

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365780	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Legacy Marietta		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801</p> <p>Based on observation, medical record review, review of a sheriff report, and interview the facility failed to ensure effective measures/interventions were in place to prevent Resident #1 from exiting the facility unsupervised. This affected one (#1) of three residents reviewed for elopement.</p> <p>Findings included:</p> <p>Medical record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including psychosis, dementia, delusional disorder, visual hallucination, panic disorder, major depression, disorientation, macular degeneration, insomnia, the need assistance with personal care, and muscle weakness.</p> <p>Review of Resident #1's admission fall and elopement assessment dated [DATE], and completed 11/09/24, revealed the resident was at risk for falls and elopement due to cognitive impairment, diagnoses, the ability to ambulate independently, visual and auditory deficits, verbally expressing a desire to go home and history of elopement. The assessment noted the resident wandered aimlessly, had wandering/seeking behaviors to find spouse or family, sustained a personal tragedy or received upsetting news and was a new admission. Interventions included a personal safety alarm, placing the resident on the wander list, and staff notification of wander risk.</p> <p>Review of Resident #1's physician's orders revealed an order, dated 11/08/24 to check placement and function of wander guard every shift.</p> <p>Review of the care plan for Resident #1 revealed the resident was at risk for elopement and injury related to being independently mobile and expressing a desire to leave facility unattended. Interventions (dated 11/09/24) were to obtain an order for a wander prevention device, apply wander prevention device and test battery as ordered, respond promptly when alarm system sounded to check on resident's safety/whereabouts, attempt to redirect the resident, divert her attention when the resident would become insistent on leaving, do not agitate, find activities of interest to resident, schedule or provide equipment/supplies preventing prolonged periods of idle time, and assure the wander guard was in place and working daily.</p> <p>Review of Resident #1's behavior task dated 11/10/24 to 12/09/24 revealed the resident had wandering behaviors on 11/10/24 and 12/01/24.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a sheriff report dated 11/30/24 revealed the facility called on 11/30/24 at 6:53 P.M., and reported a female resident (Resident #1) was combative and confused and was trying to run into the roadway.</p> <p>Review of Resident #1's progress notes dated 11/30/24 revealed no written evidence the resident had eloped. Further review revealed a note on 11/30/24 at 8:33 P.M. to see nurses note, however there was no nurse's note completed. On 11/30/24 at 9:38 P.M. a nurse's note indicated Resident #1 was moved to the 100 hall (the facility memory care unit). The resident was unpacked and resting in bed at this time.</p> <p>Review of a nurse practitioner note dated 12/02/24 revealed the resident was seen for dementia. The note indicated the resident went outside the building and would not come back inside. Emergency medical services (EMS) and facility staff were able to get the resident back inside. The resident was moved to the memory care unit under constant supervision and an ankle alarm was in place.</p> <p>Review of the facility's investigation dated 11/30/24 revealed during shift change and aide came in and stated there was a resident (Resident #1) outside in the front parking lot trying to get a ride. Several staff attempted to talk the resident into coming back inside the facility without success. The Assistant Director of Nursing (ADON) called EMS and the resident's sister was also called. After the resident spoke with her sister via phone, EMS were able to get the resident to return to the facility. The resident reported she didn't live far, she was going home, and she wasn't going back into the that facility. The immediate action taken was to start 15 minutes checks and the resident was moved to the memory care unit.</p> <p>Review of Certified Nursing Assistant (CNA) #117's written statement dated 11/30/24 revealed she had just pulled into work when she saw Resident #1 approaching the front door. The writer started getting out of her car and the resident asked CNA #117 for a ride to get her out of the facility. The writer asked Resident #1 to go inside with her, and the resident said no. The writer dropped her things and ran inside to get the nurse, who came outside immediately.</p> <p>Review of Registered Nurse (RN) #157's written statement dated 11/30/24 revealed when she walked up to the nurse's station, Certified Nursing Assistant (CNA) #117 stated that everyone was outside trying to bring Resident #1 back in. Resident #1 was at the end of the parking lot by the road with staff preventing her from going into the road. The RN notified the Director of Nursing (DON) and called 911. She then notified maintenance staff that the door alarm was not sounding. While waiting for EMS, the resident was combative with staff multiple times, yelling for help, and trying to flag down cars. EMS staff called the power of attorney (POA) who was able to calm the resident down and the resident was brought back into the facility where she laid down in bed.</p> <p>Review of Licensed Practical Nurse (LPN) #118's written statement dated 11/30/24 revealed during report she heard someone telling another nurse something and those nurses ran to the front entrance. No alarms were going off. The writer went outside and tried talking to Resident #1 and tried to bring her back inside, but she had no intentions of going back inside. The resident was telling staff she was going home. Staff tried to block her from getting to the road. EMS arrived and convinced the resident to get into the ambulance to talk.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Licensed Practical Nurse (LPN) #103's written statement dated 11/30/24 revealed she had witnessed Resident #1's elopement. The staff were alerted to being out in the parking lot by an aide coming on shift. The LPN didn't see Resident #1 get outside and no alarms had gone off warning staff of the resident's departure. Once it was discovered the resident was outside, several staff members went outside to monitor and safely try to redirect the resident back inside. Staff stayed with the resident until EMS services arrived.</p> <p>Review of Dietary Aide/Cook #300's written statement dated 12/01/24 revealed at approximately 6:30 P.M., he was walking to his car, and he heard someone yelling for help from the front parking lot. He pulled his car into a spot where he could direct the headlights towards the front of the parking lot. He watched and listened for a couple minutes and didn't hear or see anything further and left the property. A few minutes later he saw the EMS responding to the front parking lot.</p> <p>Interview on 12/09/24 at 10:30 A.M., with the DON confirmed Resident #1, who had a wander guard device in place had successfully exited the building on 11/30/24. At the time of the incident, the facility wander guard system did not function as designed and the door did not alarm (as it should have). A staff member from night shift had arrived to work early on that date, was sitting in her car and observed the resident exit and then notified staff.</p> <p>Interview on 12/09/24 at 10:37 A.M. with RN #157 revealed she was working the floor on Saturday 11/30/24 when Resident #1 had eloped. She stated she was coming out of a resident's room, and stated she didn't see hardly any staff members around and she joked with one of the oncoming staff that it looked like a ghost town in the facility. The staff member then told her that staff were outside because Resident #1 was outside. She stated she had observed Resident #1 in the grass area in front of the building near the road. RN #157 reported she checked the resident's wander guard and the front door after the incident and they both were functioning properly at that time. However, she was not sure how the resident got out the front door without alarming the system.</p> <p>Observation on 12/09/24 at 10:46 A.M. with RN #157 and the Director of Nursing (DON) of the front door with a wander guard revealed there were two doors that swung open from the middle. The right door alarmed and locked but would not open after the 15 seconds as it should have. The left door alarmed, locked initially, and then opened after the 15 seconds. The findings were confirmed with staff during observation.</p> <p>Interview on 12/09/24 at 12:46 P.M., with the Maintenance Director (MD) revealed he was notified on 11/30/24 that the front door did not alarm when Resident #1 had exited the front door with a wander guard in-place. The MD reported the following day 12/01/24 he had done a manufactory reset on the front door and memory care door. The MD reported he adjusted the sensor on the front door after the surveyor's observation and the door was functioning properly at this time.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160431 and is an example of continued non-compliance from the 11/26/24 and 10/11/24 surveys.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>32801</p> <p>Based on review of facility billing/financial ledger and interviews, the facility administration failed to operate in a manner to ensure bills were being paid in a timely manner to prevent potential interruption in service and failed to ensure adequate transfer of services following a change in ownership to provide continuity of care. This had the potential to affect all 53 residents residing in the building.</p> <p>Findings included:</p> <p>Review of the Administrator's personnel file revealed the Administrator was hired on 07/15/24.</p> <p>Review of the undated Administrator's job description revealed the primary purpose of the position was to direct day to day functions in the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long term care facilities to assure that the highest degree of quality of care could be provided to the residents at all times. Duties and responsibilities included: prepare an annual operating budget for approval by the governing board and allocate the resources to carry out programs and activities of the facility; assist in the establishment and maintenance of an adequate accounting system that reflects the operating cost of the facility; review and interpret monthly financial statements and provide such information to the governing board; plan, develop, organize, implement, evaluate, and direct the facility's programs and activities; develop and maintain written policies and procedures that govern the operation of the facility; assist the infection control coordinator and/or committee in identifying, evaluating, and classifying routine and job-related functions to ensure that tasks involving potential exposure to blood/body fluids were properly identified and recorded; make routine inspections of the facility to assure that established policies and procedures were being implemented and followed; monitor work practices in order to make a reasonable effort to detect non-compliance; provide leadership and training that would assist the quality assurance and assessment committee in developing and implementing appropriate plans of action to correct identified quality deficiencies; and ensure that an adequate number of appropriately trained professional and auxiliary personnel were on duty at all times to meet the needs of the residents.</p> <p>Interview on 12/10/24 at 9:09 A.M., with [NAME] President of Operations (VPO) #400, the VPO for the new facility corporation, revealed he had heard the previous corporation had outstanding debt, but stated the new ownership would not be assuming any of the previous corporation debt. The VPO verified the new ownership was effective 12/01/24.</p> <p>During the onsite investigation, the following concerns related to the use of vendors/service providers were identified:</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>a. Interview on 12/10/24 at 9:24 A.M., with Local Water Company Staff #301 revealed she was just getting ready to call the facility since the water bill was almost 20 days overdue. The facility currently owed the water company \$3,040.76, that had been due on 11/20/24. Water Company Staff #301 stated the water meter was not read for November 2024, so the facility would owe for the month of November 2024 in addition to October 2024. The staff member was not aware of a change in ownership for the facility and indicated a new account had not been set up as of this date for continued service with a new provider for the facility.</p> <p>Review of the facility billing/financial ledger dated 10/01/24 through 12/09/24 revealed no evidence this water account was listed on the ledger.</p> <p>b. Interview on 12/10/24 at 9:30 A.M., with Power Company Staff #303 revealed the facility owed \$6,891.91 with a current payment due date of 12/26/24. However, the power company was not aware of a change in ownership and verified no new account had been sent up as of this date for continued service with a new provider.</p> <p>c. Interview on 12/10/24 at 9:43 A.M., with Local Heating and Cooling Contractor Staff #304 revealed she had reached out the facility eight times (since 10/2024) and had been told on 10/14/24 a check was in the mail, but stated no payment had been received as of this date. The facility currently owed for three invoices from September 2024 and one for October 2024 totaling \$993.00. During the interview, the staff member revealed her company was unaware of a change in ownership and no new contract had been initiated related to the new ownership for continued or necessary services.</p> <p>Review of the facility billing/financial ledger dated 10/01/24 through 12/09/24 revealed no evidence the heating and cooling company was listed on the ledger.</p> <p>d. Interview on 12/10/24 at 10:40 A.M., with Sprinkler Company Staff #307 revealed they provided services to all of the Legacy facilities. The entire corporation had an outstanding balance of over \$300,000.00 as of this date, which included a balance of \$5,424.87 for this facility. Staff #307 revealed the company was considering discontinuing services; however, they had not due to the facility being a nursing home. Staff #307 revealed they heard a new corporation was taking over the facility, but she had not been contacted nor had a new account been set up for the corporation.</p> <p>Review of the facility billing/financial ledger dated 10/01/24 through 12/09/24 revealed the facility documented they owed the sprinkler company \$1,189.97.</p> <p>e. Interview on 12/10/24 at 11:18 A.M., with Local Sewer Company Staff #302 revealed the facility had a current balance of \$2,969.99 that was due to be paid by 12/20/24. However, Staff #302 revealed they were not aware a new company had taken over ownership nor had the new company set up an account with the sewer company.</p> <p>f. Interview on 12/10/24 at 11:50 A.M. with Door Company Staff #306 (the company utilized to ensure fire doors, wander guards, security locks, etc. were in working order) revealed the facility had two outstanding bills. One bill outstanding was from November 2024 for \$750.75 that still had not been paid and the other bill for \$833.87 which was due 12/15/24. The staff member reported a sister facility had notified them of a change in ownership; however, the facility had not reached out to them directly to set up an account or to continue services under the new ownership.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility billing/financial ledger dated 10/01/24 through 12/09/24 revealed no evidence the door company was listed on the ledger.</p> <p>Further review of the facility billing/financial ledger dated 10/01/24 through 12/09/24 revealed the corporation owed outstanding debt to 12 of 20 vendors/suppliers listed on the ledger for October 2024 and November 2024.</p> <p>Interview on 12/10/24 at 10:52 A.M. with the Administrator revealed there were two entities that owned the building previously. He stated he had spoken to one of the entities to which he was recommended to reach out to other entity for additional financial information because they had already submitted the only financial information they had to offer. The Administrator reported he had reached out to the other entity; however, he was not able to get past the receptionist. He was unable to obtain any additional financial information during the course of the survey.</p> <p>Interview 12/10/24 at 3:44 P.M., with the Director of Nursing (DON) revealed she reviewed the billing/financial ledger and confirmed the ledger was inaccurate due to not all of the vendor/suppliers (including the water, heating and cooling, dietary/housekeeping/laundry company, and the door company) being listed on the ledger. The DON also confirmed the amounts owed were inaccurate based on information directly from the vendor and what was on the ledger. The DON reported she had received a call last week from the local grocery store that they had not received payment from the facility, and she directed them to call to the facility previous corporation for payment.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00160491.</p>		