, Calcium Channel Blockers- hold if HR<60 and/or SBP<90 and notify MD/NP, and Vasodilators- hold if SBP<90 and notify MD/NP. Education completed included 16 nurses, 28 nurses' aides, 1 activity staff, 5 environmental services staff, 6 dietary staff, and 6 administrative staff. A medication administration competency will be completed by each licensed nurse prior to their next scheduled shift. Medication Administration competency includes, but is not limited to, five rights of medication administration with all routes, medication storage, receiving medication, and documentation. Competency includes assessment of pulse and/or BP checked and charted when indicated- held, if appropriate. One employee is on vacation and will be educated prior to returning to work. All other staff were educated. Education was completed by RN/ADON #128, SDC/IP #164, Diet Tech #160, Maintenance Director #141, and Activities Director #167. Department heads completed education of policies to their respective department staff. Medication Competencies are being completed by DON #, RN/ADON #128, and RN SDC/IC #164. On [DATE] (no time identified), an Ad Hoc Resident Council meeting was held with the Activities Director #167 and Administrator #200 to review the updated policies and procedures for Change in Resident Condition and Medication Administration, with regards to following physician's orders. Residents in attendance were Residents #25, #60, #59, #62, #61, and #47. There were no concerns verbalized during the resident council meeting regarding policies shared and information reviewed and residents were appreciative of the information. On [DATE] (no time identified) head to toe assessments were completed on all current residents by Licensed Nurses RN #131, RN #152, and LPN #129. Assessments included vital signs, pain assessment and skin inspections and there was no deviation from the resident's baseline and no unidentified skin impairments. On [DATE] (no time identified), Clinical Service Manager RN #102 completed audits on all resident medications to ensure that medications are available and administered per physician's orders. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] (no time identified), Clinical Services Manager # 102 and DON #147 audited the telephone orders of all current residents to ensure there were no missed orders requiring processing and implementation. There were no unprocessed orders. On [DATE] (no time identified), all current residents on cardiac medication had orders updated to reflect cardiac medication monitoring parameters by RN VPCS #103 per verbal order from NP #204. Beginning on [DATE] ongoing auditing will be implemented and completed by the Director of Nursing #147 and/or Designee 5 days a week for 4 weeks. Director of Nursing/Designee to complete telephone order audit of all residents to ensure no orders are missed. Additional auditing to include ensuring vital signs are monitored per physicians orders and any deviation from the residents baseline are reported to the physician/physician extender as a change in condition as indicated. All elements of the IJ removal plan were implemented and completed by [DATE]. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: 1. Review of the closed medical record for Resident #80 revealed an admitted [DATE] with diagnoses including diabetes mellitus, acute kidney failure, acute respiratory failure, pulmonary embolism, and cellulitis. The resident expired at the facility on [DATE]. Review of an acute care hospital discharge summary dated [DATE] revealed the resident had been admitted to the hospital on [DATE]. She presented to the emergency department with complaints of generalized weakness and a fall on [DATE]. During her stay she had low blood pressure which improved with intravenous fluids and holding of all antihypertensive therapy. Hospital records identified Resident #80's blood pressure was then stable and on discharge she would no longer be on Amlodipine (a calcium channel blocker used to treat high blood pressure) or Lisinopril (an ACE inhibitor used to treat high blood pressure). Hospital records identified Resident #80 would resume Atenolol (a beta blocker used to treat high blood pressure) on discharge from the hospital. Resident #80's blood pressures at the hospital on the day of discharge ([DATE]) were noted to be: [DATE] at 3:35 A.M. ,d+[DATE]; [DATE] at 7:31 A.M. ,d+[DATE]; and [DATE] at 10:42 A.M. ,d+[DATE]. Review of the Center for Disease Control (CDC) literature revealed a normal blood pressure is noted to be below ,d+[DATE] mmHg. Review of the National Institute of Health (NIH) literature revealed a low blood pressure is a blood pressure lower than ,d+[DATE] mmHg. Review of an admission nursing assessment completed by Registered Nurse (RN)/Assistant Director of Nursing (ADON) #128 on [DATE] revealed Resident #80 was admitted to the facility at 5:05 P.M. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A baseline care plan on admission stated the primary medical reason for admission was diabetes and atrial fibrillation. The goal was to manage or improve medical status. Interventions included vital signs every shift for three days and monitor tolerance to medications. The admission nursing assessment included a blood pressure of ,d+[DATE] at 8:03 P.M. There was no evidence the physician was notified of the blood pressure of ,d+[DATE]. The resident had a physician's order on admission on [DATE] for Atenolol 50 milligrams two times daily for hypertension (high blood pressure) which was scheduled to be given in the morning and evening. Review of a progress note on [DATE] by Certified Nurse Practitioner (CNP) #104 revealed Resident #80 had hypotension during her hospitalization and was not able to be on beta-blockers and all blood pressure medications were stopped. Resident #80 was alert and oriented. Blood pressure was ,d+[DATE] on last check. We will check blood pressure and heart rate every shift (facility has two shifts: 7:00 A.M. to 7:00 P.M. and 7:00 P.M. to 7:00 A.M.) and then do orthostatic lying, sitting, and standing blood pressure and heart rate every morning for five days and notify providers if systolic drops more than 10 mmHg (orthostatic blood pressures check for drops in blood pressure when going from lying or sitting to standing). Review of Resident #80's physician's orders revealed a paper written order on [DATE] to check blood pressure and heart rate every shift and do orthostatic blood pressure and heart rate lying, sitting, and standing every morning for five days. The physician order identified staff were to notify the CNP if Resident #80's systolic blood pressure went down by 10 mmHg or more. However, review of physician's orders in the electronic medical record revealed the orders to monitor blood pressure were not entered until [DATE] (one full day after the orders were given) and were scheduled to start on [DATE] (two full days after the orders were given). The orders were listed on the treatment administration record (TAR) for [DATE]. Review of the TAR for [DATE] revealed no documentation of the physician ordered blood pressure monitoring being completed at all. Review of Resident #80's medical record including nursing progress notes, skilled nursing assessments, and vital sign documentation revealed the only blood pressures obtained were: [DATE] at 8:03 P.M. ,d+[DATE]; [DATE] at 3:30 P.M. ,d+[DATE]; and [DATE] at 12:38 A.M. ,d+[DATE] (prior to [DATE] at 10:45 P.M.). Review of the medication administration record (MAR) and medication administration audit report revealed Registered Nurse (RN) #131 had given Resident #80 Atenolol 50 milligrams on [DATE] at 7:49 P.M. There was no evidence the resident's blood pressure had been checked prior to giving the medication since [DATE] at 12:38 A.M. (approximately 19 hours prior). Review of the nursing progress notes on [DATE] at 10:45 P.M. revealed a blood pressure of ,d+[DATE] mmHg was documented in the nurse's progress notes by RN#131. The note indicated the blood pressure was below the resident's baseline and the resident was sleeping during the shift. There was no evidence the physician was notified of the low blood pressure of ,d+[DATE] or that any type of treatment was provided. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The next nursing progress note for Resident #80 by RN #131 on [DATE] at 12:50 A.M. (approximately two hours after the blood pressure of ,d+[DATE]) revealed the nursing assistant came to the nurse and stated she did not think the resident was breathing. RN #131 went to the resident's room and listened to her heart. No respirations or heartbeat was noted. Cardiopulmonary resuscitation (CPR) was initiated and 911 was called. The responders took over CPR when they arrived, but CPR was stopped at 1:15 A.M. upon orders from the hospital emergency physician. Resident #80 expired at that time at the facility. Interview with RN #131 on [DATE] at 5:18 P.M. revealed she did not really remember Resident #80. She confirmed that she had given the resident her medication on the evening before the resident died . RN #131 stated she did not really know a lot about Resident #80. RN #131 stated blood pressure should be checked prior to giving a blood pressure medication. She stated she could not recall if Resident #80's blood pressure of ,d+[DATE] mm/Hg that was documented on [DATE] at 10:45 P.M. had been obtained prior to giving the blood pressure medication that evening or after. RN #131 stated she did not remember if the physician was notified of Resident #80's low blood pressure or not. She stated it would usually be documented in the nursing progress notes if the physician was notified. She confirmed Resident #80 expired at the facility on [DATE] as per her progress note. Interview with the Director of Nursing (DON) #147 on [DATE] at 7:20 A.M. confirmed there was no evidence the physician was notified of Resident #80's blood pressure of ,d+[DATE] on [DATE]. She stated the facility did not have a policy on when to notify physicians regarding blood pressure levels. She stated some residents had a physician's order with parameters of when to notify the physician. She confirmed Resident #80 did not have any physician ordered parameters of when to notify related to blood pressure. She stated she would have notified the physician of Resident #80's blood pressure being ,d+[DATE]. She further stated she would have re-checked the resident's blood pressure in 15 minutes to see if it was still low. She confirmed there was no evidence the resident's blood pressure was re-checked again until [DATE] at 3:30 P. M. (approximately 19 hours later) when it was ,d+[DATE] (documented under vital signs in electronic medical record). The DON confirmed a resident's blood pressure should be checked prior to administering a blood pressure medication and the medication should be held if the blood pressure is too low. She confirmed there was no evidence Resident #80's blood pressure was checked prior to giving the medication on [DATE] at 7:49 P.M. She stated the blood pressure of ,d+[DATE] mm/Hg documented on [DATE] at 10:45 P.M. may not have been obtained at the time it was documented (could have been earlier). Interview with CNP #104 on [DATE] at 8:20 A.M. confirmed neither she nor the physician was notified of Resident #80's low blood pressure of ,d+[DATE] mm/Hg on [DATE]. CNP #104 stated a blood pressure that low could be life threatening without treatment. CNP #104 stated if she had been notified of Resident #80's low blood pressure, she would have either ordered intravenous fluids to be given or if the resident was symptomatic, she would have sent the resident to the emergency room . She stated the Atenolol blood pressure medication would start taking effect within 30 minutes to one hour after given. She confirmed the low blood pressures Resident #80 had should have been rechecked within an hour and the physician should have been notified. She stated the nurses at the facility never re-check low or high blood pressure unless she tells them to. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Medical Director #105 on [DATE] at 12:09 P.M. revealed she had resigned her position at the facility due to staff competency related to issues such as putting physician orders in timely, medication errors, lack of administrative staff, etc. She stated the issues had been going on for six months and, although brought to the attention of the facility, still had not been addressed. Review of facility policies revealed the facility did not have a policy that specified what constituted an abnormal blood pressure or when to notify the physician of abnormal blood pressures. Review of the facility policy titled Change in a Resident's Condition, dated [DATE] revealed the facility shall notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition. The procedure stated the nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been a change in resident condition. Except in medical emergencies, notifications will be made timely of a change occurring in the resident's medical/mental condition or status. The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. The policy did not include any information to describe what met the definition of a change in the resident's condition. 2. Record review revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including congestive heart failure, nonrheumatic aortic stenosis, presence of prosthetic heart valve, presence of cardiac pacemaker, history of transient ischemic attack, hypertensive heart disease with heart failure, sick sinus syndrome, and anxiety. Review of Resident #34's diuretic therapy plan of care related to heart failure dated [DATE] revealed they may cause dizziness, fatigue, postural hypotension, and an increased risk for falls. Observe for possible side effects every shift. Review of Resident #34's at risk for decreased cardiac output related to heart failure plan of care dated [DATE] revealed to monitor vital signs per physician order. Review of a nursing progress note dated [DATE] at 1:23 A.M. revealed the resident's blood pressure was , d+[DATE] mm/Hg on [DATE] at 9:34 P.M. and his pulse was 64. Review of Resident #34's physician orders and medication administration record (MAR) for [DATE] revealed the resident was ordered Amlodipine (calcium channel blocker) 5 milligrams (mg) daily for hypertension in the morning, Lasix (diuretic) 40 mg daily for edema in the morning, Lisinopril (ACE inhibitor) 40 mg daily for hypertension in the morning, Buspirone (anxiolytic) 5 mg in the morning, afternoon, and evening for hypertension, Spironolactone (diuretic) 100 mg daily in the morning for hypertension, Metoprolol (beta blocker) 100 mg in the morning and 100 mg in the evening for hypertension. Staff were to check the resident's blood pressure prior to administering the Metoprolol. Record review of the MAR dated [DATE] revealed Resident #34's blood pressure was ,d+[DATE] mm/Hg for the morning dose of Metoprolol (time not specified). The medication Metoprolol was administered at this time by Licensed Practical Nurse (LPN) #130. The resident did not have blood pressure or pulse parameters for the administration of the Metoprolol. The resident had also received Oxycodone (narcotic) 5 mg at 5:38 A.M. and Tylenol (analgesic) 325 mg at 8:06 A.M. for pain (these medications can enhance the effects of hypertension medications). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the MAR dated [DATE] revealed a secondary blood pressure reading of ,d+[DATE] mm/Hg and pulse of 73 (time not specified). The MAR identified the resident had a onetime order to send Resident #34 to the emergency room for low blood pressure on [DATE]. Review of a nursing progress note dated [DATE] from 9:31 A.M. to 9:52 A.M., revealed Resident #34 was transferred to the hospital due to an emergency in which the resident's urgent medical needs necessitated an immediate transfer. The reason for the transfer was abnormal vital signs and the resident had complaints of weakness and was hypotensive (,d+[DATE] and ,d+[DATE]) and had already received his morning medications. The Nurse Practitioner (CNP) #104 was notified and orders given to send the resident to the emergency room (ER) for evaluation. Review of a nursing progress note dated [DATE] at 4:36 P.M., revealed Resident #34 was admitted to the hospital for treatment of a diagnosis of septic shock. Interview on [DATE] at 8:46 A.M., with CNP #104 and Physician #105 revealed CNP #104 was in the building doing visits (on [DATE]) when the nurse approached her and reported Resident #34's blood pressure was low and she had already administered all his morning medications including blood pressure and diuretic medications. The CNP #104 and Physician #105 confirmed the nurse should have held the resident's blood pressure and diuretic medication for a blood pressure of ,d+[DATE] and notified either CNP #104 or Physician #105. CNP #104 reported she had to send the resident to the ER due to within an hour after receiving all his medication his blood pressure had dropped to ,d+[DATE] and she knew his blood pressure was going to continue to drop even more with all the medications he had received. Resident #34 would need close monitoring and treatment the facility could not offer due to his medical history and the potential for fluid overload if she had ordered the administration of intravenous fluids at the facility. CNP #104 and Physician #105 confirmed Resident #34's hospitalization could have been prevented if staff would have notified them of the blood pressure of ,d+[DATE] prior to administering all his medication. Interview on [DATE] at 9:40 A.M., with Registered Nurse (RN) #128 revealed if a resident's blood pressure was ,d+[DATE], she would have held his blood pressure and diuretic medication and notified the physician. Interview on [DATE] at 10:48 A.M., with Clinical Service Manager (CSM) #102 revealed the facility did not have a policy on blood pressure monitoring, however the nurse should have used nursing judgement and held the resident's medication (blood pressure medications and diuretics) and contacted the physician when the resident's blood pressure was ,d+[DATE]. Review of the American Heart Association article dated [DATE] revealed a reading of less than ,d+[DATE] millimeter of mercury (mm Hg) is considered hypotension. Hypotension is the term for blood pressure that is too low. A number of drugs can cause low blood pressure, including diuretics and other drugs that treat hypertension; heart medications such as beta blockers; drugs for Parkinson's disease; tricyclic antidepressants; erectile dysfunction drugs, particularly in combination with nitroglycerine; narcotics; and alcohol. Other prescription and over-the-counter drugs may cause low blood pressure when taken in combination with high blood pressure medications. Among the heart conditions that can lead to low blood pressure are an abnormally low heart rate (bradycardia), problems with heart valves, heart attack and heart failure. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In addition, review of Resident #34's physician order dated [DATE] revealed an order for daily weights for congestive heart failure. Review of Resident #34's weights dated [DATE] to [DATE] revealed no evidence the residents' weights were obtained on [DATE], [DATE], [DATE], and [DATE]. Interview on [DATE] at 3:17 P.M. with the Director of Nursing (DON) confirmed Resident #34's had orders for daily weights and there was no evidence the weights were obtained on [DATE], [DATE], [DATE], and [DATE]. 3. Record review revealed Resident #53 was admitted to the facility on [DATE] with diagnoses including myocardial infarction, syncope and collapse, hypertensive emergency, congestive heart failure, hypovolemia, acute kidney failure, hyponatremia, dehydration, and edema. Review of Resident #53's at risk for decreased cardiac output plan of care dated [DATE] revealed to monitor vital signs per physician order. a. Review of Resident #53's hospital discharge orders dated [DATE] and [DATE] revealed since the resident has heart failure, weights should be completed daily and notify the doctor of a weight gain of three pounds in one day or five pounds in a week. Review of Resident #53's physician orders dated [DATE], [DATE], [DATE], revealed to weigh resident every Monday, Wednesday, and Friday for congestive heart failure. Review of Resident #53's weights revealed on [DATE] the resident weighed 230 pounds and [DATE] the resident weighed 233.6 pounds, (which was a 3.6-pound weight gain), there was no evidence of physician notification. On [DATE] the resident weighed 235.8 pounds and on [DATE] he weighed 244.6 and a reweigh of 247.6 pounds, which was a 11.8-pound weight gain, there was no evidence of physician notification. Review of Resident #53's nursing progress note dated [DATE] revealed the resident had left the facility to attend a medical appointment with the pulmonologist. The nursing progress note revealed the pulmonology department called and reported the resident was sent to the ER by the physician due to a 13-pound weight gain. Review of Resident #53's nursing progress note dated [DATE] revealed the resident was admitted to the hospital for treatment of congestive heart failure. Review of Resident #53's re-admission history and physical dated [DATE] revealed the resident was a [AGE] year-old male who was found to have a 13-pound weight gain when he went out to an appointment. Ultimately, he was sent to the ER at that point. The resident was given intravenous Lasix (diuretic) 40 mg twice daily, put on strict fluid restrictions, and was stabilized. The resident reported he was down about 10 pounds and the edema in his legs was improving. He will be weighed daily and staff to notify if there was a three-pound weight gain with fasting weights in the morning prior to eating or drinking. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Review of Resident #53's physician's order dated [DATE] revealed the order was changed to weight daily in the morning prior to eating breakfast and to void prior to weighing and to notify the provider if there was a three-pound weight gain in one day or five-pound weight gain in seven days or less. Review of Resident #53's cardiology orders dated [DATE] revealed to take Torsemide (diuretic) 20 mg every morning, if there was a three-pound weight gain in 24 hours take an extra dose of Torsemide. Review of Resident #53's daily weights dated [DATE] revealed the resident's weight was 237.2 pounds and on [DATE] the resident's weight was 243 pounds, which indicated a 5.8-pound weight gain. There was no evidence of physician notification and no evidence the resident was administered an extra dose of Torsemide as ordered. Review of Resident #53's orders and MAR dated ,d+[DATE] revealed on [DATE] no evidence the extra dose of Torsemide was administered per order if there was a three-pound weight gain in 24 hours. Review of Resident #53's progress no [TRUNCATED]

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, record review, policy review and interview the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to ensure timely, accurate and thorough pressure ulcer assessments were completed and to ensure adequate interventions and treatment was in place to promote healing and prevent new ulcers from developing. This affected three residents (#29, #30, and #41) of three residents reviewed for pressure ulcers. The facility census was 65. Actual Harm occurred on 04/03/24 when Resident #29, who exhibited severe cognitive impairment, had current pressure ulcers present and required substantial/maximal assistance for bed mobility and total dependence for toileting was assessed to have new in-house developed pressure ulcers. The resident was assessed to have an unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer to the left buttock and a Stage II (Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister) pressure ulcer to the right buttock. The facility failed to identify the left buttock ulcer until it was unstageable. The new pressure ulcer development occurred due to the lack of adequate interventions including turning and repositioning. Actual Harm occurred on 09/20/23 when Resident #30, who exhibited severe cognitive impairment, had current pressure ulcers present and required moderate assistance with toileting and bed mobility was assessed to have two new in-house acquired pressure ulcers. An unstageable pressure ulcer to the right lower leg and a Stage II pressure ulcer to the right heel. The facility failed to identify the right lower leg pressure ulcer until it was unstageable. The new pressure ulcer development occurred due to the lack of adequate interventions including turning and repositioning and off-loading of the resident's heels. Actual Harm occurred on 02/28/24 when Resident #41, who required staff assistance for turning and repositioning was assessed to have a deterioration in status of a coccyx pressure ulcer with an increase in the presence of slough tissue. In addition, on 03/18/24 the resident was assessed to develop a new in-house acquired Stage II pressure ulcer to the right heel. The resident complained of increased pain to the right heel and voiced concerns staff failed to provide turning and repositioning interventions as needed to prevent the development and/or deterioration. In addition, the new pressure ulcer to the right heel developed due to a lack of adequate interventions including off-loading of the resident's heels. Findings include: Review of facility documentation revealed the facility identified six residents as having pressure ulcers (including Residents #29, #30, and #41). None of the pressure ulcers were identified as facility acquired. Review of a wound log provided by the facility identified Residents #29 and #30 had been identified to have a decline in the status of their ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	At the time of the survey, there were 21 residents on the 200 hall, 17 residents on the 300 hall (where Resident #29, #30, and #41 resided), and 21 residents on the 400 hall. The facility identified 24 residents as being dependent for bathing, dressing, and transferring. The facility identified 31 residents as requiring 1-2 staff assistance for bathing, dressing, and transferring. Interviews with direct care staff revealed a lack of staffing contributed to the development and deterioration of the pressure ulcers for these residents: Interview with Nursing Assistants #117, #118, #122, and #127, on 03/28/24 between 11:00 P.M. and 11:55 P. M. and 04/01/24 at 3:05 P.M. revealed there was one nursing assistant per hallway on the 7:00 P.M. to 7:00 A.M. shift. and residents were neglected as staff were not able to provide the care needed, including turning and repositioning residents and providing incontinence care every two hours as required. Staff stated it was just survival there in getting things done that need to be done. During the interview, the STNA revealed Resident #29 would lay on her sides and would wear heel protector boots when they were applied by staff. 1. Review of the medical record for Resident #29 revealed an admitted [DATE] and diagnoses including diabetes and acute kidney failure. Review of an admission nursing assessment dated [DATE] revealed the resident had a Stage II (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) pressure ulcer on the coccyx, a Stage I (intact skin with a localized area of non-blanchable erythema (redness) , described as a diabetic ulcer to the right heel, and an unstageable diabetic ulcer on the left heel. Record review revealed there were no descriptions or measurements of the areas completed at this time. Physician's orders were obtained on 11/17/23 to offload heels in bed as tolerated and turn and reposition as tolerated and as needed. Review of a Minimum Data Set (MDS) assessment completed 11/21/23 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 (moderate cognitive impairment). The assessment revealed Resident #29 required substantial/maximal assistance with rolling left to right and was dependent for dressing, bathing, and toileting. The assessment noted the resident had two unstageable pressure ulcers. Review of weekly wound notes by the wound nurse practitioner revealed on 11/22/23 the resident was noted with moisture associated skin damage (MASD) of the sacrum measuring 3.5 cm by 4.5 cm by 0.1 cm deep. The left heel was noted to be an unstageable pressure ulcer measuring 4.5 cm by 4.3 cm. with 100% necrosis. The right heel was noted to be an unstageable pressure ulcer measuring 2 cm by 2.5 cm with 100% necrosis. The note stated to turn and reposition the resident every two hours. Review of weekly wound notes by the wound nurse practitioner on 11/29/23 revealed the ulcer measurements remained the same. Recommendations included to keep heels off the bed, heel protector boots, turn and reposition every two hours. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the plan of care dated 12/01/23 revealed the resident was noted with an activities of daily living/mobility deficit. Interventions included transfer with two assists, provide total assistance with bed mobility, mechanical lift with two assist, and total dependence with toileting. On 12/04/23 potential for alteration in skin integrity related to immobility and history of skin breakdown was added. Interventions included treatments as ordered, encourage to offload heels as tolerated, turn and reposition as needed, and use pillows/pads to support/position as appropriate. (The use of Prevalon boots was not part of the plan of care until 03/31/24). The resident was hospitalized from 12/04/23 to 12/10/23. Upon return on 12/10/23, Resident #29 was noted to have an unstageable pressure ulcer on the coccyx measuring 2.0 cm by 1.5 cm, an unstageable pressure ulcer on the right heel measuring 2.5 cm by 2.5 cm, a Stage II pressure ulcer on the sacrum measuring 2 cm by 0.5 cm by 0.1 cm, a Stage II pressure ulcer on the right buttock measuring 1.5 cm by 1 cm by 0.1 cm deep, and an unstageable pressure ulcer on the left upper spine measuring 0.5 cm by 1.5 cm. (The left heel was not mentioned). Review of wound care notes by the Wound Nurse Practitioner dated 12/20/23 revealed Resident #29 was noted to have an unstageable pressure ulcer of the left heel measuring 4.5 cm by 4.3 cm with 100% necrotic tissue; an unstageable pressure ulcer of the right heel measuring 2 cm by 2.5 cm with 100% necrotic tissue; a MASD wound of the sacrum measuring 6.5 cm by 2.5 cm by 0.1 cm deep; no other areas were noted. The wound status was noted to be declined. The note stated to keep heels off bed, heel protector boots, turn and reposition every two hours. The resident was seen at an outside wound clinic on 12/21/23 and was noted to have pressure ulcers on the coccyx (3 cm by 0.8 cm by 0.2 cm); right gluteus (1 cm by 0.5 cm by 0.1 cm); left heel (5 cm by 5 cm by 0.1 cm) and right heel (2 cm by 2 cm by 0.1 cm). Recommendations included Prevalon boots while in bed or float heels on pillows and turn from left to right every two hours and as needed. The resident was hospitalized from 12/27/23 until 01/08/24. Upon return, Wound Care notes from the wound nurse practitioner on 01/10/24 revealed the resident had the following pressure ulcers: left heel unstageable measuring 4.7 cm by 4 cm with 100% necrosis; right buttock Stage III (Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) measuring 1.7 cm by 1 cm by 0.1 cm deep; sacrum Stage III measuring 4.7 cm by 0.6 cm by 0.3 cm deep. Again, recommendations were made for keeping heels off bed, heel protector boots, and turn and reposition every two hours. The resident was hospitalized from 01/14/24 to 01/20/24. On 01/24/24 the resident had physician's orders for turn and reposition as tolerated and off load heels in bed. Weekly wound notes dated 01/24/24 revealed the resident had the following pressure ulcers: Coccyx Stage III measuring 8.2 cm by 5.0 cm by 0.4 cm deep; right gluteus Stage II measuring 4.5 cm by 2.0 cm by 0.1 cm deep; left heel Stage III measuring 5.0 cm by 4.5 cm by 0.1 cm deep; right heel Stage III measuring 1.0 cm by 1.0 cm by 0.1 cm deep. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Marietta	5001 State Route 60 Marietta, OH 45750

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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 0686 Level of Harm - Actual harm Residents Affected - Few	On 02/01/24 the outside wound clinic recommended Prevalon boots in bed or float heels on pillows and turn every two hours. Interview with Clinical Services Manager #102 on 04/03/24 at 10:00 A.M. confirmed as of this date, Resident #29 did not have a physician's order for Prevalon boots. She stated the Prevalon boots had been added to the care plan on 03/31/24, even though they were recommended by the wound clinic initially on 12/21/23. A physician progress note on 03/05/24 revealed Resident #29 had unstageable pressure ulcers on her heels that were causing her a lot of pain. An MDS assessment completed 03/18/24 documented the resident had a BIMS score of 6 (severe cognitive impairment) and was dependent on staff for rolling left to right, toileting, dressing, and transfers. Observations on 03/26/24 at 1:35 P.M. and 3:45 P.M. revealed Resident #29 was in bed on her back with the head of the bed elevated. The resident did have heel boots on both feet at those times. Observations on 03/27/24 at 9:38 A.M., 11:17 A.M., and 1:54 P.M. revealed Resident #29 was in bed on her back with slippers on (no heel protector boots) and her heels were resting on a pillow. On 03/27/24 wound notes by the wound nurse practitioner revealed the resident had an unstageable pressure ulcer on the left heel measuring 4.2 cm by 4.5 cm by 0.2 cm with 75% necrotic tissue and 25% slough, an unstageable pressure ulcer on the right heel measuring 2 cm by 2.6 cm by 0.1 cm deep with 90% slough and 10% granulation, and a Stage III pressure ulcer on the sacrum measuring 8.8 cm by 2.2 cm by 0. 3 cm deep with 75% slough and 25% granulation. Recommendations included keeping heels off bed, heel protector boots, and turn and reposition every two hours. Observations on 03/28/24 at 8:41 A.M. and 10:38 A.M. revealed the resident was in bed on her back with her heels resting on a pillow (no heel protector boots on). At 10:38 A.M. the resident had a flat pillow under her right side, but it did not tilt her enough to relieve pressure from her buttocks. At 12:11 P.M. the resident was in bed on her back with the staff feeding lunch. Interview with Certified Nurse Practitioner (CNP) #104 on 04/01/24 at 8:15 A.M. revealed Resident #29 should have Prevalon boots on and she should be turned so that the pressure was off her buttocks. Review of the March 2024 treatment administration record for Resident #29 revealed off loading heels in bed (ordered 01/24/24) was not documented as completed on 03/07/24, 03/12/24, 03/13/24, and 03/14/24. Turning and repositioning as tolerated and as needed (ordered 01/24/24) was not documented as completed on 03/07/24, 03/12/24, 03/13/24, and 03/14/24. Application of heel boots was not listed on the March 2024 treatment administration record. Interview with Nursing Assistant #122 on 04/01/24 at 3:05 P.M. Resident #29 would lay on her sides and would wear heel protector boots when they were applied by staff. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with Clinical Services Manager #102 on 04/03/24 at 10:00 A.M. confirmed the resident's pressure areas were not measured until 11/22/23 and should have been measured upon admission. She confirmed the resident's right heel was noted as a Stage I upon admission and on 11/22/23 was noted with necrosis which appeared to be a decline in the ulcer. Observation of the treatments for Resident #29 on 04/03/24 at 11:20 A.M. revealed the resident was in bed on her back. The resident had heel protector boots on but not Prevalon boots (have a cut out area near the heel to avoid any pressure at all on the heels). The resident was observed to have a 3.5 cm by 5.5 cm by 0.2 cm deep area on the left heel with 75% brown necrotic tissue covering the wound and 25% granulation. She had a 3.5 cm by 4 cm by 0.1 cm deep area on the right heel that was 75% slough and 25% granulation tissue. She had a 4 cm l by 1 cm open area on the coccyx that had 90% slough and 10% granulation described as unstageable. She also had two new areas on the buttocks: left upper buttock 2.5 cm by 4 cm unstageable with white slough and right upper buttock 0.5 cm by 0.5 cm by 0.1 cm Stage II open area. Interview with Assistant Director of Nursing #128 on 04/03/24 at 11:20 A.M. confirmed at the time of the observation, Resident #29 had developed two new pressure ulcers on her buttocks since the week prior which included an unstageable ulcer to the left upper buttock and a Stage II pressure ulcer to the right buttock. 2. Review of the medical record for Resident #30 revealed an admitted [DATE] with diagnoses including diabetes and adult failure to thrive. The resident also had diagnoses of Stage IV (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location) pressure ulcer with osteomyelitis of the vertebrae, sacral, and sacrococcygeal areas and a deep tissue injury on the left heel present upon admission. The resident received Hospice services. On 07/11/23 the resident was noted to have an unstageable pressure ulcer to the coccyx measuring 14.5 cm by 6.3 cm by 2.4 cm deep with undermining, 50% slough 10% eschar. The resident had an unstageable pressure ulcer to the left hip measuring 7 cm by 6.5 cm by 3 cm deep with undermining with 50% slough/eschar. The resident had an unstageable pressure ulcer to the left heel measuring 4 cm by 6 cm by 0. 1 cm deep with 25% eschar. Review of the plan of care dated 07/11/23 revealed the resident had an activities of daily living deficit. Staff were to provide extensive assistance with bed mobility. The care plan also noted the resident had alteration in skin integrity due to pressure ulcers and treatments were to be provided as ordered. Review of wound care notes by the Wound Nurse Practitioner revealed on 09/20/23 the resident continued with the Stage IV pressure ulcer on the coccyx (12 cm by 9 cm by 2 cm deep), Stage III pressure ulcer on the left heel (1.5 cm by 4 cm) and left posterior thigh (4.5 cm by 3.2 cm by 1.8 cm). The resident was now noted to have a new in-house developed pressure ulcer on the right heel, a Stage II pressure ulcer measuring 6 cm by 10 cm described as a blister that drained) and an in-house developed unstageable pressure ulcer on the right lateral lower leg measuring 9.5 cm by 1.5 cm. The wound care notes did not indicate how the areas developed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/09/23 (following the development of the new in-house acquired pressure ulcers on 09/20/23) the plan of care revealed the resident had potential for altered skin integrity related to a history of skin breakdown, impaired mobility, and diabetes. Interventions included to encourage to off load heels as tolerated and encourage to turn and reposition as needed. The resident was hospitalized from 10/05/23 to 10/09/23. Upon return, on 10/11/23 the resident was noted to have unstageable pressure ulcer to the coccyx (12 cm by 8.5 cm by 1.2 cm deep), an unstageable pressure ulcer to the left hip (4 cm by 1.8 cm by 1.8 cm deep), a right lower leg pressure ulcer (9 cm by 1.5 cm), a left heel pressure ulcer (3.5 cm by 4 cm) and a right heel pressure ulcer (4 cm by 5 cm). On 10/09/23 the resident had physician's orders to off load heels in bed as tolerated, turn and reposition as tolerated and as needed, and Prevalon boots to be worn to bilateral feet at all times as tolerated. (There was nothing documented in the record to indicate the resident refused care). Review of a quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 7 (severe cognitive impairment). The assessment revealed Resident #30 required moderate assistance with toileting and rolling in bed. The resident was dependent on staff for transfers. Observations on 03/26/24 at 1:33 P.M. revealed Resident #30 was in bed on her back (no pillows on either side). Her left heel was resting on a pillow and her right heel was resting on the mattress. She did not have Prevalon boots on. On 03/26/24 at 3:44 P.M. the resident remained in bed on her back. (The surveyor was unable to determine if boots were on as the resident was resting). Observations on 03/27/24 at 7:52 A.M., 9:35 A.M., and 11:15 A.M. revealed Resident #30 was in bed on her back. At 1:53 P.M. the resident was up in a wheelchair while the air mattress on her bed was changed. At 2:45 P.M. the resident was back in bed on her back. Observations on 03/28/24 at 8:36 A.M., 10:39 A.M., and 12:10 P.M. revealed Resident #30 was in bed with a flat pillow under her right side which slightly tilted her to her left side. Her upper body was tilted but her buttocks were still resting on the mattress. Interview with Certified Nurse Practitioner (CNP) #104 on 04/01/24 at 8:15 A.M. revealed Resident #30 should have her Prevalon boots on in bed. She stated that the resident did have pain with movement but staff should attempt to turn the resident, so she is off of her bottom. Interview with Nursing Assistant #122 on 04/01/24 at 3:05 P.M. revealed Resident #30 would wear the Prevalon boots when applied by staff. Review of the March 2024 Treatment Administration Record (TAR) for Resident #30 revealed a treatment to the right heel of paint with betadine every day was completed through 03/06/24. There was no evidence of treatment to the area from 03/06/24 until 03/26/24. In addition, Prevalon boots at all times, off load heels while in bed, and turn and reposition as tolerated were not documented as completed on 03/07/24, 03/12/24, 03/13/24, 03/14/24, 03/15/24, and 03/18/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the wound care notes by the wound nurse practitioner dated 03/27/24 revealed the resident's left heel was healed. The pressure ulcer on the coccyx was noted to be Stage IV, measuring 7 cm by 6 cm by 0. 8 cm deep (smaller in size). The left posterior thigh was 1.4 cm by 1.4 cm by 1.1 cm deep (smaller in size). The right heel was unstageable (3.2 cm by 2.2 cm by 0.1 cm) smaller in size. The right lateral lower leg was an unstageable pressure ulcer and measured 13 cm by 1.2 cm by 0.2 cm (larger in size since last readmission 10/09/23). Interview with ADON #128 on 04/03/24 at 8:25 A.M. and 8:50 A.M. confirmed there was no evidence Resident #30 had refused any treatment related to pressure ulcers. She confirmed the TAR lacked documentation that treatments were completed as ordered. She confirmed the pressure ulcer on the right heel developed in the facility and did not have treatment provided to it from 03/06/24 until 03/26/24. She stated the resident's pressure ulcers on the right heel and right lower leg were noted as declined on the pressure ulcer grid provided to the surveyors as the areas had gotten larger. She stated the pillows used by the facility were not thick enough to use for turning/repositioning to be able to alleviate pressure off of the residents' buttocks/backside. 3. Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including Parkinson's disease and chronic pain syndrome. Review of an admission nursing assessment dated [DATE] revealed a skin assessment which indicated a pressure ulcer on the coccyx. There was no size, description, or staging of the area. No pressure ulcers were noted to the heels. The assessment indicated the resident was at high risk for skin breakdown. The assessment indicated that friction and shear was a problem (sliding against sheets), and that heel elevation would be implemented. The resident had physician's orders on 01/20/24 to off-load heels while in bed as tolerated and turn and reposition as tolerated and as needed. Review of the wound nurse practitioner (WNP) notes on 01/24/24 revealed Resident #41 had a Stage III pressure ulcer on the coccyx with yellow slough measuring 3.7 centimeters (cm) long by 3.5 cm wide by 0.1 cm deep. The note indicated there was 90% granulation and 10 % slough. (Slough is non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed). The note stated to keep pressure off ulceration and avoid friction and shearing. An MDS assessment completed 01/25/24 documented the resident had a BIMS score of 13, indicating intact cognition. The assessment revealed the resident was dependent upon staff for toileting, showering, dressing, hygiene, rolling in bed, and transfers. The MDS indicated the resident had one Stage III pressure ulcer on admission. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the plan of care for Resident #41 dated 01/25/24 revealed an activities of daily living/mobility/functional ability performance deficit. Interventions included transfer with assist of two, provide total assist with bed mobility, provide total assist with transfer, and incontinence care after each episode. The plan of care on 01/18/24 revealed the resident had an unstageable pressure ulcer to the coccyx and to provide treatments as ordered. The plan of care on 02/04/24 revealed the resident had a potential for alteration in skin integrity related to history of skin breakdown, immobility, and incontinence. The goal was not to develop further skin breakdown. The interventions included pressure redistribution mattress to bed, turn and reposition as needed using lift pad to minimize friction and shear, and educate resident as to causes of skin breakdown including frequent positioning. (The interventions did not include Prevalon boots or floating heels). The plan of care on 03/19/24 revealed the resident had an alteration in skin integrity of self-inflicted friction blister on right heel. The interventions included treatments per order. (The plan of care also did not include the use of Prevalon boots or floating heels). Review of the medical record revealed on 02/08/24 Resident #41 went to the outside wound clinic. An unstageable pressure ulcer to the coccyx was noted measuring 4.5 cm long by 3 cm wide by 0.1 cm deep with purulent exudate. Recommendations from the wound clinic included Prevalon heel boots daily and turn every two hours. On 02/19/24 the resident returned to the outside wound clinic. An unstageable pressure ulcer to the coccyx was noted measuring 4.5 cm long by 4 cm wide by 0.1 cm deep with slough noted. Recommendations included Prevalon heel boots daily and turn every two hours. On 02/28/24 the WNP notes indicated the pressure ulcer on the coccyx was a Stage III with yellow, soft, black slough measuring 4 cm long by 2.5 cm wide by 0.1 cm deep. The note indicated the wound now had 90 % slough and 10 % granulation. The resident was hospitalized from 03/02/24 to 03/09/24. A late entry nurse's progress note, dated 03/13/24 revealed as of 03/09/24 the pressure ulcer on the coccyx measured 3.5 cm long by 2.5 cm wide. No depth was documented. 100% slough/necrosis noted. A treatment to the area started on 03/10/24 of applying small amount of iodosorb ointment to wound bed, cover with gauze, secure with Allevyn once daily. The treatment was not documented as done on 03/11/24, 03/13/24, and 03/19/24. A physician's order was written on 03/06/24 for Prevalon boots at all times in bed as tolerated. Review of the record revealed on 03/17/24 physician's orders for turn and reposition as tolerated and as needed-use lift pad to minimize friction and shear, and off load heels while in bed as tolerated were obtained post hospitalization . Record review revealed on 03/18/24 at 11:11 A.M. nurses progress notes indicated the resident was rubbing his foot back and forth on the bed. The resident stated, that is how I scratch my foot. Fluid filled blister on right heel measuring 2 cm by 1.5 cm by 0.1 cm deep. On 03/18/24 an additional order was written to encourage to wear Prevalon boots while in bed (even though already ordered previously on 03/06/24). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the treatment administration record for March 2024 revealed that the Prevalon boots were not documented as applied on 03/12/24, 03/13/24, 03/14/24, and 03/15/24 (the days leading up to the development of the blister on the right heel). In addition, offloading of the heels was not documented as done on 03/12/24, 03/13/24, 03/14/24, and 03/15/24 and turning/repositioning was not documented as done on 03/12/24, 03/13/24, 03/14/24, and 03/15/24. There was no evidence of refusals. On 03/19/24 a treatment was started for an area to the right heel noted as a self-inflicted friction blister. The area was to be cleansed with wound cleanser, pat dry, apply puracol to area and cover with foam every day. Review of wound practitioner notes on 03/20/24 revealed Resident #41 had a new friction blister that opened from the resident repeatedly rubbing his heel against the bed measuring 2.5 cm by 1.3 cm by 0.1 cm with pink granulation. The resident's Stage III pressure ulcer to the coccyx measured 3 cm by 3 cm by 0.3 cm deep. The area was noted with 10% granulation and 90% slough. Review of notes from the outside wound clinic on 03/29/24 revealed Resident #41 had a Stage III pressure ulcer on the coccyx measuring 3 cm by 2.3 cm by 0.6 cm deep with slough. The resident was noted to have a pressure injury on the right heel measuring 2.1 cm by 2.0 cm by 0.2 cm deep. It was noted as a stage two pressure ulcer. Record review revealed the pressure ulcer to the resident's right heel was not properly identified by the facility as being a pressure ulcer and was not listed on their pressure ulcer log provided to the surveyors. Interview with Resident #41 on 03/26/24 at 1:22 P.M. revealed the treatments for his pressure ulcer were to be done daily but were not always done daily. He stated the staff did not turn him every two hours. He stated the facility was understaffed. He stated he sits up in his wheelchair until he becomes uncomfortable and then staff assist him to bed. The resident was observed in the wheelchair at the time of this interview. Interview with Certified Nurse Practitioner (CNP) #104 on 04/01/24 at 8:15 A.M. revealed Resident #41 never should have developed the friction area on his right heel if he had the Prevalon boots on or if his heels were elevated as ordered. CNP #104 confirmed she had no knowledge of the resident refusing to wear the Prevalon boots or float heels. Interview with Resident #41 on 04/01/24 at 9:55 A.M. revealed he had not refused his Prevalon boots recently as they benefit him. Interview with Assistant Director of Nursing (ADON) #128 on 04/01/24 at 10:25 A.M. confirmed the pressure ulcer to the resident's coccyx had declined in the percentage of granulation tissue to slough from 01/24/24 to 02/28/24. ADON #128 confirmed the lack of documentation on the March 2024 treatment administration to indicate treatments were done as ordered and Prevalon boots were applied as ordered. She stated the resident refused to wear them but confirmed there was no documentation of this. She confirmed the plan of care was silent to the need for Prevalon boots or floating heels or refusal of care. She stated that, although the physician's orders and plan of care indicated to turn and reposition as needed, residents, including Resident #41 should be turned every two hours. ADON #128 confirmed the pressure ulcer on Resident #41's coccyx was not measured until 01/24/24. She confirmed it should have been assessed and measured on admission. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observations on 03/26/24 at 3:47 P.M. revealed Resident #41 was still sitting up in the wheelchair. Observations on 03/27/24 at 7:35 A.M. and 9:35 A.M. revealed the resident was in bed on his back (no positioning pillows noted in the bed). At 11:18 A.M. and 1:50 P.M. the resident was observed up in the wheelchair. (All observations identified the resident had pressure to the ulcer on the coccyx). Observations on 03/27/24 at 2:00 P.M. of the treatments to the coccyx and right heel revealed an open area to the right heel measuring 1.8 cm by 0.8 cm by 0.1 cm deep. The resident complained of pain to the right heel during the treatment. The pressure ulcer on the sacrum measured 2.5 cm by 1.5 cm by 0.2 cm and contained yellow slough. The wound was described by the wound nurse practitioner as 75% slough and 25% red tissue. The skin around the ulcer was very red. The treatments were completed by the wound nurse practitioner and Assistant Director of Nursing #128. During the treatments, the wound nurse practitioner explained to the resident how important it was to stay off of his bottom for healing of the wound (even though the resident was dependent upon staff for transfers and repositioning). Upon completion of the treatments, the resident was left in bed on his right side with his heels resting on the mattress and without any Prevalon boots as ordered. Observation on 03/28/24 at 8:28 A.M. revealed the resident was sitting on the edge of the bed eating breakfast. At 10:40 A.M. and 12:08 P.M. the resident was up in the wheelchair (all observations revealed the resident had pressure to the ulcer on the coccyx). Review of the facility policy titled Pressure Ulcer Prevention Protocols/Risk Assessment, dated 11/30/23 revealed resident's level of risk for pressure ulcer development would initially be determined at the time of admission or readmission taking into consideration the nature of risk to include underlying causes. Residents were considered high risk when admitted with a pressure ulcer. Pressure ulcer preventative/supportive precautions would be implemented. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295 and Complaint Number OH00151794.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on medical record review, staff interview, resident interview, and policy review, the facility failed to ensure a resident received services and assistance to maintain bladder continence and failed to ensure a resident received appropriate treatment and services to treat urinary tract infections. This affected two of 36 residents reviewed for quality of care (#25 and #29). The facility census was 66. Actual Harm occurred on 05/03/23 when Resident #25, who had been always continent of bladder as assessed to be frequently incontinent of bladder. The resident reported the increased incontinence was a result of having to wait on staff to assist him to use the urinal resulting in accidents/incidents of urinary incontinence. Actual Harm occurred on 12/08/23 to Resident #29 when she required re-hospitalization and admission for seven days for treatment of sepsis and bacteremia secondary to UTI requiring intravenous antibiotic administration and infectious diseases consult due to the facility's failure to administer intravenous antibiotics as ordered and obtain urine samples for analysis including culture and sensitivity. The facility continuously failed to follow physician orders related to the infectious disease consult as the consult was never completed even after Resident #29's physician continued to order the infectious disease consult on orders dated 12/11/23, 01/22/24, and 01/23/24. Findings include: 1. Review of the medical record for Resident #25 revealed an admitted [DATE] and diagnoses including peripheral vascular disease, chronic obstructive pulmonary disease, history of traumatic brain injury, and limited mobility. Review of an annual Minimum Data Set (MDS) assessment completed 03/26/23 revealed the resident was always continent of bladder. Review of a MDS assessment completed 05/03/23 revealed the resident was now frequently incontinent of bladder. There was no other screening assessment completed for the resident's bladder function until the 03/19/24 restorative screening was completed. Review of the plan of care for Resident #25 revealed on 12/17/23 an Activities of Daily Living/mobility deficit was noted. The goal was to maintain the current level of function in transfer, including toilet transfer. Interventions included: mechanical lift transfer with two assist; total dependence in toilet use (toilet transfer and toilet hygiene), and re-assess quarterly and as needed. On 02/16/24 an MDS assessment indicated the resident had a brief interview for mental status (BIMS) score of 15, indicating intact cognition. It further indicated the resident was dependent upon staff for toileting and was frequently incontinent of bladder. There was no evidence of an evaluation of the decline in Resident #25's urinary continence. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Review of bladder documentation from 03/21/24 to 04/03/24 revealed the resident was documented to be incontinent on 03/27/24, 03/30/24, 04/01/24, and 04/02/24. The resident was continent on the other days. (Per interview with the Director of Nursing on 04/03/24 at 4:00 P.M., the bladder documentation is only available in the computer for 30 days prior). There was no evidence the facility identified Resident #25's bladder incontinence was identified by the facility. There was no evidence the facility had developed and implemented a plan to restore Resident #25's bladder to normal function. The facility provided a Restorative Screening assessment dated [DATE] for Resident #25. It indicated the resident required the use of a Hoyer (mechanical) lift for transfer. It stated the resident was always incontinent of bladder. It stated that a trial of a toileting program had not been attempted in the facility. The section on incontinence pattern was blank. The section on appropriate interventions based on assessment was blank. The reason for not starting a toileting program was blank. The facility also provided a physician progress note 02/08/24 that stated the resident had mild neurogenic bowel and bladder. On 04/01/24 the resident's plan of care included the resident had bladder incontinence. The interventions included check resident if he/she is continent, offer to assist with toileting, and if incontinent, provide incontinence care. Interview with Resident #25 on 03/27/24 at 10:33 A.M. revealed he can use a urinal to urinate. However, he likes to use it in bed and not while up in his wheelchair. He stated that he required the use of a Hoyer (mechanical) lift and two staff assistance to transfer to bed. He stated that there was usually only one aide working on each hall. Therefore, the aide had to go and find help when he wanted to be transferred to bed to use the urinal, and this takes a long time because the staff on the other halls were busy. He stated he has accidents and is incontinent of urine waiting on the staff to assist him to use the urinal. He stated the resident care at the facility had deteriorated. He stated the nursing assistants were stressed out and say they had a lot of work to do and then they quit. He stated the Director of Nursing told him they could not have any more nursing assistants until the census went up. (There were 21 residents residing on the hallway where Resident #25 lived). Interview with Nursing Assistants (#117, #118, #122, and #127) on 03/28/24 between 11:00 P.M. and 11:55 P.M. and on 04/01/24 at 3:05 P.M. revealed there was one nursing assistant per hallway on the 7:00 P.M. to 7:00 A.M. shift. Staff stated there were not enough staff to answer call lights timely. Staff stated if a resident required two staff for transfer, they had to go find someone on another hall to help and had to wait until that staff was not busy. Staff stated residents were neglected as staff were not able to provide the care needed including toileting assistance/incontinence care. Staff stated residents sometimes had to wait a long time to use the bathroom. Interview with Nursing Assistant #125 on 04/03/24 at 9:20 A.M. confirmed Resident #25 used a urinal. Nursing Assistant #125 stated the resident usually lays down to use the urinal and the bed pan with staff assistance. Nursing Assistant #125 confirmed the resident was incontinent at times but he/she did not know why. (continued on next page)

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Legacy Marietta	5001 State Route 60 Marietta, OH 45750

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Interview with Director of Nursing (DON) #147 on 04/03/24 at 4:00 P.M. confirmed there had been no evaluation to determine why Resident #25 had declined in bladder continence. She confirmed the restorative screening assessment (dated 03/29/24) was not fully completed. The DON verified there was no evidence the facility identified Resident #25's bladder incontinence and there was no evidence the facility had developed and implemented a plan to restore Resident #25's bladder to normal function. Interview with Certified Nurse Practitioner (CNP) #104 on 04/04/24 at 10:45 A.M. revealed Resident #25 did have some urinary retention, but this did not explain a decline in continence. On 04/04/24 Assistant Administrator #137 provided information which indicated the facility did not have any residents on a restorative toileting program. Review of the facility policy titled Continence Programs, dated 06/08/22 revealed the purpose of continence programs included maintaining or improving bladder and/or bowel functioning. It stated: 1) residents who may be appropriate for a bladder and/or bowel program must fall into one of three different categories upon assessment: 2) all current residents who develop a continence problem in bladder and/or bowel, when there was no evidence of incontinence concerns when the initial MDS and quarterly reassessments were performed previously. 3) A resident who develops a continence problem which may be infrequent and warrants further investigation. Continence programs are designed for residents that are cognitively and physically able to participate in toileting activities. The policy stated an assessment should be completed and the types of continence programs were listed in the policy. 2. Review of the medical record for Resident #29 revealed an admitted [DATE] with diagnoses including diabetes and acute kidney failure. A Minimum Data Set (MDS) assessment completed 11/21/23 documented a BIMS score of 12, indicating moderately impaired cognition. It indicated the resident was dependent upon staff for dressing, bathing, and toileting. The resident was admitted to the facility from the hospital after being treated for sepsis shock and urinary tract infection. Upon admission on 11/15/23 the resident had a physician's order for Meropenem (an antibiotic to treat infections) 1 gram by intravenous every eight hours until 11/23/23. Hospital records indicated the resident got the last dose at the hospital on 11/15/23 at 11:50 A.M. The resident arrived at the facility at 7:50 P.M. Review of the medication administration record (MAR) for November 2023 revealed the facility set up the medication to start on 11/16/23 and to give at 12:00 A.M., 8:00 A.M., and 4:00 P.M. However, review of the MAR for November 2023 revealed the medication was not given at all on 11/16/23 and did not start until 12:00 A.M. on 11/17/23. Review of a physician's progress note on 11/20/23 revealed the resident had a temperature of 100.5 and was having increasing confusion. She did miss a dose of her IV antibiotics for her urinary tract infection. She missed that on 11/16/23. The patient would have her antibiotic extended for one dose as she did miss one dose on 11/16/23. Review of the MAR for November 2023 revealed the resident did get one additional dose on 11/24/23 (the resident received one additional dose even though she had actually missed three doses). (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Record review revealed a physician's order on 11/27/23 for a urinalysis by straight catheterization with culture if indicated. The urine specimen was collected on 11/28/23. The urine culture indicated gross contamination and suggested repeat if UTI still suspected. There was no evidence the urine culture was repeated. There was a physician's order for a urinalysis for culture and sensitivity on 11/30/23. However, there was no evidence that the urinalysis for culture and sensitivity was completed. Review of a physician's progress note on 12/04/23 revealed the resident recently had a UTI and was in the hospital. She also had some pneumonia and was treated with the antibiotic, Azithromycin. This morning her temperature was 101 and over the weekend it was 103. She reports chills and flank pain. The plan was to send the resident to the emergency room . The resident was admitted and remained in the hospital until 12/10/23. Review of hospital records dated 12/08/23 revealed the resident was admitted with sepsis and bacteremia secondary to UTI. Urine culture growing ESBL-E-coli. Infectious disease consulted and plan for Ertapenem (antibiotic) at discharge for 14 days. Resident #29 returned to the facility on [DATE] at 5:18 P.M. The resident had a physician's order for Ertapenem 1 gram intravenous every 24 hours for 14 doses. It was set up to start on 12/11/23. However, review of the December 2023 MAR revealed it was documented as not available on 12/11/23. The resident received the dose on 12/12/23. However, the dose was not documented as given on 12/13/23 as the resident went out to the hospital and returned on the same day. The resident received 12 additional doses from 12/14/23 to 12/25/23 for a total of 13 doses. A physician's progress note dated 12/11/23 stated to make sure the resident had a follow up with infectious disease. A physician's order dated 12/11/23 stated to follow up with infectious disease physician in two to four weeks. There was no evidence this was done. A physician's order on 01/22/24 revealed to follow up with infectious disease in one week. A physician's progress note dated 01/23/24 revealed to refer to infectious disease due to elevated white count. There was no evidence this was done. Interview with Clinical Services Manager (CSM) #102 on 04/03/24 at 10:00 A.M. confirmed Resident #29 did not receive the ordered antibiotic on 11/16/23. She stated the resident should have received the three doses on 11/16/23 and she did not know why she didn't. She confirmed the urine test ordered 11/30/23 was not completed as ordered. She confirmed the antibiotics ordered to start on 12/11/23 should have been given on 12/11/23. She confirmed there was no evidence the resident was seen by the infectious disease physician as ordered. Interview with Certified Nurse Practitioner (CNP) #104 on 04/04/24 at 10:45 A.M. confirmed that not receiving all of the doses of IV antibiotic as ordered could have contributed to the resident having to be re-hospitalized [DATE]. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295 and Complaint Number OH00151794.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, interview, and policy review the facility failed to ensure intravenous (IV) fluids were administered per orders. This affected one resident (#34) of 36 reviewed for quality of care. Findings included: Medical record review revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, heart failure, sepsis, urinary tract infection, paralytic ileus, nausea with vomiting, diabetes mellitus, anemia, hyponatremia, and liver disease. Review of Resident #34's nurses note dated 03/19/24 at 2:17 P.M., revealed the resident was lying in bed saying he's not feeling well. He had eaten less than 50% of his meals. New orders received for one liter of Sodium Chloride Solution 0.9% at 100 milliliter (ml) per hour (hr.) intravenous for acute kidney injury, stool cultures for diarrhea, hold Lasix and Spironolactone for three days for acute kidney injury, stop metformin for diarrhea and acute kidney disease, completed blood count (CBC) and basic metabolic profile (BMP) on 03/20/24 and 03/25/24, and daily weight for congestive heart failure. Review of Resident #34 written orders dated 03/19/24 and 03/20/24 revealed Sodium Chloride Solution 0.9% at 100 milliliter (ml) per hour (hr.) intravenous for acute kidney injury, however, was discontinued on 03/20/24 due to it was not administered on 03/19/24. On 03/19/24 Certified Nurse Practitioner (CNP) #104 also ordered stool cultures for diarrhea, hold Lasix and Spironolactone for three days for acute kidney injury, stop metformin for diarrhea and acute kidney disease, completed blood count (CBC) and basic metabolic profile (BMP) on 03/20/24 and 03/25/24, and daily weight for congestive heart failure. Review of Resident #34's medication administration records dated 03/2024 revealed on 03/19/24 Sodium Chloride Solution 0.9% at 100 milliliter (ml) per hour (hr.) intravenous for acute kidney injury was ordered but not administered until noon on 03/20/24 (after it was discontinued). Review of Resident #34's medication pass note dated 03/21/24 at 6:20 P.M., revealed the order for Sodium Chloride Solution 0.9% at 100 milliliter (ml) per hour (hr.) intravenous for acute kidney injury was discontinued. Interview on 03/26/24 at 1:22 P.M., with Medical Director (MD)/Physician #105 confirmed orders were written for Resident #34 to have IV fluids and these were not administered timely. Physician #105 reported the facility let orders set around and she had voiced concerns since October/November 2023 with the facility. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/01/24 at 3:17 P.M., with CNP #104 revealed she had ordered IV fluids for Resident #34 on 03/19/24 and verbally told the resident to increase his oral fluids. When she returned the morning of 03/20/24 to re-assess the resident she noticed the IV fluids had not been started/administered. The resident had blood work that morning and his lab showed slight improvement with the oral fluids the resident had taken in. CNP #104 reported she discontinued the IV fluids due to the resident labs improved and he had congestive heart failure, and she didn't want to overload him with fluids. CNP #104 confirmed the facility started the IV fluids on 03/20/24 after she had discontinued the order. CNP #104 reported in the past she has written orders and came back 36 hours later, and orders still have not been addressed. Review of the facility policy and procedure titled Medication Orders (dated 11/2021) revealed nursing would notify the prescriber for directions when a delivery of a medication would be delayed, or medication was not or will not be available. If a prescriber is present in the facility and writes a new order the nurse on duty at the time of the order was written will enter the order in the medical record. If necessary, the order and the indication for its use would be clarified and the prescriber's signature would be obtained before the prescriber leaves the nursing station. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295 and Complaint Number OH00151794.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, interview, and policy review the facility failed to ensure aerosol treatments and antibiotics were started timely for resident with a diagnosed respiratory infection. This affected one resident (#32) of 36 residents reviewed for quality of care. Findings included: Medical record review revealed Resident #32 was admitted to the facility on [DATE] with diagnoses including pneumonia, pelvis fracture, and heart disease. Review of Resident #32's Certified Nurse Practitioner (CNP) #104's note dated 03/18/24 revealed nursing staff reported the resident had wheezing and coughing. New orders for chest-Xray and four plex-respiratory panel. Review of Resident #32's chest x-ray results dated 03/19/24 revealed the resident had right sided pneumonia. Review of Resident #32's nursing note dated 03/19/24 revealed the resident chest x-ray came back positive for pneumonia. He started having labored breathing. Oxygen two liters applied via nasal cannula. Nurse Practitioner (NP) notified and new orders received for follow up chest x-ray in 10 days, Levaquin 500 milligrams (mg) daily for seven days for pneumonia, Doxycycline 100 mg twice daily for seven days for pneumonia, and albuterol inhaler two puffs four times daily for seven days and as needed every four hours for dyspnea. Review of Resident #32's medication administration record (MAR) dated 03/2024 revealed the Levaquin 500 mg was not started until 03/20/24 (ordered 03/19/24). Review of CNP #104's note dated 03/20/24 revealed unfortunately, the resident just got his first dose of Levaquin, which should have been started yesterday. (CNP #104) will go ahead and switch him over to DuoNeb nebulizer treatment four times a day for 7 days. Review of Resident #32's written orders dated 03/20/24 revealed DuoNeb breathing treatment now then every four hours for seven days, then as needed for dyspnea. Change the Albuterol Inhaler to as needed. The order was not signed off as received by nursing. Review of Resident #32's MAR dated 03/2024 revealed the DuoNeb breathing treatments were not administered until 03/22/24 (ordered 03/20/24). Interview on 03/27/24 at 1:29 P.M., with Medical Director/Physician #105 confirmed CNP #104's orders written on 03/19/24 for the Levaquin and 03/20/24 for DuoNeb's were not initiated timely. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/04/24 at 2:38 P.M., with the Director of Nursing (DON) confirmed the resident's DuoNeb order that was written on 03/20/24 was not administered until 03/22/24 and the Levaquin that was ordered on 03/19/24 was not started until 03/20/24. The DON reported both medications were available in the emergency box and could have been administered when ordered. The DON also confirmed the order written on 03/20/24 was not signed off by nursing and she was going to provide education to the nurse who took the order. Review of the facility policy and procedure titled Medication Orders (dated 11/2021) revealed nursing would notify the prescriber for directions when a delivery of a medication would be delayed, or medication was not or will not be available. If a prescriber is present in the facility and writes a new order the nurse on duty at the time of the order was written will enter the order in the medical record. If necessary, the order and the indication for its use would be clarified and the prescriber's signature would be obtained before the prescriber leaves the nursing station. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295 and Complaint Number OH00151794.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, interview, and policy review the facility failed to implement an effective and timely pain management program. This affected two residents (#44 and #67) of four reviewed for pain. Actual Harm occurred on 03/12/24 at 2:30 P.M. when Resident #67, who was admitted for orthopedic aftercare, experienced pain rated a 10 out of 10 (on a 1-10 pain scale with 10 being the most severe) to the right hip. Staff failed to notify the provider the ordered narcotic analgesic pain medication, Oxycodone was not available, resulting in the resident continuing to experience pain as evidenced by the resident's crying and moaning in pain requiring the resident being transferred to the emergency room for uncontrolled pain where the resident was treated with intravenous administration of narcotic pain medication. Actual Harm occurred on 03/15/24 when Resident #44 was admitted to the facility without a comprehensive pain assessment being completed, an ordered neuropathic pain medication was ordered and not administered for two days resulting in the resident's experiencing continuous pain the resident rated as 12 out 10 (1-10 pain scale) and delayed treatment with an ordered pain medication. Findings include: 1. Closed record review revealed Resident #67 was admitted to the facility on [DATE] with diagnoses including aftercare for orthopedic surgery, displaced condyle fracture of lower end of right femur, intervertebral disc degeneration, osteoarthritis, and replacement of right hip and knee joint. Review of Resident #67's admission orders dated 03/12/24 revealed Oxycodone 10-325 mg one tablet every four hours as needed for pain. Review of Resident #67's baseline pain care plan dated 03/12/24 revealed to administer pain medication as ordered. Review of Resident #67's nursing note dated 03/12/24 at 2:30 P.M., revealed the resident arrived via stretcher from the hospital. The resident was alert and oriented times four. The resident had a port to the upper right chest. The resident had a surgical incision to the left hip extending down to the left posterior knee. The resident reported the right posterior foot was slightly bruised due to a break of metatarsal. The resident acknowledged he was in severe pain 10/10. The facility was awaiting pharmacy to deliver medications. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #67's nursing note dated 03/13/24 at 4:43 A.M. revealed the resident was screaming out profanities in room about not being able to get pain medication all day. The writer let the resident know that staff were sending the resident out and apologized profusely for not being able to get her pain medication. The writer reported she had tried multiple times to get pain medication from the pharmacy. Around 4:00 A.M. the pharmacy called back and said they had not received the narcotic scripts. The writer searched the nurse's station and couldn't find any admission paperwork for the resident, therefore couldn't find the narcotic scripts. The resident requested to be sent to the emergency room (ER) since the facility couldn't medicate for pain. The Certified Nurse Practitioner (CNP) #104 was notified and agreed to send the resident to the ER. On 03/13/24 at 4:46 A.M. Resident #67 was transferred to the ER for uncontrolled pain. Review of Resident #67's emergency room notes dated 03/13/24 revealed the resident was seen for pain management. The resident was noted to be crying and moaning in pain. The pain was described as an aching pain in the post-surgical femur area. The resident rated the pain 10 out of 10. The resident was administered intravenous Hydromorphine 1 milligram (mg) at 6:08 A.M., 7:18 A.M., and 8:46 A.M. as well as Zofran 4 mg at 6:10 A.M., 9:26 A.M., and 12:42 P.M., for nausea. Review of Resident #67's nursing note dated 03/13/24 at 5:10 P.M. revealed the resident returned to the facility and was in an unpleasant mood and irritable. The resident stated her entire body was tingling like pins and needles and she was nauseated. The resident began vomiting bile; however, the facility was not able to administer Zofran due to the resident receiving a sublingual dose of Zofran during transport at 4:10 P.M. The staff provided non-pharmacological measures to alleviate vomiting. Review of physician note dated 03/14/24 revealed Resident #67 had fallen and sustained a right femur fracture and was transferred to the facility after having surgery for after care. She had also fractured her left fifth metatarsal and had T1 and T11 compression fractures. The resident had gone out of the hospital yesterday for uncontrolled pain, nausea, and vomiting. The resident had chronic pain and was managed by another provider and had been on Oxycodone 10 mg every four hours as needed for quite some time. Interview on 03/26/24 at 1:22 P.M., with the Medical Director, Physician #105 revealed the resident was not administered pain medication timely resulting in the resident returning to the emergency room for pain management after admission to the facility. Interview on 04/08/24 at 10:00 A.M., with Physician #105 revealed she had faxed scripts directly to the pharmacy shortly after the resident was admitted for her pain medication. The facility then called CNP #104 early in the morning the next day and requested for the resident to be transferred to the ER for uncontrolled pain. The nurses should have been able to get the pain medication out of the facility emergency supply and staff did not call to report any concerns that pain medication was not available. Interview on 04/08/24 at 10:22 A.M., with Registered Nurse (RN)/ Assistant Director of Nursing (ADON) #128 revealed there should never be a delay in getting pain medication since the providers can fax or e-script prescriptions directly to the pharmacy from home and there was medication in the emergency supply including Oxycodone. ADON #128 confirmed Resident #67 had to been sent to the emergency room for uncontrolled pain due to the facility did not administer pain medication timely. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	2. Record review revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus, heart disease, malignant neoplasm of part of the lung, acquired absence of the lung, age-related physical disability, and neuropathy. Review of Resident #44's admission assessment dated [DATE] indicated the resident had no pain as evidenced by facial expression. The remaining parts of the assessment were left blank including if the resident had pain in the last five days, frequency of pain, what causes your pain, what alleviates the pain, and does the pain affect activities of daily living. Review of Resident #44's Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed the resident BIMS was 15 out of 15 (cognition intact). Review of orders dated 03/13/24 revealed order for a referral to a neurologist for neuropathy. Review of Resident #44's occupational therapy notes dated 03/15/24 revealed the resident reported increased exertion and chronic pain. Further review of therapy notes revealed on 03/18/24 the resident declined to do any more therapy due to pain all over though refused anything for pain management including over the counter medications. Review of Resident #44's pain plan of care dated 03/24/24 revealed the resident was at risk for pain/discomfort related to depression, age-related debility. Intervention included to acknowledge the presence of pain and discomfort. Listen to residents' concerns, administer pain medication per physician orders. Observe and report changes to the physician. Assess pain using the Wong-Baker faces pain scale. Offer change in position. Report changes to the nurse. Review of Resident #44 paper orders dated 03/25/24 revealed Gabapentin (anti-convulsant, nerve pain medication) 100 mg three times daily for neuropathy. The order was signed off on 03/26/24 at 12:45 A.M. There was no evidence the resident or family were notified of the new order. Review of Resident #44 electronic orders dated March 2024 revealed no evidence of an order for Gabapentin, however nursing entered an order for Gabadone (dietary management for sleep disorders) on 03/26/24. Gabadone and Gabapentin are not the same medication. Interview on 03/26/24 at 1:06 P.M. with Resident #44 and his wife revealed CNP #104 would not order the resident's Gabapentin for neuropathy pain because it was considered a narcotic. The resident reported his pain level was high at the time of the interview but wouldn't give a number (on a 1-10 pain scale). The resident's wife reported the resident could not take pain medication because it affected his cognition, however staff are telling them that Gabapentin was a narcotic. Interview on 03/26/24 at 1:22 P.M., with Physician #105 revealed she had spoken to CNP #104, and she reported she had written orders yesterday for the resident's Gabapentin per the resident request. Interview on 03/26/24 at 3:39 P.M. with CNP #104 revealed she was in the facility on 03/25/24 until 2:30 P. M. and wrote a prescription for the Gabapentin due to the facility's pharmacy was Kentucky and requires a written prescription for the Gabapentin due to in Kentucky it is considered a narcotic but not in Ohio. CNP #104 confirmed she did not order Gabadone. (continued on next page)

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Legacy Marietta	5001 State Route 60 Marietta, OH 45750

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Interview on 03/26/24 at 4:08 P.M. with the Director of Nursing (DON) confirmed the order for Gabapentin was entered incorrectly by the nursing staff, however the resident did not receive the Gabadone due to it not being available. Interview on 03/27/24 at 4:14 P.M., with Resident #44 revealed he just finally received the first dose of Gabapentin, and his neuropathy pain was rated a 12 out 10 (1-10 pain scale). Interview on 03/27/24 from 4:18 P.M. to 4:35 P.M., with Licensed Practical Nurse (LPN) #129 and Registered Nurse (RN) #126 confirmed the resident just received his first dose of Gabapentin around 2:00 P.M., and it was originally ordered on 03/25/24. RN# 126 reported she had used a different resident's (#42) Gabapentin to give Resident #44 due to his had not arrived at this time. LPN #129 confirmed there was Gabapentin in the emergency box the RN could have utilized. LPN #129 reported she called the pharmacy, and they had the signed scripts for the Gabapentin since 03/25/24 and was not sure why the Gabapentin was not sent, and they would send it out with tonight's delivery. Interview on 03/28/24 at 8:36 A.M., with RN #128 (ADON) revealed on 03/17/24 the resident had pain 9 out of 10, however there was no evidence the provider was notified The RN reported the resident didn't have a pain assessment completed after the admission assessment, which indicated the resident had no pain as evidence of facial expressions. Review of the facility policy and procedure titled Pain Assessment and Management, dated 11/30/23 revealed pain management was defined as the process of alleviating the resident's pain to a level that was acceptable to the resident and is based on his or her clinical condition and established treatment goals. Review the medication administration records to determine how often the individual requests and receives pain medication, and to what extent the administered medication relieves the resident's pain. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295 and Complaint Number OH00151794.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observations, medical record review, staff interview, resident interview, review of the facility assessment, and review of resident council meeting minutes, the facility failed to have sufficient nursing staff to meet the needs of residents in areas including bathing, incontinence care, toileting, interventions to prevent pressure ulcers such as turning/repositioning, answering call lights, dining service, and medication administration. This had the potential to affect all 65 residents in the facility. Findings include: 1. Review of the medical record for Resident #50 revealed an admitted [DATE]. Review of a Minimum Data Set (MDS) assessment completed 03/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The assessment further stated the resident was incontinent of bowel and bladder, required substantial/maximal assistance with toileting,and partial/moderate assistance with rolling left to right on the bed. The resident was not identified to have any pressure areas. The plan of care dated 12/28/23 stated the resident was incontinent of bowel and bladder. Interventions included check for wetness before and after meals, at bed time, and on rounds during the night. If continent, offer to assist with toileting. If incontinent, provide incontinence care. Review of a resident/family concern/grievance form dated 03/11/24 revealed Director of Nursing #147 reported a concern to Social Services #159 from Resident #50's daughter. The family member stated that Resident #50 was not checked on, changed, or rotated from 03/09/24 at 11:00 P.M. until 03/10/24 at 1:00 P. M. Family member was also concerned that wash rags were not being used during care. Family stated chux not being used. The plan of action stated that the Director of Nursing was to check in on the resident two times daily for two weeks to ensure proper care was occurring. The plan of action was signed by the Director of Nursing. Under resolution it stated the Director of Nursing to talk with staff and the family. The date of the concern resolution was 03/11/24. Family member notified on 03/11/24. The administrator had signed the form on 03/11/24. Interview with Resident #50's family member who filed the concern/grievance form on 04/01/24 at 3:30 P.M. revealed the resident had been left incontinent for 14 hours and was not changed. They don't wash the urine off after incontinent. Her brother came in on 03/11/24 and the mattress was soaked in urine. They were out of chux (incontinent pads). Resident #50 has a history of pressure ulcers and she does not want her to get another one. She stated she does not feel the issues were rectified. She stated the resident had gone 12 hours after that without being changed. She stated she had not spoken with the Director of Nursing after the initial report. Interview with Resident #50 on 04/02/24 at 7:45 A.M. revealed she goes to bed between 10:30-11:00 P.M. She stated the staff do not check her for incontinence until around 5:30 A.M. She stated she was wet right now and had not been changed since she went to bed. (The resident was observed in bed with her breakfast tray which would have been provided by staff). She stated there were not enough staff to provide timely care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The surveyor reported to staff that Resident #50 indicated she had been incontinent. On 04/02/24 at 8:00 A. M. Nursing Assistant #209 came to Resident #50's room. Nursing Assistant #209 stated she did not know when the resident was changed last. She stated she had come on duty at 7:00 A.M. Incontinence care was provided. The resident's incontinent brief was observed to be wet which was confirmed by Nursing Assistant #209. Resident #50 was observed to have a small red area on the left inner buttock. Licensed Practical Nurse (LPN) #150 entered the room during the care and stated she would notify the physician of the red area and would obtain an order for a dressing to prevent pressure. Interview with LPN #150 on 04/02/24 at 8:40 A.M. revealed she came into the room during incontinence care because she had overheard an aide on night shift say that the resident's bottom was hurting so she came in to see. 2. Review of the medical record for Resident #54 revealed an admitted [DATE] and diagnoses including morbid obesity, diabetes, hypertension, and schizophrenia. Review of a MDS Assessment completed 03/19/24 revealed a BIMS score of 15, indicating intact cognition. Interview with Resident #54 on 03/27/24 at 10:50 A.M. revealed it was hard to get assistance with a shower at the facility. He stated you have to keep after the staff to get them to assist you with a shower. He stated he preferred two showers a week but had not received that since admitted . Review of shower records revealed only two showers had been provided to Resident #54 since admission (03/21/24 and 03/28/24). Therefore, he went eight days from 03/13/24 to 03/21/24 without a shower and seven days from 03/21/24 to 03/28/24 without a shower. Interview with Director of Nursing #147 on 04/01/24 at 1:05 P.M. revealed Resident #54 was to receive a shower on Monday and Thursday of each week. She confirmed he had only had two showers since admission. 3. Review of the closed medical record for Resident #79 revealed an admitted [DATE] and diagnoses including malignant neoplasm of the bile duct, chronic kidney disease, and heart failure. A nursing progress note on 03/13/24 stated the resident had no memory issues and required staff supervision with showers/bathing. Review of a physician history and physical on 03/14/24 revealed the resident was at the facility for a hospice respite stay. The resident is confused and cannot give any reliable history. Review of a physician's progress note on 03/18/24 revealed the resident was complaining of some pain under her right breast. The note stated the physician reviewed the shower log. It stated the resident had been at the facility for five days and had not had a shower. She is agreeable to a shower. The note stated the resident had significant yeast under the right breast. The physician documented that the resident needed to be showered on that day. A powder to treat yeast infections was ordered three times daily for 14 days. The resident was discharged home on 03/18/24. There was no evidence the resident received a shower while at the facility from 03/13/24 to 03/18/24. Interview with Assistant Administrator #137 on 04/04/24 at 11:10 A.M. confirmed there was no evidence Resident #79 received a shower/bath while at the facility. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Review of the medical record for Resident #13 revealed an admitted [DATE] and diagnoses including adult failure to thrive, rheumatoid arthritis, and hypertension. A MDS assessment completed 01/15/24 stated the resident had a BIMS score of 15, indicating intact cognition. It stated the resident required supervision or touching assistance with bathing. The medical record indicated the resident was scheduled for showers on Tuesday and Friday. Review of shower records for March 2024 revealed the resident was documented as receiving one shower for the month on Friday 03/29/24. The resident did have three refusals documented on Tuesday 03/05/24, Friday 03/22/24, and Tuesday 03/26/24. There was no evidence showers were provided on 03/01/24, 03/08/24, 03/12/24, 03/15/24, or 03/19/24 as scheduled. There were no refusals of showers documented in the nursing progress notes for March 2024. Interview with Resident #13 on 03/27/24 at 9:40 A.M. revealed the facility does not have enough help and she had not had a shower for three weeks. She stated her showers were supposed to be on Tuesday and Friday but the staff say they don't have enough staff to do showers as scheduled. She stated she had never refused a shower except for one time in March 2024 after a fall. 5. Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including Parkinson's disease and chronic pain syndrome. A MDS assessment completed 01/25/24 documented a BIMS score of 13, indicating intact cognition. It further stated the resident was dependent upon staff for toileting, showering, dressing, hygiene, rolling in bed, and transfers. Review of bathing records for March 2024 revealed the resident had received a bed bath two times in March 2024 (03/13/24 and 03/29/24). Interview with Assistant Director of Nursing #128 on 04/01/24 at 10:25 A.M. revealed Resident #41 was to receive a shower/bath on Tuesday and Friday of each week. She confirmed there was no documentation to indicate this was done. Review of Resident Council Meeting minutes for 03/18/24 revealed a topic discussed by residents was residents not getting their scheduled showers. 6. Observations of medication administration on 03/28/24 at 11:15 P.M. revealed Licensed Practical Nurse (LPN) #153 was still passing medications at that time. Interview with LPN #153 on 03/28/24 at 11:15 P.M. revealed she still had six residents who had not had their medications yet that were due to be given between 7:00 P.M. and 11:00 P.M. She stated those residents were Residents #9, #15, #16, #24, #25, and #26. Record review revealed that all six residents (Residents #9, #15, #16, #24, #25, and #26) had between 2-8 medications that were due to be given between 7:00 P.M. and 11:00 P.M. Interview with Director of Nursing #147 on 04/01/24 at 10:00 A.M. revealed the medications should have been administered by 11:00 P.M. She stated she did not know why it would take longer than four hours to pass all of the medications for that time period. 7. Review of the medical record for Resident #25 revealed an admitted [DATE] and diagnoses including peripheral vascular disease, chronic obstructive pulmonary disease, history of traumatic brain injury, and limited mobility. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of an annual Minimum Data Set (MDS) assessment completed 03/26/23 revealed the resident was always continent of bladder. Review of a MDS assessment completed 05/03/23 revealed the resident was now frequently incontinent of bladder. There was no other screening assessment completed for the resident's bladder function until the 03/19/24 restorative screening was completed. Review of the plan of care for Resident #25 revealed on 12/17/23 an Activities of Daily Living/mobility deficit was noted. The goal was to maintain the current level of function in transfer, including toilet transfer. Interventions included: mechanical lift transfer with two assist; total dependence in toilet use (toilet transfer and toilet hygiene), and re-assess quarterly and as needed. On 02/16/24 an MDS assessment indicated the resident had a brief interview for mental status (BIMS) score of 15, indicating intact cognition. It further indicated the resident was dependent upon staff for toileting and was frequently incontinent of bladder. There was no evidence of an evaluation of the decline in Resident #25's urinary continence. Review of bladder documentation from 03/21/24 to 04/03/24 revealed the resident was documented to be incontinent on 03/27/24, 03/30/24, 04/01/24, and 04/02/24. The resident was continent on the other days. (Per interview with the Director of Nursing on 04/03/24 at 4:00 P.M., the bladder documentation is only available in the computer for 30 days prior). The facility provided a Restorative Screening assessment dated [DATE] for Resident #25. It indicated the resident required the use of a Hoyer (mechanical) lift for transfer. It stated the resident was always incontinent of bladder. It stated that a trial of a toileting program had not been attempted in the facility. The section on incontinence pattern was blank. The section on appropriate interventions based on assessment was blank. The reason for not starting a toileting program was blank. The facility also provided a physician progress note 02/08/24 that stated the resident had mild neurogenic bowel and bladder. On 04/01/24 the resident's plan of care included the resident had bladder incontinence. The interventions included check resident if he/she is continent, offer to assist with toileting, and if incontinent, provide incontinence care. Interview with Resident #25 on 03/27/24 at 10:33 A.M. revealed he can use a urinal to urinate. However, he likes to use it in bed and not while up in his wheelchair. He stated that he required the use of a Hoyer (mechanical) lift and two staff assistance to transfer to bed. He stated that there was usually only one aide working on each hall. Therefore, the aide had to go and find help when he wanted to be transferred to bed to use the urinal, and this takes a long time because the staff on the other halls were busy. He stated he has accidents and is incontinent of urine waiting on the staff to assist him to use the urinal. He stated the resident care at the facility had deteriorated. He stated the nursing assistants were stressed out and say they had a lot of work to do and then they quit. He stated the Director of Nursing told him they could not have any more nursing assistants until the census went up. (There were 21 residents residing on the hallway where Resident #25 lived). Interview with Certified Nurse Practitioner (CNP) #104 on 04/04/24 at 10:45 A.M. revealed Resident #25 did have some urinary retention, but this did not explain a decline in continence. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. Record review revealed Resident #29, who exhibited severe cognitive impairment, had current pressure ulcers present and required substantial/maximal assistance for bed mobility and total dependence for toileting was assessed to have new in-house developed pressure ulcers. The resident was assessed to have an unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer to the left buttock and a Stage II (Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister) pressure ulcer to the right buttock. The facility failed to identify the left buttock ulcer until it was unstageable. The new pressure ulcer development occurred due to the lack of adequate interventions including turning and repositioning. Record review revealed Resident #30, who exhibited severe cognitive impairment, had current pressure ulcers present and required moderate assistance with toileting and bed mobility was assessed to have two new in-house acquired pressure ulcers. An unstageable pressure ulcer to the right lower leg and a Stage II pressure ulcer to the right heel. The facility failed to identify the right lower leg pressure ulcer until it was unstageable. The new pressure ulcer development occurred due to the lack of adequate interventions including turning and repositioning and off-loading of the resident's heels. Record review revealed Resident #41, who required staff assistance for turning and repositioning was assessed to have a deterioration in status of a coccyx pressure ulcer with an increase in the presence of slough tissue. In addition, on 03/18/24 the resident was assessed to develop a new in-house acquired Stage II pressure ulcer to the right heel. The resident complained of increased pain to the right heel and voiced concerns staff failed to provide turning and repositioning interventions as needed to prevent the development and/or deterioration. In addition, the new pressure ulcer to the right heel developed due to a lack of adequate interventions including off-loading of the resident's heels. Interview with Medical Director (MD)/Physician #105 on 03/26/24 at 1:22 P.M. confirmed the facility was short staffed. Residents are not receiving shower per preference, call lights were not answered timely, staff aren't checking on residents frequently, nursing not addressing new orders timely, assessments were not completed timely, mediation aren't administered per orders or timely, and resident have odors and were unkempt. Physician #105 reported she has resigned due to she had voiced concerns to administration since October/November 2023 and her concerns still have not been resolved. Interview with Nursing Assistant #117 on 03/28/24 at 11:00 P.M. revealed there are not enough staff to be able to complete scheduled showers or answer call lights timely. He/she stated there is usually only one aide per hallway so if you are in with a resident completing a bed bath, there might be four call lights going off. She stated it might be 30 minutes before he/she can answer them because of being on the hall by him/herself. He/she stated that if a resident requires a two person assist, you have to go find someone to help and wait until that staff person is not busy because they are on a hall by themselves. He/she stated staff on the 7:00 P.M. to 7:00 A.M. shift don't have a chance to start scheduled showers until 11:00 P.M. to 12:00 A.M. and residents don't like it. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Nursing Assistant #118 on 03/28/24 at 11:15 P.M. revealed there are not enough staff and showers are hit and miss for residents. He/she stated there is usually only one aide per hallway and that is not enough. He/she stated staff were not able to check and change residents who are incontinent every two hours or turn and reposition residents every two hours. He/she stated residents sometimes have to wait a long time in the bathroom for assistance. He/she stated he/she felt residents were neglected due to not enough staff to provide the care needed. Interview with Licensed Practical Nurse #154 on 03/28/24 at 11:20 P.M. revealed she does not feel there is enough staff to meet resident needs. She stated she feels rushed and does not take any breaks or a lunch. She stated residents have to wait longer for call lights to be answered and to go to the bathroom with only one aide per hallway (four aides total at night). She stated sometimes she can't get the medications administered timely if she has to help the aide. Interview with Licensed Practical Nurse #153 on 03/28/24 at 11:25 P.M. revealed there are not enough staff to be able to complete scheduled showers. She said sometimes they are done in the middle of the night. She stated she was new at the facility and had trouble getting the medications administered within the scheduled time frame of 7:00 P.M. to 11:00 P.M. She stated she had to do things the aides are too busy to do. She stated she does not take any breaks and feels defeated when she leaves the facility. Interview with Nursing Assistant #127 on 03/28/24 at 11:55 P.M. revealed there is not enough staff to meet the needs of the residents including showers. He/she stated staff can't answer call lights timely or give the care the residents need. He/she stated some residents require the assistance of two staff and there is no one to help her/him. He/she stated staff have to go look for another staff to assist them and that takes time. He/she stated residents have to wait too long if he/she is in another room with another resident providing care. He/she stated staff can't give showers to residents who require a hoyer lift with only one staff person on each hall. She confirmed staff are not able to check and change residents who are incontinent every two hours. He/she stated he/she is not able to get residents up in the morning that want to get up because there is not enough staff. He/she stated there is usually one aide per hallway (four total) or sometimes less. She stated she had worked with only two aide for the whole building. Interview with Nursing Assistant #149 on 03/28/24 at 12:00 A.M. revealed there is usually one aide per hallway (four total). He/she stated he/she had worked when there were only two aides for the whole building. He/she stated there were not enough staff to meet resident needs. He/she stated he/she had been told no to do showers because of not enough staff. Interview with Nursing Assistant #201 on 03/28/24 at 12:15 A.M. revealed there is not enough staff to being able to complete resident showers as scheduled. He/she stated there is anywhere from 2-4 aides working at night for the whole building. He/she stated there had been a lot of change in routine due to the changes in administration. He/she stated there was a lack of communication in the facility. He/she stated staff have to give showers at times when residents don't want them but the residents know if they don't take them at that time, then they won't get a shower. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Nursing Assistant #122 on 04/01/24 at 3:05 P.M. revealed the facility is very short staffed. He/she stated most days there is only one aide per hallway (7:00 A.M. to 7:00 P.M.). He/she stated the aide would have to leave their hall to go assist another staff who needed help with a resident who required two person assistance. He/she stated call lights were then not answered timely. He/she stated it is just survival there in getting things done that need to be done. He/she confirmed showers are not completed as scheduled. He/she stated the dining room is often closed for most meals due to not enough staff to supervise residents in the dining room and on the hallways. Interview with Licensed Practical Nurse #150 on 04/02/24 at 8:40 A.M. revealed she was new to the facility. She stated there were not enough staff to be able to meet resident needs. She stated aides are not able to get showers done. She confirmed residents are not able to go to the dining room at times. Interview with Scheduler #140 on 03/28/24 at 10:00 A.M. revealed there are typically three nurses on each of the two shifts (7:00 A.M. to 7:00 P.M. and 7:00 P.M. to 7:00 A.M. She stated there are typically five aides on day shift (one per hall plus one to float) and four aides on night shift (one per hall). She stated the nurses are to cover for the aide when they are off the floor but can't answer call lights if they occur during a medication pass. Interview on 04/04/24 at 10:15 A.M. revealed she is instructed to follow an equation to determine how many nursing assistants and nurses to schedule each day. She stated the census is multiplied by 1.10 for nurses and 1.62 for nursing assistants. She stated that she had expressed to the Director of Nursing and Administrator that there is not enough staff to meet resident needs but was instructed to continue to follow the equation. Interview with Director of Nursing (DON) #147 on 04/04/24 at 10:30 A.M. confirmed an equation is used to determine staffing levels. She confirmed she felt there was not enough staff to meet resident needs and she had discussed with the previous administrator but they still must follow the staffing equation. Interview with the current Administrator/Regional Director of Operations #200 on 04/04/24 at 11:20 A.M. revealed there is a formula (equation) for how many staff are allowed based on a budget goal. She stated she was not aware of a need for additional staff. Interview on 04/09/24 at 12:43 PM with Assistant Administrator #137 and Director of Nursing (DON) #147 confirmed that multiple changes in Administrator and Director of Nursing in the past year and the lack of leadership was the root cause of the concerns noted at the time of this survey. Interview with Resident #44 on 03/26/24 at 1:06 P.M. revealed the facility didn't have enough staff to care for the residents. Most of the staff don't wear name badges and when you ask for assistance, they say we can't help you or we need to find someone else to help because they all have back problems and can't do anything by themselves. It takes up to an hour or longer for staff to answer call lights. The staff have attitudes, and you can tell they don't want to be there. There was usually one aide for 40 residents. Staff verbally tell him they are short staff. (continued on next page)

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	365780	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Marietta	5001 State Route 60 Marietta, OH 45750

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with Resident #25 on 03/27/24 at 10:33 A.M. revealed there is not enough staff and the aides are too busy. He confirmed it had been brought up in resident council about not getting showers timely. He stated the care has deteriorated. He stated he likes to eat in the dining room but it is closed sometimes due to not enough staff. He stated he will go down to the dining room and they will say it is closed. He stated he can use a urinal to urinate. However, he likes to use it in bed and not while up in his wheelchair. He stated that he required the use of a Hoyer (mechanical) lift and two staff assistance to transfer to bed. He stated that there was usually only one aide working on each hall. Therefore, the aide had to go and find help when he wanted to be transferred to bed to use the urinal, and this takes a long time because the staff on the other halls were busy. He stated he has accidents and is incontinent of urine waiting on the staff to assist him to use the urinal. He stated the resident care at the facility had deteriorated. He stated the nursing assistants were stressed out and say they had a lot of work to do and then they quit. He stated the Director of Nursing told him they could not have any more nursing assistants until the census went up. (There were 21 residents residing on the hallway where Resident #25 lived). Interview with Resident #54 on 03/27/24 at 10:50 A.M. revealed he would eat in the dining room if it was open. He stated the aides would say it was not open without any explanation. Interview with Resident #37 on 03/27/24 at 11:00 A.M. (BIMS score of 15) revealed the facility is short of staff and she does not get her showers twice weekly as scheduled. Interview with Resident #13 on 04/01/24 at 8:26 A.M. revealed there was only one aide for each hall and the aide on the secure can't leave the hall to help. The 300 and 400 halls have a lot of residents that require two assistance with care. She has to wait 30 minutes or longer for staff to answer the call light. On 03/27/24 at 9:40 A.M. the resident stated that medications are not administered on time. She stated that from day to day you don't know who the nurses or aides will be as they leave or get fired. She stated she had not met the new administrator and they change all the time. She stated the facility was having staff pass trays and help residents on that day that don't normally. She stated this is all a show because you are here. She stated the aides will say they will come right back and never come back when you need something. She stated staff are always on their cell phones. She stated there was no stability at the facility and everything is wrong. She stated there was no communication amongst staff. She stated she was concerned the facility was not going to have a physician. She stated the dining room is closed a lot due to not enough staff. At the time of the survey, there were 21 residents on the 200 hall, 17 residents on the 300 hall, and 21 residents on the 400 hall. The facility identified 24 residents as being dependent for bathing, dressing, and transferring. The facility identified 31 residents as requiring 1-2 staff assistance for bathing, dressing, and transferring. Review of the facility assessment dated [DATE] revealed it was used to determine what resources are necessary to care for the patient population served during day to day operations as well as during emergency situations. It stated the facility had an average daily census of 54 in the past year. The CMS 672 and the MDS Resident Profile Report are used to identify the care required for the patient population. General Staffing Guidelines for nursing included: State Staffing requirements 2.5; 12 hour shifts with one RN per shift; Staffing to include 12 full time licensed nurse supervisors, 18 full time nursing assistants, 2 part time nursing assistants, and 1 as needed nursing assistant. The facility assessment was not specific to how many nurses and nursing assistants were to be scheduled per shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This deficiency represents non-compliance investigated under Master Complaint Number OH00152295 and Complaint Number OH00151794.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, review of grievance log, interview, and policy review the facility failed to provide medically related social services to ensure social services ensured a safe discharge and grievances/concerns were followed up with timely. This affected three residents (#50, #54, and #67) of 50 sampled residents. The facility census was 65. Findings included: Review of the grievance/concern log dated 01/2024 to 03/2024 revealed no evidence of a grievance/concern log for 02/2024. Interview on 04/01/24 at 10:49 AM with Social Service (SS) #159 revealed he can not find the grievance/concern log for February 2024. He tried reaching out to the previous SS and was not able to reach her. She was still employed by the facility as needed. 1. Record review revealed Resident #67 was admitted to the facility on [DATE] and was discharged on [DATE]. The resident's diagnoses included orthopedic aftercare, fracture of lower end of right femur, presence of right artificial joint, asthma, pneumonia, acute kidney failure, bronchitis, dorsalis, heart disease, hypertension, gastro-esophageal reflux disease, hernia, osteoarthritis, history of falling, difficulty walking, and need for assistance with personal care. Review of Resident #67's admission progress note dated 03/12/24 revealed the resident arrived at the facility via stretcher from the hospital. The resident was in a pleasant mood, alert, and oriented times four. Resident #67 had a port to the right upper chest with a single lumen. The resident had a surgical incision to the hip extending down to the posterior knee. The resident was in severe pain, rated a 10 on a scale of one to 10 with 10 being the most severe pain. The facility was awaiting pharmacy to deliver medications. Review of Resident #67's progress notes dated 03/13/24 revealed the resident was sent to the emergency room (ER) with uncontrolled pain at 4:46 A.M., due to the facility being unable to administer the resident ordered pain medication due to the pharmacy not delivering the medication. The resident returned from theER on [DATE] at 5:10 P.M. via stretcher. The resident was in an unpleasant mood, irate, and irritable. The resident began vomiting and non-pharmacological interventions were attempted to alleviate the vomiting. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #67's progress note dated 03/16/24 (Saturday) at 5:54 P.M. revealed the resident was discharged from the facility after being seen earlier smoking marijuana and drinking alcohol. The resident reported she had a medical marijuana card, and it helped her calm down. The resident reported she only had a few sips of alcohol and she had hit a couple joints. The Director of Nursing (DON) contacted the Administrator to determine what the proper channel would be. The facility Medical Director/Physician #105 was notified, and all agreed that she would be immediately discharged . The resident was given all medication including narcotics. The writer went over the discharge with her and told the resident if she had any issue to call 911 or to be taken to the nearest ER. Discharge papers were sent with the resident's friend who was taking her home. The resident was sent home in a wheelchair to make sure the resident could get around safely. The police escorted the resident out. The resident did become loud with staff saying she wanted to know how and why she was being discharged and the police told her to come with them as they could not change the decision. The resident was discharged for violating facility policy. Further review of the electronic and paper medical record revealed no evidence of discharge paperwork. Review of Resident #67's hospital emergency department note dated 03/16/24 at 7:30 P.M. revealed the resident was a [AGE] year-old female who presented to the ER for evaluation of back pain and bilateral leg pain. She recently had orthopedic surgery for right femur fracture and was sent to a local skilled facility for aftercare. Today there was an incident at the facility, and she was forcibly removed. Afterwards she did not know where to go so a family member picked her up and dropped her off at the ER. She has chronic back pain and pain from surgery on her right leg. She was not able to go home because she could not care for herself. Due to the resident walking on her leg and worsening pain will obtain an x-ray of right leg. The resident would also need to be placed (for continued medical/nursing care). Review of Resident #67's hospital note dated 03/16/24 revealed the resident had a right distal femur fracture repair approximately one week ago. The resident also noted she had fractured her left fifth metatarsal. She was forcibly removed from the facility by staff and law enforcement after she was found drinking alcohol (ethanol level was undetectable). The resident admitted she had a couple sips. The resident reported she was unable to return home because she was not able to care for herself nor complete her activities of daily living as she could not bear weight on either leg. Review of the hospital record revealed a call was placed to this skilled nursing home and the facility reported they would not be willing to take the resident back due to the resident threatening staff and overall behavioral issues. Case management attempted to be contacted but were not available to assist with further placement at this time. During the onsite investigation, it was determined the resident was currently residing in her home (after receiving hospital treatment). The resident was discharged home from the hospital on 03/22/24. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/26/24 at 1:22 P.M. and 04/08/24 at 10:00 A.M. with the Medical Director/Physician #105 confirmed Resident #67 was improperly discharged when she was found outside smoking and drinking wine. Physician #105 reported the facility had called after the decision was made to discharge the resident on 03/16/24. It was her understanding they were sending the resident to the ER. Physician #105 reported she had spoken to the facility Monday (03/18/24) morning regarding her concerns with the discharge not being appropriate. Physician #105 was not aware of any concerns that would have warranted an immediate discharge such as the resident being of harm to herself or others. Interview on 04/08/24 at 10:22 A.M., with Registered Nurse (RN)/ Assistant Director of Nursing (ADON) #128 reported when a resident was discharged there was a form under the assessment tab that would be completed and a copy would be signed and given to the resident upon discharge, however there was no discharge assessment started or completed for Resident #67. The RN/ADON #128 looked through the paper medical record as well with the surveyor and was not able to locate any discharge paperwork. Interview on 04/08/24 at 11:08 A.M. and 12:05 P.M. with Clinical Service Manager (CSM) #102 reported Resident #67 was issued an immediate discharge notice for violating the facility's smoking policy. CSM #102 confirmed the facility was not able to locate any evidence of discharge paperwork for Resident #67. CSM #102 confirmed the discharge paperwork should have been documented under the assessment tab in the electronic medical record and there was no evidence it was completed. CSM #102 reported she was not able to locate any documented evidence of discharge paperwork in the resident's paper chart either. Interview on 04/08/24 at 11:32 A.M. with Assistant Administrator (AA) #137 confirmed the facility was a smoking facility. The residents had designated times and smoking areas for use. Interview on 04/08/24 at 11:58 A.M. with Resident #67 revealed she was told she was discharged from the facility for drinking alcohol, and she was only given a bag of pills upon discharge. She was not given instructions on how to take the medication, no wound supplies or instruction, and no home health services or equipment were arranged. The resident reported she had only taken a few sips of her friend's wine cooler. The resident reported she had nowhere to go upon discharge (from the facility on 03/16/24) because she could not get into her house. The resident reported she ended up going to the ER because she was non-weight bearing and had no place to go. The resident reported she was not safe to return home because she could not care for herself. Review of the facility policy and procedure titled Resident Transfer and Discharge (dated 06/08/22) revealed it was the facility policy to permit each resident to remain in the facility and not to transfer or discharge a resident, unless the transfer or discharge meets the criteria identified in this policy. A facility-initiated transfer or discharge was one in which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences. If a facility-initiated discharge was determined the interdisciplinary team (IDT) would determine whether one of the following conditions exist: The resident improved and no longer needs services, the facility cannot meet the resident's needs, the resident or other individuals would be endangered, or the resident failed to pay for their stay. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of the policy revealed once the IDT determine a discharge was appropriate, the following would be documented in the record. The reason for discharge. If a resident's need could not be met, the documentation would include what specific needs that could not be met. If the reason for the discharge was because the resident no longer needs nursing home services or because the facility can no longer meet the resident's needs, the required documentation supporting those reasons must be completed by the resident's physician. If the reason for the discharge was because the health or safety of the resident or individuals in the facility was endangered, the documentation supporting those reasons must be completed by any physician. Appropriate discharge planning, including any resident and/or family education and referrals. Once a determination was made the resident discharge was appropriate, a written discharge notice would be issued to the resident and a copy to the office of general counsel, the department of health, and the long-term care ombudsman. The notice must include the reason of discharge, the proposed date of discharge (not the date must be 30 days from the sate the notice was issued), a statement that the resident would not be discharged before the date specified in the notice, the proposed location of discharge (which must met the resident safety needs), the statement that the resident has the right to appeal, the name, address ,and telephone number of the state long term care ombudsman. The written notice must be provided to the resident at least 30 days in advance of the proposed discharge, unless any of the following applies: resident health has improved sufficiently, the resident has resided in the facility for less than thirty days, and emergency exist where the safety of individuals in the facility was endangered or the health of the individual in the facility would otherwise be endangered or the resident has urgent medical needs that require a more immediate or discharge. If a resident was to be discharged for any of the above reasons notice should be provided as many days in advance of the proposed transfer or discharge as was practicable. The IDT would provide the resident with appropriate preparation prior to discharge to ensure a safe and orderly discharge in accordance with the facility discharge planning policy. If a resident request an appeal of the discharge, the facility will not discharge the resident while the appeal was pending, unless the failure to discharge the resident would endanger the health and safety of the resident or other residents in the facility. Review of the facility policy and procedure titled Resident Smoking, (dated 06/08/22) revealed the admission coordinator or designee will inform the resident in writing, at the time of admission, regarding the facility smoking policy and resident responsibility. If a resident was unable to adhere to the facility smoking policy, facility Administration may determine this ground for immediate discharge if it impedes the safety of this and/or other residents. 07316 2. Review of the medical record for Resident #54 revealed an admitted [DATE] and diagnoses including morbid obesity, diabetes mellitus, hypertension, and schizophrenia. Review of an admission Minimum Data Set assessment 03/19/24 revealed the resident had a brief interview for mental status score of 15, indicating intact cognition. It stated the resident was occasionally incontinent of bowel and bladder and was not on a toileting program. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of bladder tracking revealed the resident had been incontinent of bladder on 03/14/24 and 03/28/24. Review of a Social Service admission assessment dated [DATE] revealed Resident #54 was admitted from an acute hospital. It stated the resident planned to return to the community to home/community (not specified). It stated discharge planning was occurring but did not specify what type. Review of social service notes on 03/14/24 and 03/18/24 revealed that it only stated that Resident #54 planned to return to the community. It did not specify any needs the resident had or a plan on how to transition the resident back to the community. Interview with Resident #54 on 03/27/24 at 10:50 A.M. revealed he has an apartment in the community that he does not want to lose. He stated it was very difficult to complete all the paperwork to obtain an apartment so he wanted to be able to return to the apartment. He stated he needed help with learning how to maintain his blood sugar. He stated that was what led to his hospitalization . He stated the facility had acted like they did not want him to discharge home and he wants to. He stated he had asked to speak to social services but no one had come to speak with him. Interview with Social Services (SS) staff #159 on 04/01/24 at 12:45 P.M. revealed he had spoken to Resident #54 the week prior and he was planning to return home to his apartment. He stated the resident had concerns with maintaining blood sugar control at home and incontinence issues at home. He stated there had been no follow up on providing teaching for the resident on blood sugar control or incontinence. He stated that was not his job. He stated the resident was receiving physical therapy but he did not know how long the resident's stay was anticipated to be. Interview with Physical Therapist/Director of Rehab #168 on 04/01/24 at 1:00 P.M. revealed Resident #54 was receiving physical therapy and occupational therapy. She stated that, based on his type of insurance, his stay would probably only last another two weeks. Review of the facility policy titled Discharge Planning (dated 06/08/22) revealed when a resident's discharge in anticipated, the facility will develop and implement a discharge plan that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The discharge plan: the discharge needs of each resident will be identified and result in the development of a discharge plan for each resident. The discharge plan will: include regular re-evaluation of residents to identify changes that require modification of the discharge plan; involve the interdisciplinary team in the ongoing process of developing the discharge plan; address the resident's goals of care and treatment preferences. Interview with Director of Nursing #147 on 04/01/24 at 1:05 P.M. revealed the nursing department was not made aware of Resident #54's needs for education/training regarding blood sugar control or incontinence by social services. Therefore, this had not been provided. 3. Review of the medical record for Resident #50 revealed an admitted [DATE]. Review of a Minimum Data Set assessment completed 03/15/24 revealed a Brief Interview for Mental Status score of 15, indicating intact cognition. The assessment further stated the resident was incontinent of bowel and bladder, required substantial/maximal assistance with toileting,and partial/moderate assistance with rolling left to right on the bed. The resident was not identified to have any pressure areas. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The plan of care dated 12/28/23 stated the resident was incontinent of bowel and bladder. Interventions included check for wetness before and after meals, at bed time, and on rounds during the night. If continent, offer to assist with toileting. If incontinent, provide incontinence care. Review of a resident/family concern/grievance form dated 03/11/24 revealed Director of Nursing #147 reported a concern to Social Services #159 from Resident #50's daughter. The family member stated that Resident #50 was not checked on, changed, or rotated from 03/09/24 at 11:00 P.M. until 03/10/24 at 1:00 P. M. Family member was also concerned that wash rags were not being used during care. Family stated chux not being used. Family member also stated resident was having difficulty feeding herself. The plan of action stated that the Director of Nursing was to check in on the resident two times daily for two weeks to ensure proper care was occurring. The plan of action was signed by the Director of Nursing. Under resolution it stated the Director of Nursing to talk with staff and the family. The date of the concern resolution was 03/11/24. Family member notified on 03/11/24. The administrator had signed the form on 03/11/24. Interview with Resident #50's family member who filed the concern/grievance form on 04/01/24 at 3:30 P.M. revealed the resident had been left incontinent for 14 hours and was not changed. They don't wash the urine off after incontinent. Her brother came in on 03/11/24 and the mattress was soaked in urine. They were out of chux (incontinent pads). Resident #50 has a history of pressure ulcers and she does not want her to get another one. She stated she does not feel the issues were rectified. She stated the resident had gone 12 hours after that without being changed. She stated she had not spoken with the Director of Nursing after the initial report. Interview with Resident #50 on 04/02/24 at 7:45 A.M. revealed she goes to bed between 10:30-11:00 P.M. She stated the staff do not check her for incontinence until around 5:30 A.M. She stated she was wet right now and had not been changed since she went to bed. (The resident was observed in bed with her breakfast tray). The surveyor reported to staff that Resident #50 indicated she had been incontinent. On 04/02/24 at 8:00 A. M. Nursing Assistant #209 came to Resident #50's room. Nursing Assistant #209 stated she did not know when the resident was changed last. She stated she had come on duty at 7:00 A.M. Incontinence care was provided. The resident's incontinent brief was observed to be wet which was confirmed by Nursing Assistant #209. Resident #50 was observed to have a small red area on the left inner buttock. Licensed Practical Nurse (LPN) #150 entered the room during the care and stated she would notify the physician of the red area and would obtain an order for a dressing to prevent pressure. Interview with LPN #150 on 04/02/24 at 8:40 A.M. revealed she came into the room during incontinence care because she had overheard an aide on night shift say that the resident's bottom was hurting so she came in to see. Review of the facility policy titled Investigating Grievances/concerns (dated 08/08/22) revealed the facility investigates all grievances/concerns filed with the facility. The Administrator will assign the responsibility of investigating grievances and concerns to appropriate department. Upon receiving a grievance/concern report, appropriate department will begin an investigation into the allegations. The resident or person acting on behalf of the resident will be informed of the findings of the investigation, as well as any corrective actions recommended, within five working days of the filing of the grievance. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Director of Nursing #147 on 04/01/24 at 3:40 P.M. revealed she had checked on the resident daily (not twice per day per the grievance form) but had not documented any findings. She further confirmed she had not spoken with the resident's family since the concern was voiced. There was no evidence of involvement by the social service staff with the resolution of the grievance. Review of the undated job description for Social Service Designee revealed the primary purpose of the job position was to assist in planning, developing, organizing, implementing, evaluating, and directing social service programs in accordance with current existing federal, state, and local standards, as well as established policies and procedures, to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis. Duties and responsibilities included: participate in discharge planning; review complaints and grievances made by residents and make a written/oral report to the Director indicating what action(s) were taken to resolve the complaint or grievance; record and maintain regular social service progress notes indicating response to the treatment plan and/or adjustment to institutional life; coordinate social service activities with other departments as necessary; make routine visits to residents and perform services as necessary. This deficiency represents non-compliance investigated under Complaint Number OH00151794.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365780	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Marietta	5001 State Route 60 Marietta, OH 45750

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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** 07316 Based on observations, medical record review, staff interview, policy review, and resident interview, the facility failed to provide pharmaceutical services to meet the needs of each resident. This affected 11 residents (#4, #9, #15, #16, #24, #25, #26 #35, #41, #44, and #60) of 50 residents reviewed. The facility census was 65. Findings include: 1. Review of the medical record for Resident #4 revealed an admitted [DATE] and diagnoses including gastroesophageal reflux (GERD), pain, dementia, and Parkinson's disease. The resident had physician's orders 01/18/24 for a nerve pain medication (Gabapentin) 100 milligrams (mg) two times daily in the morning and evening for pain, and an antacid (Pepcid) 20 mg two times daily in the morning and evening for GERD. Review of the medication administration record (MAR) for March 2024 revealed the Gabapentin and Pepcid were documented as not available and not given on the morning of 03/26/24. The facility had a Cubex/Medbank system that stored extra medications that could be dispensed for residents when needed. Review of the Cubex/Medbank contents list revealed the Cubex/Medbank contained 10 Gabapentin 100 mg capsules, and six Pepcid 20 mg tablets. Interview with Director of Nursing (DON) #147 on 03/27/24 at 8:50 A.M. revealed she did not know why the medication was not available in Resident #4's supply of medications and did not know why the nurse did not pull the medication from the Cubex/Medbank system to give to the resident as it was available in the machine. 2. Review of the medical record for Resident #41 revealed an admitted [DATE] and diagnoses including Parkinson's disease, chronic pain syndrome, and radiculopathy (a disease of the nerve root). The resident had a physician's order 03/05/24 for a nerve pain medication (Gabapentin) 600 mg every six hours for radiculopathy which was set up to be given at 12:00 A.M., 6:00 A.M., 12:00 P.M. and 6:00 P.M. Review of the MAR for March 2024 revealed the Gabapentin was documented as not available and not given at 12:00 P.M. and 6:00 P.M. on 03/24/24. The facility had a Cubex/Medbank system that stored extra medications that could be dispensed for residents when needed. Review of the Cubex/Medbank contents list revealed the Cubex/Medbank contained five Gabapentin 300 mg capsules. Review of a pharmacy delivery sheet for 03/24/24 revealed 60 Gabapentin capsules were delivered on 03/24/24 for Resident #41. Interview with DON #147 on 04/01/24 at 10:15 A.M. confirmed the Gabapentin was documented as not available and not given for Resident #41 on 03/24/24. She stated the Gabapentin should have been available as it was delivered on 03/24/24 (pharmacy comes on night shift). She stated the facility used agency nurses and that may be the reason why it was not given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the medical record for Resident #35 revealed an admitted [DATE] and diagnoses including atrial fibrillation and syncope. The resident had a physician's order on 01/19/24 for a blood thinner medication (Xarelto) 20 mg daily for atrial fibrillation to be given in the morning. Review of the MAR for February 2024 revealed the Xarelto was documented as not available and not given on 02/17/24 and 02/19/24. (The medication was documented as given on 02/18/24). Interview with Assistant Director of Nursing (ADON) #128 on 03/27/24 at 9:00 A.M. confirmed the Xarelto was documented as not available and not given on 02/17/24 and 02/19/24. She stated the Xarelto was not available in the Cubex/Medbank system. Therefore, she could not explain how the medication was not available 02/17/24, then available on 02/18/24, then not available on 02/19/24. Review of the facility undated pharmacy policy titled What to do if a medication is not available during a med pass, revealed the following steps to take: Review the pharmacy packing slip to verify if the medication has been delivered. You may also check the pharmacy facility portal to review the delivery status of the medication; Check all medication carts for the missing medication; Check the medication room and confirm all pharmacy deliveries have been properly checked in; Utilize the Medbank (Cubex) for availability of the medication. Remove dose and administer to resident; If the medication is not available in the Medbank, is there an alternative medication available to administer with a prescribers order?; If the medication can not be located and is not available in the Medbank, please notify the pharmacy to request delivery from a back up pharmacy, or request a stat delivery, and finally verify the medication will be sent on the next pharmacy delivery; Notify the provider the medication will not be available for administration at the current scheduled time. Request an order to hold the medication and administer upon delivery from the pharmacy. 4. Observations of medication administration on 03/28/24 at 11:15 P.M. revealed Licensed Practical Nurse (LPN) #153 was still passing medications at that time. Interview with LPN #153 on 03/28/24 at 11:15 P.M. revealed she still had six residents who had not had their medications yet that were due to be given between 7:00 P.M. and 11:00 P.M. She stated those residents were Residents #9, #15, #16, #24, #25, and #26. Review of the medication administration record (MAR) for March 2024 for Resident #9 revealed the resident had six medications past due that included: Alprazolam for anxiety, Fexofenadine for allergies, Depakote for Schizoaffective disorder, Flonase spray for allergies, Omeprazole for GERD, and Nystatin for thrush. 5. Review of the medication administration record (MAR) for March 2024 for Resident #15 revealed the resident had four medications past due that included: Simvastatin for cholesterol, Eliquis for atrial fibrillation, Metoprolol for blood pressure, and Senna for bowel management. 6. Review of the medication administration record (MAR) for March 2024 for Resident #16 revealed the resident had eight medications past due that included: Atorvastatin for high cholesterol, Melatonin for sleep, Senna for constipation, Carvedilol for blood pressure, Clonidine for blood pressure, Heparin for blood clot prevention, Hydralazine for blood pressure, and Isosorbide for heart. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of the medication administration record (MAR) for March 2024 for Resident #24 revealed the resident had five medications past due that included: Atorvastatin for cholesterol, Glycolax for constipation, Tamulosin for urinary retention, Metoprolol for blood pressure, and Sodium Bicarbonate for supplement. 8. Review of the medication administration record (MAR) for March 2024 for Resident #25 revealed the resident had seven medications past due that included: Xarelto for blood thinner, Voltarin gel for pain, Advair inhaler, Carbamazepine for seizures, Guaifenesin for cough, Propranolol for tremors, and Senna for constipation. 9. Review of the medication administration record (MAR) for March 2024 for Resident #26 revealed the resident had seven medications past due that included: Melatonin for sleep, Mirtazepine for depression, Rosuvastatin for cholesterol, Carafate for stomach, Docusate for constipation, Eliquis for blood thinner, and Preservision as a supplement. Review of the facility medication administration schedule dated 11/30/23 revealed medications that were due either twice daily or three times daily would have the evening dose administered between 7:00 P.M. and 11:00 P.M. Interview with DON #147 on 04/01/24 at 10:00 A.M. revealed the medications for all six should have been administered by 11:00 P.M. She stated she did not know why it would take longer than four hours to pass all of the medications for that time period. Interview with Resident #13 on 03/27/24 at 9:40 A.M. revealed medications are not administered on time. 32801 10. Record review revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus, heart disease, malignant neoplasm of part of the lung, acquired absence of the lung, age-related physical disability, and neuropathy. Review of Resident #44's Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed the resident BIMS was 15 out of 15 (cognition intact). Review of Resident #44 paper orders dated 03/25/24 revealed Gabapentin 100 milligrams (mg) three times daily for neuropathy. Interview on 03/26/24 at 3:39 P.M. with CNP #104 revealed she was in the facility on 03/25/24 until 2:30 P. M. and wrote a prescription for the Gabapentin due to the facility's pharmacy was located in Kentucky and required a written prescription for the Gabapentin due to in Kentucky it consider a narcotic but not in Ohio. Interview on 03/27/24 at 4:14 P.M., with Resident #44 revealed he just finally received the first dose of Gabapentin, and his neuropathy pain was a 12 out 10. (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 03/27/24 from 4:18 P.M. to 4:35 P.M., with Licensed Practical Nurse (LPN) #129 and Registered Nurse (RN) #126 confirmed the resident just received his first dose of Gabapentin around 2:00 P.M., and it was originally ordered on 03/25/24. RN# 126 reported she had used a different resident's Gabapentin to give Resident #44 due to his had not arrived at this time. LPN #129 confirmed there was Gabapentin in the emergency box the RN could have utilized. LPN #129 reported she called the Pharmacy, and they had the signed scripts for the Gabapentin since 03/25/24 and was not sure why the Gabapentin was not sent, and they would send it out with tonight's delivery. 11. Record review revealed Resident #60 was admitted the facility on 07/27/17 and readmitted [DATE] with diagnoses including convulsions, metabolic encephalopathy, insomnia, presence of cerebrospinal fluid drainage device, muscle spasms, and expressive language disorder. Review of Resident #60 hospital discharge orders dated 01/19/24 revealed new orders were received for Xcopri (anticonvulsant) 12.5 mg daily for 14 days and then 25 mg for 14 days for anticonvulsant. Review of Resident #60's medication pass note dated 01/25/24 revealed the writer contacted the pharmacy regarding Xcopri. The pharmacy representative stated that they needed a script for the medication. The medication was not available in the emergency medication box. Will notified medical provider to fax script to the pharmacy. Awaiting pharmacy to deliver. No signs or symptoms of seizure activity. Review of Resident #60's MAR dated 01/2024 revealed the Xcopri was not administered until 01/26/24 (ordered 01/19/24). Interview on 04/01/24 at 9:00 A.M., with the Medical Director (MD) #105 confirmed Resident #60 seizure medication was not available timely and has not been available several times in the past. Interview on 04/03/24 at 8:44 A.M., with Clinical Service Manager (CSM) #102 confirmed Resident #60's Xcopri was not started timely. The facility was not aware the medication required a prescription until 01/25/24 and the medication was originally ordered on 01/19/24 and not started till 01/26/24. Review of the pharmacy contract (dated 05/19/23) revealed the pharmacy company would provide products and services in a prompt and timely manner. The pharmacy agrees to deliver to the facility, twice daily, any prescriptions, unless the failure of delivery is a result of circumstances and condition beyond its control, which will include, but not be limited to, situations, where the Pharmacy's manufacture/supplier is unable, using it best efforts, to provide the required item and the Pharmacy is unable to provide an acceptable alternative. Emergency drug service: The pharmacy will provide any products needed on an emergency basis in a prompt and timely manner in the event Pharmacy cannot furnish an order medication on a prompt and timely basis, the Pharmacy will make arrangements with another Pharmacy supplier in a community local to the facility to provide such products and services to the facility. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295 and Complaint Number OH00151794.

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F 0757 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review and interview the facility failed to ensure a resident's drug regimen was free from unnecessary medication when the facility failed to receive ordered clarification of anticoagulation medication therapy resulting in a resident receiving an unnecessary anticoagulation medication for ten days, and failed to complete adequate blood sugar monitoring to ensure the correct amount of insulin was administered for a resident. This affected two residents (#16, #44) of 36 residents reviewed for quality of care. Actual Harm occurred on 03/21/24 to Resident #16 when Certified Nurse Practitioner (CNP) #104 and Medical Director/Physician #105 wrote the first order to call Resident #16's cardiologist to clarify the Heparin (anticoagulant medication) order. Resident #16 continued to receive Heparin three times a day for ten days following Physician #105's orders written repeatedly on 03/22/24, 03/25/24 and 04/01/24 to clarify orders due to the resident's hemoglobin continued to drop down to 7.8 g/dL (normal range 13.3 -17.7 g/dL) and the ordered diagnostic test for occult blood was delayed in completion. Findings include: 1. Record review revealed Resident #16 was admitted to the facility on [DATE] with diagnoses including dissection of unspecified site of aorta, hypertensive emergency, substance abuse, cerebral infarction due to embolism, acute kidney failure with tubular necrosis, and presence of coronary angioplasty implant and graft. Further review of Resident #16's orders dated 03/20/24 revealed the resident was receiving Aspirin (blood thinning medication) 81 mg daily for prevention, Brilinta (anti platelet medication) 90 milligrams (mg) twice daily, and Heparin (anticoagulant medication) 5000 units every eight hours for blood clot prevention. There was no documented evidence of an order to interchange Brilinta with Plavix. Review of Resident #16's orders dated 03/21/24 to 04/01/124 revealed orders were written by Certified Nurse Practitioner (CNP) #104 and/or the Medical Director/Physician #105 on 03/21/24, 03/22/24, 03/25/24 to follow up with cardiologist regarding how long and why the resident needed to be on Heparin along with Brilinta (antiplatelet medication) (Brilinta was later interchanged to Plavix, also an antiplatelet medication) and Aspirin (anticoagulant medication and nonsteroidal anti-inflammatory medication). On 04/01/24 the order written by NP#104 indicated the Heparin needed clarified today due to having significantly worsening anemia. Also, an order was re-written on 04/01/24 by NP #104 that indicated the hemoccult need done as soon as possible for anemia and there was a note in parentheses that indicated the order was originally written on 03/29/24. Further review of the orders revealed NP#104's order for Hemoccult stool times two for anemia was actually written on 03/28/24. Review of Resident #16's laboratory results revealed the resident's Hemoglobin on 03/22/24 was 9.1 g/dL (13.3-17.7), 03/25/24 8.5 g/dL, 03/27/24 8.4 g/dL, 04/01/24 8.1 g/dL and 04/02/24 7.8 g/dL. Review of Resident #16's nurses note dated 04/01/24 revealed the writer spoke to the cardiologist to clarify the Heparin orders. The cardiologist reported the Heparin was just a therapeutic dose and new orders were received to discontinue the Heparin. (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	Interview on 04/02/24 at 8:46 A.M. with Certified Nurse Practitioner (CNP) #104 revealed the resident was admitted on the 20th or 21st with orders for Brilinta, Aspirin, and Heparin. Physician #105 wrote orders to call cardiologist for clarification on Heparin and she re-wrote the order once or twice and it was still not clarified as of 04/01/24. Yesterday (4/01/24) she had the Assistant Director of Nursing (ADON) #128 call to get clarification on the Heparin due to the resident's Hemoglobin having dropped from 11 to 8 g/dL. The cardiologist reported the resident didn't need the Heparin. CNP #104 reported she was upset the resident was on Heparin for 10 days and the resident could have possibly bled out with the combination of all three drugs (Heparin, Plavix, and Aspirin) and staff never clarified the order. CNP #104 reported pharmacy had interchanged the Plavix for the Brilinta, which she had verbally told staff she didn't want it interchanged. Interview on 04/02/24 at 2:39 P.M. with Clinical Service Manager (CSM) #102 confirmed there was no documented evidence the cardiologist was contacted to clarify heparin order per the physician's order written on 03/21/24, 03/22/24, and 03/25/24. CSM #102 confirmed there was no evidence the hemoccult cards were collected per orders written on 03/28/24. CSM #102 confirmed a progress note written on 03/29/24 indicated the resident had a bowel movement, however there was no evidence the hemoccult sample was collected. Interview on 04/03/24 at 7:36 A.M. with Resident #16 and CSM #102 revealed the resident reported staff just told him the day before yesterday about needing a stool sample, however they just brought him the supplies yesterday afternoon to collect the stool and he had already had a bowel movement earlier that day. The resident denied active rectal bleeding or any abnormal bleeding/bruising. Review of Resident #16's progress note dated 04/08/24 revealed the resident's hemoccult card was positive. The provider ordered a gastrointestinal (GI) consultation. (Resident #16's medical record did not contain the exact date when the hemoccult test was completed). 2. Record review revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus, heart disease, malignant neoplasm of part of the lung, acquired absence of the lung, age-related physical disability, and neuropathy. Review of Resident #44's hyper/hypoglycemia plan of care dated 03/24/24 revealed to give medication as ordered and monitor lab values per physician order. Review of Resident #44's admission orders dated 03/11/24 revealed Humalog insulin inject as per sliding scale: if 200-249 = 2 units, 250-299 = 4 units, 300-349 = 6 units, 350-399 = 8 units, and 400 and above give 10 units and call the provider. Administer subcutaneously before meals and at bedtime for diabetes. Keep refrigerated before opening. Review of Resident #44's Medication Administration Records (MAR) dated March 2024 revealed on 03/18/24 the 11:30 A.M., blood sugar was taken at 2:39 P.M. and 4 units of insulin was administered and the 4:30 P. M. blood sugar was taken at 5:18 P.M. and Resident #44 received 4 units of insulin. On 03/21/24 the 11:30 A. M., blood sugar was taken at 1:21 P.M. and administered 2 units of insulin, the 4:30 P.M. blood sugar was taken at 6:16 P.M. and the resident was administered 2 units of insulin. On 03/22/24 the 4:30 P.M. blood sugar was taken at 6:14 P.M., and the resident was administered 2 units of insulin. (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	Interview on 03/28/24 at 8:15 A.M., with Resident #44's wife revealed she had concerns the nurses were checking Resident #44's blood sugar after he had eaten his meals which required him to have insulin administered based on the results after he had eaten. Resident #44's wife reported the resident was receiving insulin unnecessary due to his blood sugar being high after he has eaten, and the staff should have checked his blood sugar before his meals. Interview on 03/28/24 at 2:13 P.M., with Registered Nurse (RN) #128 revealed Resident #44 meals are delivered at 7:45 A.M., 11:45 A.M., and 4:45 P.M. Interview on 04/01/24 at 7:58 A.M. and 8:53 A.M. with the Director of Nursing (DON) confirmed per the MAR Resident #44's blood sugar check was obtained after the resident ate a meal and insulin was administered after meals on 03/18/24, 03/21/24, and 03/22/24. The DON confirmed the blood sugars and insulin should have been administered prior to meals per the physician orders. The DON reported the facility didn't have a policy or procedure for obtaining blood sugar and the nurse should follow the doctors' orders. Interview on 04/01/24 at 8:21 A.M. with Certified Nurse Practitioner (CNP) #104 confirmed the resident's blood sugar and insulin should be taken prior to meals so it can be accurately regulated. CNP #104 reported if the resident's blood sugars were taken after meals the blood sugars would be elevated requiring additional insulin which would also affect Resident #44's treatment plan. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295 and Complaint Number OH00151794.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, interview, and policy review the facility failed to ensure residents were free of significant medication errors. This affected five residents (#16, #34, #60, #66 and #73) of 36 residents reviewed for quality of care. Findings included: 1. Record review revealed Resident #16 was admitted to the facility on [DATE] with diagnoses including dissection of unspecified site of aorta, hypertensive emergency, substance abuse, cerebral infarction due to embolism, acute kidney failure with tubular necrosis, and presence of coronary angioplasty implant and graft. Review of Resident #16's medication administration record (MAR) dated 03/2024 revealed the Brilinta (antiplatelet) 90 milligrams(mg) was ordered one tablet twice daily on 03/20/24, however it was never administered due to the drug was not available, and then discontinued on 03/24/24. Plavix (antiplatelet) 75 milligram (mg) once a day was started on 03/25/24. Interview on 04/02/24 at 8:46 A.M., with Certified Nurse Practitioner (CNP) #104 revealed the resident was admitted on [DATE] with orders for Brilinta, however, never received it or another antiplatelet medication for 3-4 days after his admission. CNP #104 reported she had seen a sticky note at the nurse's station regarding interchanging Plavix for Brilinta and she personally spoke to the Director of Nursing (DON) and told her the medication could not be interchanged, however Pharmacy interchanged anyway a few days later. CNP #104 reported she worked in cardiology prior and once a resident was started on Brilinta or Plavix cardiology doesn't recommend the patient to switch medication and they should not be interchanged. CNP #104 also reported it was very concerning the resident went without an antiplatelet medication for more than 24 hours due to he could have had a stroke within 24 hours without the medication. Interview on 04/02/24 at 1:59 P.M., with Clinical Service Manger (CSM) #102 and Assistant Administrator (AA) #137 confirmed Resident #16 missed eight doses of Brilinta from 03/20/24 to 03/24/24 and there was no documented evidence CNP #104 had agreed to the interchange from Brilinta to Plavix. CSM #102 confirmed the Plavix was not started until 03/25/24. Interview on 04/02/24 at 2:39 A.M., with the Director of Nursing (DON) and Clinical Service Manger (CSM) #102 revealed Pharmacy had the Medical Director (MD)/Physician #105 sign a list of medication that could be interchanged including Brilinta and Plavix on 08/11/23, however the facility did not have written evidence CNP #104 had signed an agreement to interchange medications. 2. Record review revealed Resident #60 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including convulsions, metabolic encephalopathy, insomnia, presence of cerebrospinal fluid drainage device, muscle spasms, and expressive language disorder. Review of Resident #60's hospital discharge orders dated 01/19/24 revealed new orders were received for Xcopri (anticonvulsant) 12.5 mg daily for 14 days, then 25 mg for 14 days for anticonvulsant and then titrate up to 50 mg. Follow up with neurology in three to four weeks. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #60's medication pass note dated 01/25/24 revealed the writer contacted the pharmacy regarding Xcopri. The pharmacy representative stated that they needed a script for the medication. The medication was not available in the emergency medication box. Will notify MD to fax script to the pharmacy. Awaiting pharmacy to deliver. No signs or symptoms of seizure activity. Review of Resident #60's MAR dated 01/2024 to 02/2024 revealed the Xcopri was not started until 01/26/24 and then was discontinued after the 14 days of 25 mg. Review of the Certified Nurse Practitioner (CNP) #104 progress note dated 02/20/24 revealed the resident was recently hospitalized due to some complications with medication as well as seizures. The resident was on Xcopri now and has been titrated every two weeks. The resident will need to be going to the next dose, which will be 50 mg daily for two weeks and then 100 mg two weeks, 150 mg times two weeks, and then 200 mg. CNP #104 documented she wrote the prescription for the Xcopri, and the resident needed to follow up with neurology. Review of Resident #60's orders dated 03/27/24 revealed an appointment was arranged for the resident with neurology on 03/28/24 at 10:30 A.M. Review of the neurologist progress note dated 03/28/24 revealed the reason of the visit was a hospital follow up for seizure disorder. The resident had not started the new seizure medication and it is unclear if it was denied by insurance or not. Will send in Xcopri to the patient's pharmacy, titrate up to 50 mg. Follow up with me in 3 or 4 weeks. Further review of Resident #60's MAR's dated 02/2024 to 04/2024 revealed no evidence the Xcopri was started after the NP note/orders on 02/20/24 or the neurologist note on 03/28/24. Interview on 04/01/24 at 9:00 A.M., with the Medical Director (MD)/Physician #105 confirmed Resident #60's seizure medication was not available timely and has not been available several times in the past. Interview on 04/03/24 at 8:44 A.M., with Clinical Service Manager (CSM) #102 confirmed Resident #60's Xcopri was not started timely. The facility was not aware the medication required a prescription until 01/25/24 and the medication was originally ordered on 01/19/24 and not started till 01/26/24. Interview on 04/03/24 at 3:23 P.M., with the Assistant Administrator (AA) #137 confirmed Resident #60 did not follow up timely with the neurologist per the hospital orders on 01/19/24, and Xcopri was not continued after new orders were received on 02/20/24 from CNP #104, and again on 03/28/24 after the resident saw the neurologist. 3. Record review revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including sepsis due to Escherichia coli (E. coli), urinary tract infections (UTI), diabetes, congestive heart failure, nonrheumatic aortic stenosis, presence of prosthetic heart valve, presences of cardiac pacemaker, history of transient ischemic attack, hypertensive heart disease with heart failure, sick sinus syndrome, acute respiratory failure, and anxiety. Review of Resident #34's Clostridium difficile (C-diff) laboratory results dated [DATE] revealed on 03/20/24 Resident #34's stool tested positive for C-diff at 8:33 A.M. and results were called and reported to the Director of Nursing (DON) #143. (continued on next page)

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	365780	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Marietta	5001 State Route 60 Marietta, OH 45750

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #34's orders dated 03/20/24 revealed new orders for Vancomycin 125 mg four times a day for 10 days for C-diff. Review of Resident #34's MAR dated 03/2024 revealed the resident did not receive the first dose of Vancomycin until 1:00 P.M. on 03/21/24 (ordered on 03/20/24). Interview on 03/26/24 at 1:22 P.M., with the Medical Director (MD)/Physician #105 confirmed Resident #34 tested positive for C-diff and antibiotics were ordered 03/20/24, however the antibiotics were not started until 03/21/24, which was not timely. Physician #105 reported there had been previous and continued concerns with orders not being implemented timely. 4. Review of Resident #66's closed record revealed the resident was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of brain, spinal cord, liver, and skin, heart disease, anxiety, shortness of breath, insomnia, and pain. Review of Resident #66's orders dated 10/14/23 revealed to administer Levaquin 750 mg daily for 10 days for pleural effusion. Review of Resident #66's orders dated 10/16/23 and written by CNP #104 revealed to increase the resident's Trazadone to 100 mg at bedtime for insomnia and Xanax 0.25 mg at bedtime if the resident was unable to sleep 2 hours after given the Trazadone. There was an additional clarification order written on 10/16/23 indicating the order was clarified to give Trazadone 100 mg at bedtime and if ineffective give Xanax 0.25 mg two hours later. Xanax order good for 14 days. Review of Resident #66's orders dated 10/22/23 revealed the resident's Cancer Doctor (CA) #208 ordered Lorazepam 0.5 mg at 10:00 P.M. scheduled. Review of Resident #66's orders dated 10/23/23 revealed new orders for Doxycycline 100 mg twice daily for infection until 10/30/23. Review of Resident #66's MAR dated 10/2023 revealed Lorazepam 0.5 mg was entered to be administered at 9:00 P.M. not 10:00 P.M. per the written order. The Lorazepam was not administered/available on the 22nd, 23rd, 24th, 25th, and 27th of October, 2023. The Doxycycline 100 mg was not administered on the night dose on the 23rd and 24th and 30th of October, 2023. Xanax 0.25 mg was entered to administer daily for insomnia for 14 days and the order was to administer only if Trazadone was ineffective. Staff administered Xanax on October 16th to 22nd and the 28th and 29th, 2023. On 10/23/23- 10/27/23 staff charted the medication was not available. The resident ordered Levaquin 750 mg daily for 10 days; however, the last dose was not administered due to it not being available. Interview on 03/26/24 at 1:22 P.M., with the MD/Physician #105 verified the residents' antibiotics/medications were not administered timely or as ordered and it was a continuous concern with the facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/08/24 at 1:59 P.M. with CSM #102 confirmed the resident's order for Lorazepam 0.5 mg was ordered for 10:00 P.M. and the order was entered incorrectly at 9:00 P.M The CSM confirmed staff had documented the Lorazepam was not administered/available on the 22nd, 23rd, 24th, 25th, and 27th of October, 2023, which staff could have gotten the medication out of the emergency medication box. The CSM confirmed the resident's Doxycycline 100 mg was not administered on the night dose on the 23rd and 24th and 30th of October 2023. The CSM confirmed the last dose of Levaquin was not administered per the physician's orders. The CMS confirmed the after staff clarified the order for Xanax the order was not correct in the electronic medical record. The order should have been to administer two hours after the Trazadone if the Trazadone was ineffective, however the order was written as daily. The CMS also confirmed the Xanax was not available on the 23rd, 24th, 25th, 26th, or 27th of October 2023 and staff could have also got this medication out the emergency medication box if the resident would have needed it. 5. Record review revealed Resident #73 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation, heart failure, ischemic cardiomyopathy, and presence of a pacemaker and defibrillator. Review of Resident #73's orders dated 10/16/23 revealed to administer Warfarin (anticoagulant) 5 mg daily for atrial fibrillation. Review of Resident #73's MAR dated 10/2023 revealed the resident did not receive the Warfarin 5 mg on 10/26/23 due to it not being available. Interview on 04/09/24 at 7:00 A.M. with CSM #102 confirmed staff did not administer the Warfarin 5 mg on 10/26/23 due to it not being available. The CSM reported the Warfarin was available in the emergency medication box and staff could have pulled the medication from the box. Review of the facility's policy and procedure titled Medication Orders (dated 11/2021) revealed orders would be written on physician order sheets/telephone orders and entered into the electronic medical record. The order would be called, faxed, or electronically transferred to the pharmacy. Review of the facility's policy and procedure titled Preparation and General Guidelines: (dated 11/2021) revealed medications are administered as prescribed in accordance with good nursing principles and practices. The facility has sufficient staff and a medication distribution system to ensure safe administration of medication without unnecessary interruptions. If a medication with a current, active order cannot be located in the medication cart/drawer contact the pharmacy or the medication can be removed from the night box/emergency kit. Medication is administered in accordance with written orders by the prescriber. If a medication is not available for three consecutive doses the physician will be notified and an explanatory note written. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295 and Complaint Number OH00151794.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review, interview, and policy review the facility failed to ensure laboratory results were obtained per orders. This affected two residents (#32 and #73) of 50 records reviewed. Findings included: 1. Closed record review revealed Resident #73 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation, heart failure, ischemic cardiomyopathy, and presence of a pacemaker and defibrillator. The resident was discharged on [DATE]. Review of Resident #73's orders dated 10/17/23 revealed check prothrombin/international normalized ratio (PT/INR) every Monday, Tuesday, Wednesday, Thursday, and Friday due to the resident being on an anticoagulant. Review of Resident #73's MAR dated 10/2023 revealed the resident was on Warfarin (anticoagulant) 5 milligrams (mg) daily and Plavix (antiplatelet)75 mg daily. Review of Resident #73's laboratory results dated [DATE] to 10/28/23 revealed no evidence a PT/INR was collected on 10/17/23, 10/18/23, 10/19/23, 10/20/23, 10/23/23, 10/24/23, 10/25/23, or the 10/26/23 as per orders. Interview on 03/26/24 at 1:22 P.M., with Medical Director (MD)/Physician #105 confirmed Resident #73's PT/INRs were not obtained per orders. Interview on 04/09/24 at 7:00 A.M. with Clinical Service Manager (CSM) #102 confirmed Resident #73 PT/INRs were not collected on 10/17/23, 10/18/23, 10/19/23, 10/20/23, 10/23/23, 10/24/23, 10/25/23, or the 10/26/23 per the physician's order. 2. Record review revealed Resident #32 was admitted to the facility on [DATE] with diagnoses including hepatic encephalopathy, acute kidney failure, nonalcoholic steatohepatitis, and viral pneumonia. Review of Resident #32 orders dated 03/26/24 revealed to obtain an Ammonia level, complete metabolic profile, and complete blood count on 03/27/28. Review of Resident #32's laboratory results revealed no evidence the labs ordered on 03/26/24 were completed as ordered on 03/27/24. Interview on 03/27/24 at 1:29 P.M., with the MD/Physician #105 confirmed Resident #32's laboratory testing order on 03/26/24 was not completed on 03/27/24 per orders. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure titled Lab and Diagnostic Tests (dated 06/08/22) revealed to check the physician order for the test, specimen collection directions, and date test was due. Inform resident of the test to be performed and if there was any special instructions. Nurses would notify the physician of the results of the test. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on observation, record review, review of facility billing/financial information, review of the facility assessment, review of the Administrator and Director of Nursing Job Description, and interviews, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident resulting in Immediate Jeopardy and actual harm or the potential for serious harm, injury and/or death to all facility residents. The facility administration failed to take appropriate action resulting in substandard quality of care deficiencies identified under Freedom from Abuse, Neglect, and Exploitation and Quality of Care. The facility administration failed to take appropriate action resulting in Immediate Jeopardy when Resident #80's blood pressure was not adequately monitored to prevent incidents of hypotension (low blood pressure) and failed to notify the physician of the resident's hypotension resulting in a delay in care and treatment. Resident #80 subsequently passed away. The facility administration failed to take appropriate action resulting in substandard quality of care when the facility neglected to operate in a manner to ensure all bills were being paid in a timely manner to prevent potential interruption in service. The facility administration failed to ensure residents were provided appropriate and timely care related to pressure ulcers, safe and comprehensive discharge, monitoring of medical conditions and change in condition, continence, pain management, monitoring of medication usage resulting in unnecessary medication administration, comprehensive pharmacy support, and personal care/hygiene. The facility's inaction caused and/or had the potential to cause serious harm, injury or death to all residents. The facility census was 65. On [DATE] at 1:38 P.M. Licensed Nursing Home Administrator (LNHA) #200, Director of Nursing (DON) #147, [NAME] President of Clinical Services #103, Assistant Administrator #137, and Regional Clinical Service Manager (RCSM) #102 were notified Immediate Jeopardy began on [DATE] when the facility failed to maintain effective administrative services to meet the total care needs of all residents. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 8:00 A.M., Physician #206 assumed role of facility Medical Director, with initiation of [NAME] Services for Nurse Practitioner oversight. Contact information of both parties posted throughout facility. Letters to be either hand delivered or mailed certified to all current residents and/or responsible parties of the update in medical director. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] (no time identified), an Ad Hoc Policy Review was held with the Administrator #200, Assistant Administrator #137, Director of Nursing #147, Regional Clinical Services Manager #102, [NAME] President of Nursing Operations #103, Chief Nursing Officer #207, Medical Director #206, Social Service Designee #159, Activities Director #167, Diet Tech #160, Medical Records/Accounts Payable #157, RN/MDS #161, Director of Rehab #168, RN/ADON #128, RN Staff Development Coordinator/Infection Control #164, Admission Staff #144 , Business Office Manager #142, Maintenance Director #141, Central Supply/Scheduler #140, and NP #205 to review facility polices for Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property; Resident Rights; Staffing and Scheduling Policies: Change in Resident Condition; Medication Administration; Pressure Ulcer Prevention; Incontinence Management; Pain Management; Discharge Planning; Infection Control; and QAPI. Medication Administration Policy was updated to reflect following physician's orders for blood pressure and pulse monitoring with parameters per orders from the physician/physician extender. Change in Resident Condition policy was updated to specifically address acute changes in condition including abnormal vital signs. Parameters were provided by the facility Nurse Practitioner #204 for administration of cardiac medications as follows: Ace Inhibitors- hold if SBP<90 and notify MD/NP, angiotensin 2 Receptor Blockers (ARBs)- hold of SBP<90 and notify MD/NP, Beta Blockers- hold if HR<60 and notify MD/NP, Calcium Channel Blockers- hold if HR<60 and/or SBP<90 and notify MD/NP, and Vasodilators- hold if SBP<90 and notify MD/NP. Staffing and Scheduling Policies were updated to reflect staffing would be based off resident needs, acuity, and State staffing requirements. The staffing pattern was updated to reflect a full time 3p-11p State tested Nursing Assistant (STNA) and an additional 20 hours for an Infection Control Nurse. These policies were incorporated into the Facility Assessment. On [DATE] (no time identified)-, the Regional Clinical Services Managers educated the Administrator #200, Assistant Administrator #137, Director of Nursing #147, RN ADON #128, and RN SDC/IC #164 regarding updated policies and procedures for Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property; Resident Rights; Staffing and Scheduling Policies; Change in Resident Condition; Medication Administration; Pressure Ulcer Prevention; Incontinence Management; Pain Management; Discharge Planning; Infection Control; and QAPI. On [DATE] (no time identified)-, the Administrator #200 and Director of Nursing #147 educated Administrative Staff, including Social Services Designee #159, Admissions Director #167, Business Office Manager #142, RN/MDS #161, Diet Tech #160, Maintenance Director #141, Activities Director #167, Central Supply/Scheduler #140, Medical Records #157, and Director of Rehab #168 regarding updated policies and procedures for Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property; Resident Rights; Staffing and Scheduling Policies: Change in Resident Condition; Medication Administration; Pressure Ulcer Prevention; Incontinence Management; Pain Management; Discharge Planning; Infection Control; and QAPI. On [DATE] (no time identified)-, all facility staff were educated on updated policies and procedures for Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property; Resident Rights; Staffing and Scheduling Policies: Change in Resident Condition; Medication Administration; Pressure Ulcer Prevention; Incontinence Management; Pain Management; Discharge Planning; Infection Control; and QAPI. Education completed included 16 nurses, 28 nurses' aides, 1 activity staff, 5 environmental services staff, 6 dietary staff, and 6 administrative staff. 1 employee who was on vacation would be educated prior to returning to work. All other staff were educated. Education was completed by RN/ADON #128, SDC/IP #164, Diet Tech #160, Maintenance Director #141, and Activities Director #167. Department heads completed education of policies to their respective department staff. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] (no time identified), an Ad Hoc Resident Council meeting was held with Activities Director #167 and Administrator #200 to review the updated policies and procedures for Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property; Resident Rights; Staffing and Scheduling Policies: Change in Resident Condition; Medication Administration; Pressure Ulcer Prevention; Incontinence Management; Pain Management; Discharge Planning; Infection Control; and QAPI. Residents in attendance were Residents #25, #60, #59, #62, #61, and #47. There were no concerns verbalized during the resident council meeting regarding policies shared and information reviewed, and residents were appreciative of the information. On [DATE] (no time identified)- complete head to toe assessments on all current residents were completed by Licensed Nurses RN #131, RN #152, and LPN #129. Assessments included vital signs, pain assessment and skin inspections and there was no deviation from the resident's baseline and no unidentified skin impairments. On [DATE] (no time identified)-, Guardian Angels consisting of administrative staff conducted rounds for all interviewable residents to discuss any care concerns. Guardian Angels is a customer service program at the facility where the IDT meets with each resident ,d+[DATE] days a week to discuss and resolve any needs or concerns, they may have. If a concern arises during this interaction, then the facility would follow its policy for concerns. Concerns are recorded on a log and are investigated and resolved within five working days. Findings of the concern logs were reviewed with QAPI for potential quality improvement areas. Four (4) residents verbalized concerns which were reviewed and resolved on [DATE] by the Administrator #200. On [DATE] (no time identified)-RN/ADON #128 and RN SDC/IC #164 reviewed all non-interviewable residents to ensure they remain at their psychosocial baseline with no evidence of inadequate care being provided. On [DATE] (no time identified)-, RN/MDS #161 completed bowel and bladder screens on all current residents to ensure appropriate toileting interventions were implemented per the residents' level of need. The facility would be completing a staffing meeting five days a week and forecast the weekend shifts to ensure that the resident needs and acuity were being reviewed with the resident census. The staffing pattern was updated to reflect a full time 3p-11p STNA and an additional 20 hours for an Infection Control Nurse. On [DATE] (no time identified)- SSD #159 reviewed all current residents to ensure that an appropriate plan for discharge was in place. There were no changes to the discharge plan of care for any resident assessed. Thirteen (13) vendors who were due bills per their contracts were issued a payment between [DATE] and [DATE] following terms of condition. Twenty-five (25) vendors who were due bills per their contracts were issued payments on [DATE] following terms of condition. The facility determined all vendors who provide good and services with Legacy [NAME] were in good standing as of [DATE]. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Beginning on [DATE] (no time specified)- ongoing auditing would be implemented and completed by the Director of Nursing #147 and/or Designee to be completed five days a week for four weeks. Auditing to include ensuring residents with wounds have appropriate treatments, interventions, and documentation in place; that residents feel their care needs are being met; that appropriate level of toileting assist was being completed per the residents' assessed needs; medications were available for administration and administered per physician's order; pain was assessed and medications were available and administered; and that residents had appropriate discharge plans implemented upon admission as indicated. Audit information would be reviewed with weekly QAPI meeting. Any negative findings will initiate changes to the improvement plan. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings Include: Upon entrance to the facility on [DATE], Assistant Administrator #137 introduced herself to the survey team as the Acting Administrator; however, after additional information was gathered it was determined Assistant Administrator #137 was not a licensed administrator in the State of Ohio and Administrator #101 was actually the administrator of record for the facility at the time of the survey team's entrance. The survey team requested additional information from the facility regarding the administration and leadership changes of the facility. On [DATE] at 1:22 P.M. and [DATE] at 12:09 P.M., interview with Medical Director/Physician #105 revealed she was resigning due to the lack of administration and corporate involvement at the facility and lack of staff competency to perform job duties to ensure resident safety. Physician #105 reported she had brought concerns to the facility's attention for the last six months and the concerns still had not been addressed. Per Physician #105, in [DATE] the Administrator and DON were fired, however this did not resolve the issues occurring at the facility. Physician #105 reported the issues were worse now than they were. Physician #105 reported she started attending the morning meeting at the facility to make sure resident care issues were followed up on and not falling through the cracks. Physician #105 reported she felt her licenses were in jeopardy as well as the licenses of others who worked at the facility. Review of an email from Administrator #200 dated [DATE] at 12:00 P.M. revealed there had been five changes in Administrator at the facility since [DATE]: [DATE] to [DATE] Administrator #300 [DATE] to [DATE] Administrator #301 [DATE] to [DATE] Administrator #302 [DATE] to [DATE] Administrator #101 (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	[DATE] to present Administrator #200. The email further revealed there had been five changes in Director of Nursing since [DATE]: [DATE] to [DATE] Director of Nursing #303 [DATE] to [DATE] Director of Nursing #304 [DATE] to [DATE] Director of Nursing #305 [DATE] to [DATE] Director of Nursing #306 [DATE] to present Director of Nursing #147. Interview on [DATE] at 8:01 A.M. with the DON and Assistant Administrator #137 revealed the DON started in February 2024 and the Assistant Administrator started in mid-March (2024). Assistant Administrator #137 was licensed (as an Administrator) in [NAME] Virginia, but not Ohio at this time. Per the DON and Assistant Administrator #137, the previous Administrator (#101) was a traveling Administrator, and he didn't keep track of concerns or outcomes in the facility. The DON reported corporate had little involvement except the corporate nurse who would come weekly and review records for missing information. The DON and Assistant Administrator #137 reported the root cause of many of the concerns the surveyors were finding was there were so many changes in leadership (Administration/DON) in the last 13 months. During the survey, the following care concerns were identified by the survey team. The facility's inaction caused serious harm including death and had the likelihood of causing serious harm or injury to all residents: 1. The facility failed to ensure Resident #80's blood pressure was adequately monitored to prevent incidents of hypotension (low blood pressure) and failed to notify the physician of the resident's hypotension resulting in a delay in care and treatment. This resulted in Immediate Jeopardy with serious life threatening harm on [DATE] when the resident, who had a history of hypotension, had a blood pressure of ,d+[DATE] which was not reported to the physician, physician ordered blood pressure and pulse monitoring was not completed, a beta blocker medication (works to lower blood pressure) was administered with a resulting blood pressure of , d+[DATE] which was not reported to the physician and no treatment was provided. The resident was found two hours later without a pulse or respiration and was declared deceased . In addition, concerns that were actual harm that did not rise to the level of Immediate Jeopardy occurred due to the facility failure to notify Resident #34's physician of low blood pressure and staff administered hypertensive and diuretic medication that resulted in a significant drop in the resident's already low blood pressure that required hospitalization of the resident for treatment. Actual harm occurred when the facility failed to follow Resident #53's physician orders for weight monitoring and the resident sustained a significant weight gain with staff failure to notify the physician with the change in condition resulting in a delay in care and treatment until the resident attended a medical appointment with the pulmonologist resulting in a direct admission to the hospital for three days for treatment of congestive heart failure. (continued on next page)

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	365780	A. Building B. Wing	04/18/2024

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	2. The facility neglected to operate in a manner to ensure all bills were being paid in a timely manner to prevent potential interruption in services as evidenced by the facility owing 38 vendors outstanding fees for services and supplies that were rendered. 3. The facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to ensure timely, accurate and thorough pressure ulcer assessments were completed and to ensure adequate interventions and treatment was in place to promote healing and prevent new ulcers from developing. Actual Harm occurred on [DATE] when Resident #29, who exhibited severe cognitive impairment, had current pressure ulcers present and required substantial/maximal assistance for bed mobility and total dependence for toileting was assessed to have new in-house developed pressure ulcers. The resident was assessed to have an unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer to the left buttock and a Stage II (Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister) pressure ulcer to the right buttock. The facility failed to identify the left buttock ulcer until it was unstageable. The new pressure ulcer development occurred due to the lack of adequate interventions including turning and repositioning. Actual Harm occurred on [DATE] when Resident #30, who exhibited severe cognitive impairment, had current pressure ulcers present and required moderate assistance with toileting and bed mobility was assessed to have two new in-house acquired pressure ulcers. An unstageable pressure ulcer to the right lower leg and a Stage II pressure ulcer to the right heel. The facility failed to identify the right lower leg pressure ulcer until it was unstageable. The new pressure ulcer development occurred due to the lack of adequate interventions including turning and repositioning and off-loading of the resident's heels. Actual Harm occurred on [DATE] when Resident #41, who required staff assistance for turning and repositioning was assessed to have a deterioration in status of a coccyx pressure ulcer with an increase in the presence of slough tissue. In addition, on [DATE] the resident was assessed to develop a new in-house acquired Stage II pressure ulcer to the right heel. The resident complained of increased pain to the right heel and voiced concerns staff failed to provide turning and repositioning interventions to prevent the development and/or deterioration. In addition, the new pressure ulcer to the right heel developed due to a lack of adequate interventions including off-loading of the resident's heels. 4. The facility failed to ensure services and assistance to maintain bladder continence for Resident #25 and failed to ensure Resident #29 received appropriate treatment and services to treat urinary tract infections Actual Harm occurred on [DATE] when Resident #25, who had been always continent of bladder as assessed to be frequently incontinent of bladder. The resident reported the increased incontinence was a result of having to wait on staff to assist him to use the urinal resulting in accidents/incidents of urinary incontinence. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Actual Harm occurred on [DATE] to Resident #29 when she required re-hospitalization and admission for seven days for treatment of sepsis and bacteremia secondary to UTI requiring intravenous antibiotic administration and infectious diseases consult due to the facility's failure to administer intravenous antibiotics as ordered and obtain urine samples for analysis including culture and sensitivity. The facility continuously failed to follow physician orders related to the infectious disease consult as the consult was never completed even after Resident #29's physician continued to order the infectious disease consult on orders dated [DATE], [DATE], and [DATE]. 5. The facility failed to implement an effective and timely pain management program. Actual harm occurred when Resident #67 who was admitted for orthopedic aftercare, experienced pain rated a 10 out of 10 (on a ,d+[DATE] pain scale with 10 being the most severe) to the right hip. Staff failed to notify the provider the ordered narcotic analgesic pain medication, Oxycodone was not available, resulting in the resident continuing to experience pain as evidenced by the resident's crying and moaning in pain requiring the resident being transferred to the emergency room for uncontrolled pain where the resident was treated with intravenous administration of narcotic pain medication. Actual harm occurred when Resident #44, admitted to the facility without a comprehensive pain assessment being completed and an ordered neuropathic pain medication was ordered and not administered for two days resulting in the resident's experiencing continuous pain the resident rated as 12 out 10 (,d+[DATE] pain scale) and delayed treatment with an ordered pain medication. 6. The facility failed to ensure residents drug regimen was free from unnecessary medication. The facility failed to receive order clarification of anticoagulation medication therapy for Resident #16 resulting in a resident receiving an unnecessary anticoagulation medication for ten days. Actual harm occurred for Resident #16 when the resident's medical providers wrote the first order to call the resident's cardiologist to clarify the Heparin (anticoagulant medication) order. The resident continued to receive Heparin three times a day for ten days following the resident's medical provider orders written repeatedly on [DATE], [DATE] and [DATE] to clarify orders due to the resident's hemoglobin continued to drop down to 7.8 g/dL (normal range 13.3 -17.7 g/dL) and the ordered diagnostic test for occult blood was delayed in completion. The facility failed to complete adequate blood sugar monitoring for Resident #44 to ensure the correct amount of insulin was administered. 7. The facility failed to provide Resident #67 a safe discharge and failed to provide the resident or resident representative with required documentation upon discharge resulting in actual harm. Resident #67 was admitted with primary diagnosis of post-surgical hip repair and was immediately discharged by the facility, without a safe place to be discharged to, after being observed in the facility parking lot on one occasion smoking and taking sips of alcohol. Following the resident's discharge, she did not have a safe place to go, 911 was called and the resident was transported to the emergency room where she was subsequently admitted to the hospital as the resident was assessed/deemed unsafe to return home and the facility refused to re-admit the resident. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with Nursing Assistant #127 on [DATE] at 11:55 P.M. revealed there were not enough staff to meet the needs of the residents including showers. He/she stated staff can't answer call lights timely or give the care the residents need. He/she stated some residents require the assistance of two staff and there was no one to help her/him. He/she stated staff have to go look for another staff to assist them and that takes time. He/she stated residents have to wait too long if he/she was in another room with another resident providing care. He/she stated staff can't give showers to residents who require a Hoyer lift with only one staff person on each hall. He/she confirmed staff were not able to check and change residents who were incontinent every two hours. He/she stated he/she was not able to get residents up in the morning that want to get up because there is not enough staff. He/she stated there was usually one aide per hallway (four total) or sometimes less. He/she stated he/she had worked with only two aides for the whole building. Interview with Nursing Assistant #149 on [DATE] at 12:00 A.M. revealed there was usually one aide per hallway (four total). He/she stated he/she had worked when there were only two aides for the whole building. He/she stated there were not enough staff to meet residents' needs. He/she stated he/she had been told not to do showers because of not enough staff. Interview with Nursing Assistant #201 on [DATE] at 12:15 A.M. revealed there were not enough staff to being able to complete resident showers as scheduled. He/she stated there were anywhere from ,d+[DATE] aides working at night for the whole building. He/she stated there had been a lot of change in routine due to the changes in administration. He/she stated there was a lack of communication in the facility. He/she stated staff have to give showers at times when residents don't want them, but the residents know if they don't take them at that time, then they won't get a shower. Interview with Nursing Assistant #122 on [DATE] at 3:05 P.M. revealed the facility was very short staffed. He/she stated most days there was only one aide per hallway (7:00 A.M. to 7:00 P.M.). He/she stated the aide would have to leave their hall to go assist another staff who needed help with a resident who required two-person assistance. He/she stated call lights were then not answered timely. He/she stated it was just survival there in getting things done that need to be done. He/she confirmed showers were not completed as scheduled. He/she stated the dining room was often closed for most meals due to not having enough staff to supervise residents in the dining room and on the hallways. Interview with Licensed Practical Nurse #150 on [DATE] at 8:40 A.M. revealed she was new to the facility. She stated there were not enough staff to be able to meet residents' needs. She stated aides were not able to get showers done. She confirmed residents were not able to go to the dining room at times. Interview with Scheduler #140 on [DATE] at 10:15 A.M. revealed she was instructed to follow an equation to determine how many nursing assistants and nurses to schedule each day. She stated the census was multiplied by 1.10 for nurses and 1.62 for nursing assistants. She stated she had expressed to the Director of Nursing and Administrator there were not enough staff to meet resident needs but was instructed to continue to follow the equation. Interview with Director of Nursing (DON) #147 on [DATE] at 10:30 A.M. confirmed an equation was used to determine staffing levels. She confirmed she felt there was not enough staff to meet residents' needs and stated she had discussed it with the previous Administrator, but stated she was told they still must follow the staffing equation. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with the current Administrator/Regional Director of Operations #200 on [DATE] at 11:20 A.M. revealed there was a formula (equation) for how many staff were allowed based on a budget goal. She stated she was not aware of the need for additional staff. Interview on [DATE] at 12:43 PM with Assistant Administrator #137 and Director of Nursing (DON) #147 confirmed that multiple changes in Administrator and Director of Nursing in the past year and the lack of leadership was the root cause of the concerns noted at the time of this survey. Interview with Resident #44 on [DATE] at 1:06 P.M. revealed the facility didn't have enough staff to care for the residents. Most of the staff don't wear name badges and when you ask for assistance, they say we can't help you or we need to find someone else to help because they all have back problems and can't do anything by themselves. It takes up to an hour or longer for staff to answer call lights. The staff have attitudes, and you can tell they don't want to be there. There was usually one aide for 40 residents. Staff verbally tell him they are short staff. Interview with Resident #25 on [DATE] at 10:33 A.M. revealed there was not enough staff, and the aides were too busy. The resident stated this had been brought up [TRUNCATED]

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 32801 Based on review of quality assurance/performance improvement (QAPI) minutes, review of the facility governing body information, review of list of previous and current Administrators and Director of Nursing, interviews, and policy review the facility failed to have an effective governing body to oversee the functions of the facility. This had the potential to affect all 65 residents residing in the facility. Finding included: Review of the facility governing body form (undated) revealed the facility was governed by a management service agreement that consists of a President, [NAME] President, Secretary, and a Treasurer. Review of QAPI minutes dated 11/2023, 12/29/23, 01/25/24, 02/22/24 and 03/29/24 revealed the November 2023 meeting minutes had no exact date the meeting was conducted, or concerns except a mock survey was conducted in the dietary department. There was no list of who attended the meeting. The December 2023 meeting minutes included the facility needed for better communication with the lab and audits were done on code status and would be repeated in December. There was no evidence the audits were completed. The January 2024 meeting minutes didn't identify any new concerns and indicated a mock survey was conducted in October 2023 of the kitchen and recommendations were made to clean the kitchen walls and walk in coolers. The February 2024 meeting minutes revealed no concerns were identified. The March 2024 meeting minutes indicated the state was currently in the building and it was very eye opening the amount of work the facility was going to have to do including in-services, education, and audits to get them back into and maintain compliance. There was no evidence the governing body was involved with any of the QAPI meetings. Review of an email from Administrator #200 dated 03/28/24 at 12:00 P.M. revealed there had been five changes in Administrators at the facility since 01/01/23: 01/01/23 to 03/06/23 Administrator #300 03/01/23 to 12/04/23 Administrator #301 12/04/23 to 03/19/24 Administrator #302 03/20/24 to 03/27/24 Administrator #101 (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	03/27/24 to present Administrator #200. Review of the list of Director of Nursing's (DONs) dated 01/01/23 to 03/28/24 revealed the facility had five different DONs within 13 months. Interview on 03/26/24 at 1:22 P.M. and 04/09/24 at 12:09 P.M., with the Medical Director/Physician #105 confirmed she was resigning due to the lack of administration and corporate involvement and staff competency to perform job duties to ensure resident safety. Physician #105 reported she has brought concerns to the facility's attention for the last six months and the concerns still have not been addressed. In December 2023 they fired the Administrator and DON however never corrected the issues. The issue is worse now than it was. The QAPI committee was not effective, and she had to beg for a QAPI meeting. Physician #105 reported she started attending the morning meeting to make sure resident care issues were followed up on and not falling through the cracks. Physician #105 reported she felt her licenses were in jeopardy as well as others that work there. Interview on 04/10/24 at 8:01 A.M. with the DON and Assistant Administrator #137 confirmed the facility has not identified concerns including pharmacy, pressure, pain, discharge, quality of care, and weights that were identified during the complaint survey. The facility currently had no performance improvement plans in-place. The DON reported she started in February 2024 and the Assistant Administrator started in mid-March. The Assistant Administrator was licensed in [NAME] Virginia, but not Ohio at this time. The Assistant Administrator will take over as soon as she passes her Ohio test. The DON reported the facility has stand up meeting in the morning and at the end of the day they have a stand down meeting to ensure concerns were addressed for the day. The DON confirmed the meeting was not documented to provide evidence of concerns/issues identified or addressed, however concerns were prioritized from most important to least important. The DON confirmed the QA did not really have a plan or implementation of plans. The DON reported corporate had little involvement except the corporate nurse would come weekly and review records for missing information. The DON and Assistant Administrator reported the root cause of many of the concerns the surveyors were finding was there were so many changes in leadership (Administration/DON's) in the last 13 months. Review of the facility policy and procedure title Quality Assurance Performance Improvement (dated 10/24/22) revealed the governance and leadership would be responsible for ensuring all ongoing QAPI programs were defined, implemented, and maintained and that it addresses identified priorities. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295 and Complaint Number OH00151794.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record reviews, interviews, and policy review the facility failed to ensure admission assessment were completed timely, skilled charting was documented daily, and appointments, wounds, and adverse reactions were documented accurately. This affected ten residents (#1, #18, #35, #41, #44, #66, #72, #77, #78, and #81) of 50 residents records reviewed. Findings included: 1. Medical record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including lymphedema, candida esophagitis, and need for assistance with personal care. Review of Resident #1's paper and electronic medical record revealed no evidence of a consult note from an outside dental office or a dental appointment. Review of a social service note dated 11/22/22 revealed the resident had an appointment at an outside dental office on 01/30/23 and would be placed on a cancellation list. Review of a fax from a dental office dated 04/10/24 revealed the resident was only seen once on 10/25/23 and the doctor had to cancel the appointment on 01/20/23. The attached note dated 10/25/23 revealed the resident was having pain with tooth #20 that was broken off. Resident stated the nursing had him on antibiotics recently for this and tooth #18 was root tips as well. Next visit will extract teeth #18 and #20. Interview on 04/01/24 at 1:49 P.M., with Resident #1 and the Director of Nursing (DON) revealed the facility had taken him to see a dentist not affiliated with the facility and he was supposed to go back in April (2023) sometime for extractions but there was no documentation regarding the appointment including the doctor or location. The resident reported he has asked numerous staff and they tell him they don't know anything about an appointment. The DON reported all appointments should be documented in the orders tab in the electronic medical records, however there was no documented evidence regarding a dental appointment in the orders or medical records. The DON reported the only records in the medical record were from the facility's contracted dental company. Interview on 04/01/24 at 2:33 P.M., with the dental office revealed the resident had an appointment on 04/15/24 at 11:20 A.M. Interview on 04/01/24 at 2:53 P.M., with Scheduler #115 confirmed she called the outside dental office, and they confirmed the resident had an appointment on 04/15/24. 2. Record review revealed Resident #66 was originally admitted to the facility on [DATE] and readmitted on [DATE] after being discharged on [DATE]. The resident diagnoses included malignant neoplasm of brain, spinal cord, liver, and skin, heart disease, anxiety, shortness of breath, insomnia, and pain. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #66's assessment revealed no evidence an admission assessment was completed on 11/09/23. Interview on 03/26/24 at 1:22 P.M., with the Medical Director (MD)/Physician #105 confirmed Resident #66's admission assessment was not completed. Interview on 04/08/24 at 1:59 P.M., with Clinical Service Manager (CSM) #102 confirmed the resident should have had an admission assessment completed on 11/09/23 when he was readmitted , however there was no documented evidence an assessment was completed. 3. Record review revealed Resident #72 was admitted to the facility originally on 11/15/23 with diagnoses heart and respiratory failure, diabetes, kidney disease, radiculopathy, anxiety, cholecystitis, and malignant neoplasm. Review of Resident #72's assessment dated [DATE] revealed the resident admission assessment was not completed. Interview on 03/26/24 at 1:22 P.M., with MD/Physician #105 confirmed Resident #72's admission assessment was not completed in a timely manner. Interview on 04/08/24 at 2:36 P.M., with CSM #102 confirmed Resident #72' admission assessment was not completed. 4. Record review revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus, heart disease, malignant neoplasm of part of the lung, acquired absence of the lung, age-related physical disability, and neuropathy. Review of Resident #44's skilled charting revealed no evidence daily skilled charting was completed on 03/13/24, 03/14/24, 03/16/24, 03/18/24, 03/20/24, 03/21/24, 03/25/24, 03/27/24. Interview on 03/28/24 at 8:36 A.M., with the Assistant Director of Nursing (ADON) #128 confirmed skilled charting should be completed at least once daily. ADON #128 confirmed Resident #44's skilled charting was not completed on 03/13/24, 03/14/24, 03/16/24, 03/18/24, 03/20/24, 03/21/24, 03/25/24, 03/27/24. Review of the facility policy titled Documentation-Skilled Notes (dated 11/30/23) revealed skilled residents would have documentation daily per the Federal Guidelines. The purpose is to accurately reflect the resident status on a daily basis for the interdisciplinary team to have available as needed. A skilled note would be completed daily for each skilled resident. If these assessments cannot be completed, a progress note would be used to document the current resident's status including vital signs. 07316 5. Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including Parkinson's disease and chronic pain syndrome. A MDS assessment completed 01/25/24 documented a BIMS score of 13, indicating intact cognition. It further stated the resident was dependent upon staff for toileting, showering, dressing, hygiene, rolling in bed, and transfers. (continued on next page)

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	365780	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Marietta	5001 State Route 60 Marietta, OH 45750

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #41 on 03/26/24 at 1:22 P.M. revealed he had an appointment outside of the facility later that day. On 03/26/24 at 3:47 P.M. Resident #41 was in his room. He stated that he did not go for the appointment and did not know why. Review of Resident #41's medical record revealed no evidence of an appointment on 03/26/24. However, there was a nursing progress note on 03/21/24 that stated the resident had an appointment on 03/25/24. The note did not indicate what the appointment was for. Interview with Director of Nursing #147 on 04/01/24 at 10:15 A.M. revealed Resident #41 was supposed to go out to a dermatology appointment on 03/25/24 but the appointment had been canceled by the hospital when the resident was admitted there from 03/02/24 to 03/09/24. She stated the facility not aware the appointment had been canceled. She confirmed the medical record was not completely and accurately documented regarding Resident #41's appointments. Interview with Licensed Practical Nurse #150 on 04/02/24 at 8:40 A.M. revealed there is confusion with resident appointments. She stated there are too many staff involved in the process of resident appointments. 6. Review of the facility incident log revealed on 02/19/24 Resident #35 was noted to have a choking incident. Review of a facility incident report revealed on 02/19/24 a nursing assistant called for a nurse to help. The nurse documented that she ran down and found Resident #35 choking on lunch while in bed. The nurse performed the Heimlich maneuver until the resident had a clear airway and was able to breath and talk. Lung sounds clear. Review of the medical record for Resident #35 revealed an admitted [DATE] and diagnoses including dysphagia, atrial fibrillation, and syncope. Review of the medical record did not reveal any incident related to choking had been documented. Interview with Director of Nursing #147 on 03/27/24 at 8:05 A.M. confirmed the choking incident should have been documented in the medical record. 7. Review of the facility incident log revealed on 02/25/24 a choking incident was logged for Resident #18 then lined out. Review of the medical record for Resident #18 revealed a nursing progress note on 02/25/24 at 4:25 P.M. that stated the nurse was called to the resident's room. The resident had been eating food from McDonalds and got choked on a french fry. The resident was able to cough and clear it up without doing the Heimlich. Lung sounds and vital sounds assessed. Physician notified. Family in room. New order for speech therapy evaluation. However, the whole entry on 02/25/25 at 4:25 P.M. had been lined through in the nursing progress notes. Interview with Director of Nursing #147 on 03/26/24 at 4:25 P.M. revealed the facility had determined the incident should not have required an incident report since the resident did not require the Heimlich maneuver. That is why it was lined through on the incident log. She stated the incident should have been documented in the medical record and should not have been lined through as if an error, as the incident did occur. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Review of the closed medical record for Resident #81 revealed an admitted [DATE]. Review of the admission nursing assessment revealed it was started on 07/03/23 but not signed as completed until 07/12/23 (nine days later). The resident was out to the hospital from 10/17/23 to 10/26/23. Review of that admission nursing assessment revealed it was started on 10/26/23 but not signed as completed until 10/29/23 (three days later). Interview with Administrator #200 on 04/08/24 at 11:34 A.M. revealed admission nursing assessments are to be completed within 24 hours of admission. Interview with Corporate Registered Nurse #103 on 04/08/24 at 11:40 A.M. confirmed the admission nursing assessments for Resident #81 were not completed timely. 9. Review of the closed medical record for Resident #77 revealed an admitted [DATE]. Review of the admission nursing assessment revealed it was started on 11/09/23 but not signed as completed until 11/13/23 (four days later). Interview with Administrator #200 on 04/08/24 at 11:34 A.M. revealed admission nursing assessments are to be completed within 24 hours of admission. Interview with Corporate Registered Nurse #103 on 04/08/24 at 11:40 A.M. confirmed the admission nursing assessment for Resident #77 was not completed timely. 10. Review of the medical record for Resident #78 revealed an admitted [DATE] with diagnoses including venous insufficiency. Review of treatment administration records (TAR) for December 2023 and February 2024 revealed the resident had physician's orders for dressing changes daily to his lower legs. Record review did not reveal any documentation to show what wounds the resident had or that they were being monitored for improvement/decline. In addition, review of the TAR for December 2023 revealed there were 11 times that the treatments were not documented as completed. Review of the TAR for February 2024 revealed there were three times the treatments were not documented as completed. Interview with Assistant Director of Nursing #128 on 04/09/24 at 9:40 A.M. revealed Resident #78 had vascular wounds on his legs in December 2023 and February 2024. She confirmed there was missing documentation to indicate that the treatments were completed and that the areas were being monitored for improvement/decline. She confirmed this should be documented in the medical record. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295.

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F 0844 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. 32801 Based on review of the facility record of Administrators and Directors of Nursing (DON) and interview the facility failed to notify the state agency of changes in administration. This had the potential to affect all 65 residents residing in the facility. Findings included: Review of an email from Administrator #200 dated 03/28/24 at 12:00 P.M. revealed there had been five changes in Administrator at the facility since 01/01/23: 01/01/23 to 03/06/23 Administrator #300 03/01/23 to 12/04/23 Administrator #301 12/04/23 to 03/19/24 Administrator #302 03/20/24 to 03/27/24 Administrator #101 03/27/24 to present Administrator #200. The email further revealed there had been five changes in Director of Nursing since 01/01/23: 01/02/23 to 05/24/23 Director of Nursing #303 05/22/23 to 12/04/23 Director of Nursing #304 12/04/23 to 01/25/24 Director of Nursing #305 01/25/24 to 02/07/24 Director of Nursing #306 02/05/24 to present Director of Nursing #147. Interview on 03/28/24 at 11:30 A.M., with Administrator #200 confirmed the facility did not update the state agency on changes in Administration on 12/04/23 when the facility hired a traveling Administrator, on 03/20/24 and on 03/27/24 when two Corporate Administrators took over the Administration position temporarily. Administrator #200 confirmed the facility did not report DON changes from 01/02/23 to 03/28/24 to the state agency. Administrator #200 confirmed there were five DON's during that timeframe and none of the five were reported. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295 and Complaint Number OH00151794.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 32801 Based on review of quality assurance/performance improvement (QAPI) minutes, interviews, and policy review the facility failed to have an effective QAPI program. This had the potential to affect all 65 residents residing in the facility. Finding included: Review of QAPI minutes dated 11/2023, 12/29/23, 01/25/24, 02/22/24 and 03/29/24 revealed the November 2023 meeting minutes had no exact date the meeting was conducted, or concerns except a mock survey was conducted in the dietary department. There was no list of who attended the meeting. The December 2023 meeting minutes included the facility needed for better communication with the lab and audits were done on code status and would be repeated in December. There was no evidence the audits were completed. The January 2024 meeting minutes didn't identify any new concerns and indicated a mock survey was conducted in October 2023 of the kitchen and recommendations were made to clean the kitchen walls and walk in coolers. The February 2024 meeting minutes revealed no concerns were identified. The March 2024 meeting minutes indicated the state was currently in the building and it was very eye opening the amount of work the facility was going to have to do including in-services, education, and audits to get them back into and maintain compliance. There was no evidence the governing body was involved with any of the QAPI meetings. Interview on 03/26/24 at 1:22 P.M. and 04/09/24 at 12:09 P.M., with the Medical Director/Physician #105 confirmed she was resigning due to the lack of administration and corporate involvement and staff competency to perform job duties to ensure resident safety. Physician #105 reported she has brought concerns to the facility's attention for the last six months and the concerns still have not been addressed. In December 2023 they fired the Administrator and DON, however never corrected the issues. The issue is worse now than it was. The QAPI committee was not effective, and she had to beg for a QAPI meeting. Physician #105 reported she started attending the morning meeting to make sure resident care issues were followed up on and not falling through the cracks. Physician #105 reported she felt her licenses were in jeopardy as well as others that work there. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 04/10/24 at 8:01 A.M. with the Director of Nursing (DON) and Assistant Administrator #137 confirmed the facility has not identified concerns including pharmacy, pressure, pain, discharge, quality of care, and weights that were identified during the complaint survey. The facility currently had no performance improvement plans in-place. The DON reported she started in February 2024 and the Assistant Administrator started in mid-March. The Assistant Administrator was licensed in [NAME] Virginia, but not Ohio at this time. The Assistant Administrator will take over as soon as she passes her Ohio test. The DON reported the facility has stand up meeting in the morning and at the end of the day they have a stand down meeting to ensure concerns were addressed for the day. The DON confirmed the meeting was not documented to provide evidence of concerns/issues identified or addressed, however concerns were prioritized from most important to least important. The DON confirmed the QA did not really have a plan or implementation of plans. The previous Administrator was a traveling Administrator, and he didn't keep track of concerns or outcomes. The DON reported corporate had little involvement except the corporate nurse would come weekly and review records for missing information. The DON and Assistant Administrator reported the root cause of many of the concerns the surveyors were finding was there were some many changes in leadership (Administrators/DONs) in the last 13 months. Review of the facility policy and procedure titled Quality Assurance Performance Improvement (dated 10/24/22) revealed the facility and organization will have ongoing Quality Assurance Performance Improvement would be designed with scope that was ongoing and comprehensive dealing with a full range of services offered by the facility including the full range of departments that addresses all aspects of care. The design and scope of the program would systematically monitor and evaluate the quality and appropriateness of resident care, pursue opportunities to improve resident care, resolve identified problems, and identify opportunities for improvement. The QAPI committee (Governing Body) has the responsibility for designing and implementing corrective action plans as needed to resolve identified resident care/service problems. This would be accomplished within local, state, federal, and corporate guidelines as well as fiscal restraints. All improvement plans would contain the change, corrective action to be implemented, who would be responsible, and time intervals. The improvement plan and effectiveness of action will be documented in the committee minutes. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295 and Complaint Number OH00151794.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, review of infection control log, interview, and policy review the facility failed to ensure the infection control log was comprehensive. This affected one resident (#34) of 36 reviewed for quality of control, with the potential to affect all 65 residents residing in the building. Findings included. 1. Record review revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including sepsis due to Escherichia coli (E. coli), urinary tract infections (UTI), diabetes, congestive heart failure, nonrheumatic aortic stenosis, presence of prosthetic heart valve, presences of cardiac pacemaker, history of transient ischemic attack, hypertensive heart disease with heart failure, sick sinus syndrome, acute respiratory failure, and anxiety. a. Review of Resident #34's orders and medication administration records dated 03/04/24 to 03/11/24 revealed the resident was ordered and received Nystatin cream to the tip of penis three times a day for yeast infection for seven days. Review of the infection control log dated 03/2024 revealed no documented evidence Resident #34 received Nystatin cream for the yeast infection. b. Review of Resident #34's orders and medication administration records dated 03/12/24 to 03/21/24 revealed the resident was ordered and received Cipro 500 milligram (mg) twice daily for 10 days for urinary tract infection (UTI). Review of the infection control log dated 03/2024 revealed no documented evidence Resident #34 received Cipro 500 mg for a UTI and no evidence the resident met criteria for treatment. Interview on 04/02/24 at 9:39 A.M. with the Infection Prevention (IP) Nurse #164 confirmed Resident #34 was ordered and received Cipro and Nystatin and it was not on the infection control log. The IP nurse confirmed she had no documentation regarding the UTI, and she was looking into why it was ordered. c. Review Resident #34's urinalysis results, which was not in the medical record and faxed to the facility on [DATE], dated 03/05/24 revealed the resident tested positive for Enterobacterales and Klebsiella pneumoniae (ESBL) on 03/07/24 and contact isolation protocols should be used with this resident. There was no evidence Cipro was listed as one of the antibiotics sensitive or resistant to. Review of Resident #34's orders and medical record revealed no evidence the resident was placed on isolation protocols from 03/07/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 04/02/24 at 10:48 A.M. with Clinical Service Manager (CSM) #102 confirmed the urologist ordered a urinalysis on 03/05/24. The urine came back positive for Enterobacterales and Klebsiella pneumoniae (ESBL) 03/07/24 and contact isolation protocols should have been implemented. The CSM reported the urologist called the facility on 03/12/24 and ordered Cipro 500 mg twice daily for 10 days, however the facility never followed up on the urinalysis results and was unaware the resident tested positive for ESBL. The CSM also confirmed the facility did not follow up to ensure the resident meet criteria for treatment. 2. Review of the paper infection control log dated 09/2023 to 03/2024 revealed no evidence infections were being monitored for trends. There was a facility floor plan for the months of November 2023 and December 2023, however the floor plans only trended urinary tract infections (UTI), respiratory, ears eyes nose and throat (EENT), gastro-intestinal, skin, and other. There was no evidence infection/organism were monitored for trends those months. The logs had several infections that indicated a culture was completed, however there was no evidence of what the organism was. There was no evidence that any of the infections met criteria for treatment. There was no infection control log for the month of February 2024, however the facility had pharmacy print out an antibiotic report to show there were infections. Interview on 03/26/24 at 2:24 P.M. and 3:25 P.M. with the Director of Nursing (DON) revealed the facility was looking for infection control logs as requested from October 2023 to February 2024 however the facility was not able to produce them at this time. The previous IP nurse quit two weeks ago, and the facility doesn't have access to her computer. The DON reported she was going to call pharmacy and have them fax over an antibiotic report. Interview on 03/27/24 at 1:39 P.M. with IPN #164 revealed today was only her 3rd day and she just started the IP training yesterday. IPN #164 reported she found some paper infection control logs except for 02/2024. The IP nurse confirmed the infection control logs dated 09/01/23 to 03/26/24 were not complete or comprehensive to include organism for all infections if indicated, there was no evidence if the resident met criteria for treatment, monitoring for trends was not completed monthly to show if there was an outbreak/trend in infections. Review of the facility policy and procedure titled Infection Prevention and Control Program (dated 11/30/23) revealed the facility has developed and maintains an infection prevention and control program that provides a safe, sanitary, and comfortable environment to help prevent the development and transmission of infections. The program will protect residents from healthcare-associated infections by developing prevention, surveillance, and control measures. Surveillance activities include monitoring and investigating causes of infection to prevent infections from spreading. A record would be maintained to record infections. Procedure would be developed and applied to certain individuals, such as isolation. The infection control program would be monitored quarterly or as indicated by the IP and control committee. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy and procedure titled Antibiotic Stewardship Program (dated 11/30/23) revealed the facility utilizes the McGeer's definition of infection to determine appropriate infectious diagnoses, and treatment thereof. Nursing staff would notify the IP, or designee, when an infection was suspected. This would allow for early detection and management of potential infections, as well as implementation of appropriate transmission-based precautions if appropriate. When a culture and sensitivity is ordered lab results and current clinical situation would be communicated to the prescriber when available to determine if antibiotic therapy should be started, continued, modified, or discontinued. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, review of infection control log, interview, and policy review the facility failed to ensure residents met criteria for antibiotic treatment. This affected one resident (#34) of 36 residents reviewed for quality of care. Findings included. 1. Record review revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including sepsis due to Escherichia coli (E. coli), urinary tract infections (UTI), diabetes, congestive heart failure, nonrheumatic aortic stenosis, presence of prosthetic heart valve, presences of cardiac pacemaker, history of transient ischemic attack, hypertensive heart disease with heart failure, sick sinus syndrome, acute respiratory failure, and anxiety. Review of Resident #34's urinalysis results, which were not in the medical record and faxed to the facility on [DATE], dated 03/05/24 revealed the resident tested positive for Enterobacterales and Klebsiella pneumoniae (ESBL) 03/07/24 and contact isolation protocols should be used with this resident. There was no evidence Cipro was listed as one of the antibiotics sensitive or resistant to. Review of Resident #34's orders and medication administration records dated 03/12/24 to 03/21/24 revealed the resident was ordered and received Cipro 500 milligram (mg) twice daily for 10 days for urinary tract infection (UTI). Review of the infection control log dated 03/2024 revealed no documented evidence Resident #34 received Cipro 500 mg for a UTI and no evidence the resident met criteria for treatment. Interview on 04/02/24 at 9:39 A.M. with the Infection Prevention (IP) Nurse #164 confirmed Resident #34 was ordered and received Cipro and it was not on the infection control log. The IP nurse confirmed she had no documentation regarding the UTI, and she was looking into why it was ordered. Interview on 04/02/24 at 10:48 A.M. with Clinical Service Manager (CSM) #102 confirmed the urologist ordered a urinalysis on 03/05/24. The urine came back positive for Enterobacterales and Klebsiella pneumoniae (ESBL) 03/07/24 and contact isolation protocols should have been implemented. The CSM reported the urologist called the facility on 03/12/24 and ordered Cipro 500 mg twice daily for 10 days, however the facility never followed up on the urinalysis results and was unaware the resident tested positive for ESBL. The CSM also confirmed the facility did not follow up to ensure the resident met criteria for treatment. (continued on next page)

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the paper infection control log dated 09/2023 to 03/2024 revealed no evidence infections were monitored for trends. There was a facility floor plan for the months of November 2023 and December 2023, however the floor plans only trended urinary tract infections (UTI), respiratory, ears eyes nose and throat (EENT), gastro-intestinal, skin, and other. There was no evidence infection/organism were trended those months. The logs had several infections that indicated a culture was completed, however there was no evidence of what the organism was. There was no evidence that any of the infections met criteria for treatment. There was no infection control log for the month of February 2024, however the facility had pharmacy print out an antibiotic report to show there were infections. Interview on 03/26/24 at 2:24 P.M. and 3:25 P.M. with the Director of Nursing (DON) revealed the facility was looking for infection control logs as requested from October 2023 to February 2024, however the facility was not able to produce them at this time. The previous IP nurse quit two weeks ago, and the facility doesn't have access to her computer. The DON reported she was going to call pharmacy and have them fax over an antibiotic report. Interview on 03/27/24 at 1:39 P.M. with IPN #164 revealed today was only her 3rd day and she just started the IP training yesterday. The IP reported she found some paper infection control logs except for 02/2024. The IP nurse confirmed the infection control logs dated 09/01/23 to 03/26/24 were not complete or comprehensive to include organism for all infection if indicated, there was no evidence if the resident met criteria for treatment, and no evidence monitoring for trends completed monthly to show if there was an outbreak/trend in infections. Review of the facility policy and procedure titled Infection Prevention and Control Program (dated 11/30/23) revealed the facility has developed and maintains an infection prevention and control program that provides a safe, sanitary, and comfortable environment to help prevent the development and transmission of infections. The program will protect residents from healthcare-associated infections by developing prevention, surveillance, and control measures. Surveillance activities include monitoring and investigating causes of infection to prevent infections from spreading. A record would be maintained to record infections. Procedure would be developed and applied to certain individuals, such as isolation. The infection control program would be monitored quarterly or as indicated by the IP and control committee. Review of the facility's policy and procedure titled Antibiotic Stewardship Program (dated 11/30/23) revealed the facility utilizes the McGeer's definition of infection to determine appropriate infectious diagnoses, and treatment thereof. Nursing staff would notify the IP, or designee, when an infection was suspected. This would allow for early detection and management of potential infections, as well as implementation of appropriate transmission-based precautions if appropriate. When a culture and sensitivity is ordered lab results and current clinical situation would be communicated to the prescriber when available to determine if antibiotic therapy should be started, continued, modified, or discontinued. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365780	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Marietta	5001 State Route 60 Marietta, OH 45750

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 32801 Based on review the facility's timeline for who was the infection preventionist (IP), interview, and policy review the facility failed to ensure the IP was qualified. This had the potential to affect all 65 residents residing in the building. Findings included: Review of the facility's timeline for IP staff (undated) revealed from 07/28/23 to 10/27/23 was IP #202 and from 10/27/23 to 03/14/24 was IP #203. Interview on 03/27/24 at 1:39 P.M., with Unit Manager (UM) #164 reported she just started three days ago as the UM and IP nurse. The UM reported she just started her IP training course yesterday and has not completed it at this time. Interview on 03/28/24 at 10:14 A.M., with the Assistant Administrator (AA) #137 confirmed the facility was unable to provide evidence IP #202 and IP #203 had completed an IP training course. Review of the facility policy and procedure titled Infection Prevention and Control Program (dated 11/30/23) revealed no evidence of the IP qualifications or training requirements. Review of the facility policy and procedure titled Antibiotic Stewardship Program (dated 11/30/23) revealed staff would receive education on antibiotic stewardship. The training would emphasize the importance of antibiotic stewardship and would include how inappropriate use of antibiotics affects residents and the overall community. There was no evidence of the IP qualification or training requirements. This deficiency represents non-compliance investigated under Master Complaint Number OH00152295.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 07316 Based on staff interview and policy review, the facility failed to maintain an effective pest control program to ensure the facility was free of pests. This affected 65 of 65 residents in the facility. Findings include: Interview with Director of Nursing (DON) #147 on 03/27/24 at 12:55 P.M. revealed when an unspecified resident was admitted to the facility on [DATE] to room [ROOM NUMBER], he had bites on him. She stated the family was bringing his personal items in and they had bites on them also so the facility stopped them from bringing in anything further. She said the facility was concerned about bed bugs so they moved the resident to another room (room [ROOM NUMBER]). She stated they shut room [ROOM NUMBER] down until it could be cleaned and they dried all of the resident's clothes in the heat of the dryer. She stated that staff said they saw one bed bug but administration did not see any. DON #147 further stated on 03/27/24 at 12:55 P.M. that on 03/16/24 two unspecified residents were moved out of room [ROOM NUMBER] to room [ROOM NUMBER] because a staff person said they had a bed bug on their shoe. Maintenance went and checked the room, the room was cleaned, and the residents clothing was dried in the dryer. Interview with Nursing Assistant #117 on 03/28/24 at 11:00 P.M. revealed approximately two weeks ago, he/she felt a bite at the nurse's station on his/her leg. He/he stated he/she found a bug that he/she felt was a bed bug. He/she took a picture of the bug and the bite mark and also stuck the bug to tape and put it on Scheduler #140's desk. Interview with Scheduler #140 on 04/01/24 at 2:45 P.M. revealed she gave the bug to the Maintenance Director the next day. Interview with Maintenance Director #141 on 04/01/24 at 3:45 P.M. revealed no bug was given to him. Review of documentation provided by Housekeeping/Laundry Supervisor #162 revealed a paper titled Bed Bug 102: 03/04/24 issue identified in room [ROOM NUMBER]. The patient was removed and housekeeping stripped all linens and personal clothing and sent to launder under high heat. Alcohol was used to spray the room in its entirety. Non-essential items like boxes of tissues were discarded. 102 was closed for 24 hours. On 03/05/24, 03/06/24, and 03/07/24 no issues were noted or reported. Review of documentation provided by Housekeeping/Laundry Supervisor #162 revealed a paper titled Bed Bug 304: Issue identified in room [ROOM NUMBER] on 03/15/24 and residents exited the room. The housekeeper then entered the room with alcohol to spray down the room. All the linen including personal clothing was sent to the laundry. The mattress from bed 1 was left in room as the frame was cleaned and sprayed with alcohol. The frame was then moved with resident to room [ROOM NUMBER]-1. room [ROOM NUMBER] received a second spray and was closed for the next 24 hours. On 03/16/24, room [ROOM NUMBER] was re-sanitized and a new resident admitted to the room with no issues as of 03/21/24. As of 03/25/24, with daily monitoring, there have been no pest issues in either 304 or 213. (continued on next page)

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	365780	A. Building B. Wing	04/18/2024

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled Observation of Bed Bugs (dated 11/13/19) revealed the policy was to eradicate bed bugs from the affected room(s) to ensure bed bugs do not infest other residents or staff. The procedure stated that if bed bugs have been sighted on resident or in room, or if resident displays suspicious bites, one of the steps was to alert the exterminator of bed bug observation and request a visit as soon as possible. The policy did not include the use of alcohol. Review of pest control visit reports revealed the exterminator visited the facility on 03/06/24. However, there was no evidence he was made aware of the concern for bed bugs. There was no evidence of a visit since 03/06/24. Interview with Maintenance Director #141 on 04/01/24 at 3:45 P.M. confirmed the exterminator was not notified of the concern for bed bugs and was not called to come in after the issues were noted. According to the pest control company Orkin, rubbing alcohol with concentrations of 70-91% does kill bed bugs upon contact if applied correctly and directly to the pests. However, bed bugs are small and habitually hide in well protected, hard to see places so only using alcohol is largely inefficient since they may be hiding inside mattresses, within furniture, and in gaps and crevices within appliances or electrical outlets. Since bed bugs are excellent hiders, using alcohol will probably miss bed bugs that will then continue laying eggs and feeding on blood. As a result, rubbing alcohol is not likely to control a bed bug infestation. Rubbing alcohol should be used carefully and sparingly since it is highly flammable. Improper use of rubbing alcohol is likely to create an unsafe situation. This deficiency represents non-compliance investigated under Complaint Number OH00151794.