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	10/11/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review and interview, the facility failed to ensure call lights were within reach of residents. This affected two residents (#8 and #15) of 20 sampled residents. The census was 61. Findings include: 1. Medical record review revealed Resident #8 was admitted on [DATE] with diagnoses including cerebral infarction, hemiparesis and hemiplegia following cerebral infarction affecting left non-dominant side, Type 2 Diabetes Mellitus, generalized anxiety disorder, and need for assistance with personal care. Review of the Skilled Note -V 3 assessment (dated 09/30/24) revealed Resident #8 required extensive assist of one for bed mobility and toilet use, transfers did not occur and required supervision with eating. On 09/30/24 at 10:23 A.M., observation revealed Resident #8 was laying in bed and his call light was looped around the air bed mattress pump at the foot of the bed. At the time of the observation, Resident #8 was asked if he could activate his call light. Resident #8 stated he did not know where it was but if he needed help or had to go to the bathroom or anything, he would need his call light to get help. 2. Medical record review revealed Resident #15 was admitted on [DATE] with diagnoses including congestive heart failure, urinary retention, falls, syncope. Type 2 diabetes mellitus, and schizophrenia. Review of the Health Documentation - V 4 assessment (dated 10/01/24) revealed Resident #15 required extensive assist with bed mobility and transfers, and was dependent on staff for toilet use. On 09/30/24 at 10:25 A.M., observation revealed Resident #15 was laying in bed and the call light was observed on the floor and out of reach. At the time of the observation, Resident #15 was asked if he could activate or reach his call light. Resident #15 stated he could not find his call light but needed to find it so he could call for staff help when he needed something. (continued on next page)

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
	365780	A. Building B. Wing	10/11/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/30/24 at 10:31 A.M., interview with state tested nurse aide (STNA) #321 verified the call light was not within reach and stated they should be within reach at all times. STNA #321 verified Resident #8 required assistance with all ADL's and needed his call light to alert staff when he needed help. On 10/01/24 at 3:48 P.M., interview with STNA #332 verified residents were to have their call lights within reach at all times.

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	10/11/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 28923 Based on record review, resident and family interview, and staff interview, the facility failed to ensure a resident and their resident representative were notified of laboratory and diagnostic test results that had been performed for the resident. This affected one resident (#28) of five residents reviewed for unnecessary medications. Findings include: Review of Resident #28's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included hypertensive heart disease and chronic kidney disease with heart failure, atherosclerotic heart disease, and gastroesophageal reflux disease (GERD). Review of Resident #28's progress notes revealed a nurse's note dated 09/22/24 at 10:03 A.M. that indicated the resident had complaints of burning with urination and the physician was notified. A new order was received to straight catheterize the resident for a urinalysis (U/A). The resident reported she did not want to be catheterized and would void in a pilgrim's hat. The physician was updated and was okay with that. The resident's representative was notified. Further review of Resident #28's progress notes revealed a nurse's note dated 09/23/24 at 2:35 P.M. that revealed new orders were received to obtain a complete blood count (CBC) on the next lab day and to obtain a hemocult stool sample. The resident was notified of the new order for blood work and checking her stool sample for occult blood. A nurse's progress note dated 09/24/24 at 6:52 P.M. revealed the physician was in the facility and received the resident's laboratory results and he reviewed them. No new orders were received. A medication pass note dated 09/27/24 at 9:32 P.M. revealed a stool sample for a hemocult was obtained via clean catch and sent to the local hospital lab. The progress note was absent for any evidence of the resident and her resident representative being notified of any of the results of the laboratory or diagnostic testing done. Review of the laboratory results for the U/A collected on 09/22/24 revealed abnormalities were noted as the urine sample showed blood and protein in it, along with innumerable white blood cells and bacteria in her urine. The lab result was signed off by the physician but did not indicate that the resident or her resident representative was notified of the results. The laboratory results for the CBC done on 09/24/24 was unremarkable with the exception of a slightly low hemoglobin level of 11.5 grams/ deciliter. Again, the physician signed off on the lab results but there was no indication of the resident or her resident representative being notified. On 10/07/24 at 1:32 P.M., an interview with the Director of Nursing (DON) revealed residents and/ or their resident representatives should be informed of the results of any laboratory or diagnostic testing that was being done for them. She acknowledged there was no documented evidence of Resident #28 or her resident representative being made aware of the results of the resident's CBC that was done on 09/24/24, her U/A that was done on 09/22/24, or her stool for hemoccult that was done on 09/30/24.

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	10/11/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on observation, interviews, policy review, and record review the facility failed to maintain a comfortable temperature on the memory care unit. This affected seven residents (#33, #36, #46, #47, #48, #51, and #259) of seven residents residing on the memory care unit. Additionally, the facility failed to ensure walls of residents rooms remained in good repair. This affected two residents (#8 and #15) of two residents reviewed for environmental concerns. The facility census was 61. Findings included: 1. Record review revealed Resident #33 was admitted to the facility on [DATE] with diagnoses including dementia, senile degeneration of brain, anxiety disorder, hyperlipidemia, and mild neurocognitive disorder. Record review revealed Resident #36 was admitted to the facility on [DATE] with diagnoses including wandering, schizophrenia, and dementia. Record review revealed Resident #46 was admitted to the facility on [DATE] with diagnoses including dementia, schizoaffective disorder bipolar type, and intermittent explosive disorder. Record review revealed Resident #47 was admitted to the facility on [DATE] with diagnoses including dementia, other amnesia, and disorientation. Record review revealed Resident #48 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, anxiety disorder, and anemia. Record review revealed Resident #51 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, depression, and hypertension. Record review revealed Resident #259 was admitted to the facility on [DATE] with diagnoses including acute kidney failure, metabolic encephalopathy, and dementia. Observation on 09/30/24 at 1:46 P.M. revealed Resident #259 was in the doorway of his room, rubbing his arms and stating he was cold. Observation of the thermostat revealed the temperature was set to 68 degrees Fahrenheit. Observation on 10/02/24 at 9:14 A.M. revealed the memory care unit thermostat was set to 68 degrees Fahrenheit. Observation on 10/03/24 at 11:01 A.M. revealed the thermostat on the memory care unit was set at 68 degrees Fahrenheit. The unit was chilly. (continued on next page)

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	10/11/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/03/24 at 11:06 A.M. with Maintenance Supervisor (MS) #306 confirmed the thermostat on memory care was set to 68 degrees. MS #306 stated the temperature should be set between 72-74 degrees. MS #306 was unable to recall what the requirement was but stated he has seen floor staff break into the thermostat box and adjust the temperature to their preference. Review of a policy titled Extreme Temperatures dated 11/30/23 revealed the temperatures should be maintained between 71 and 81 degrees Fahrenheit. 28704 2. Medical record review revealed Resident #8 was admitted to the facility on [DATE] and Resident #15 was admitted on [DATE]. On 09/30/24 at 10:16 A.M., observation of Resident #8 and #15's room revealed the following: a. Torn wallpaper and exposed drywall with deep gouges along the wall adjacent to Resident #8's bed and behind the headboard of Resident #8 and #15. b. Approximately 20 feet of looped television (TV) cable was also observed extending up the wall and screwed into the top of the drywall next to the ceiling. The looped TV cable was hanging on a hook attached to the back of the residents door. At the time of the observation, Resident #15 stated the staff pull the TV cable out in the hallways at night and use it. c. The wall between the window and the air conditioner unit wallpaper was flaking off and a dried black substance was observed on the exposed drywall. On 10/01/24 at 2:06 P.M., observation and interview with Registered Nurse #357 verified the looped television cable wire, the walls were not in good repair, torn wall paper and deep gouges that penetrated through the 5/8 drywall board were observed. On 10/01/24 at 2:25 P.M., interview with Resident #8 revealed the wallpaper had been torn/gouged since he was admitted to the facility in July 2024. On 10/01/24 at 2:25 P.M., observation with Maintenance Supervisor #306 revealed Resident #8's wall adjacent to his bed revealed torn wallpaper measuring 27 inch length (l) by 24 inch width (w) exposing four gouges in the drywall approximately four inches in (l) by one inch in (w) and greater than 5/8 inches in depth as it went through the entire depth of the drywall. The wall at the head of Resident #8's bed was observed to have torn/rolled wallpaper measuring four inches in (l) by four inches in (w). At the time of the observation, Maintenance Supervisor #306 stated it was from the bed being too close to the wall and the trapeze bar was digging into the wall when the bed was lowered and raised. Resident #15's wall at the head of the bed had an area measuring six inches in (l) by seven inches in (w) of torn wallpaper. Observation of the resident room window revealed the exterior screen was bent and displaced out of the frame and the window was full of spider webs, dead insects and debris. Maintenance Supervisor #306 verified the above at the time of the observation. (continued on next page)

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	10/11/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/01/24 at 3:45 P.M., interview with state tested nurse aide (STNA) #332 stated Resident #8 had been pulling at the loose wallpaper this morning and made it worse; therefore, she removed it as she was concerned he would put it in his mouth. STNA #332 verified the wall was in disrepair prior to today.

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	10/11/2024

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 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** 28923 Based on record review, review of the facility's grievance/ concern log, resident interview, staff interview, and policy review, the facility failed to ensure a resident's report of missing clothing was timely addressed. This affected one resident (#53) of two residents reviewed for personal property. Findings include: Review of Resident #53's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses did not include any cognitive related diagnoses. Review of Resident #53's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. She was not known to have displayed any behaviors nor was she known to reject care during the seven days of the assessment period. Further review of Resident #53's medical record revealed it was absent for a personal inventory sheet that indicated what possessions the resident was known to have upon her admission to the facility. On 09/30/24 at 3:46 P.M., an interview with Resident #53 revealed she had a brown long sleeve shirt with leopard print on the pocket that was missing for about three weeks now. She reported it to the staff and was told they would look for it. They (staff) just keep telling her they are looking for it, but she hasn't got it back, nor was she reimbursed for it. Review of the facility's grievance/ concern log for the past 30 days (provided by the facility as their missing item log) revealed there were no concerns from Resident #53 that involved missing clothing or any other complaints from the resident. On 10/02/24 at 2:10 P.M., an interview with Certified Nursing Assistant (CNA) #307 revealed she had worked at the facility since April 2024. She denied she had any knowledge of Resident #53 having had any missing clothing reported. If it was reported to her, she would report it to laundry. (continued on next page)

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	10/11/2024

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/24 at 3:20 P.M., an interview with Laundry/ Housekeeping Supervisor #500 revealed Resident #53 did report to the CNA's that she was missing items of clothing. If the laundry staff could not find the items, it got reported to her. She recalled the resident had a couple clothing items reported as being missing not long ago. She thought they had been found and returned to the resident. She recalled it was two blouses that were found and returned to her. She then recalled the resident mentioned something about a brown shirt and black shirt. She knew the black shirt was found for sure. She was not sure what the status of the brown shirt was. She was asked to go talk with her laundry staff to see if the brown shirt (blouse) had been found or not. She returned a short time later and confirmed the brown shirt (blouse) had not been found. She thought it was about a week ago that the items were reported missing. It may have been explained to her that the brown shirt had not been found and she may have just misunderstood. She did not think it had been three weeks ago that the clothing was reported as being missing as was thought by the resident. She again stated she thought it had only been about a week. She indicated she would fill out a grievance form now and replace the item if needed. On 10/02/24 at 3:37 P.M., an interview with Laundry Aide #303 revealed Resident #53 had told her about the missing clothes about a week ago. She reported it was a tan blouse with leopard print on her pocket and a black shirt. They were able to find the black shirt, but was unable to locate the tan one. They found the black shirt two days after it was first reported (likely around Friday). When she was first made aware of the missing clothing items, she looked for them first. She could not find them in the resident's closet or in the unclaimed clothing. She stated clothes may take a day or so for them to get processed through the laundry room. She notified her supervisor (Laundry/ Housekeeping Supervisor #500) that the tan shirt (blouse) was still missing. She was asked what specifically she had told her supervisor about the missing clothing. She said she told her there were two clothing items missing and they were only able to find the black one. It was the end of last week when she informed her supervisor. Review of the facility's policy on Personal Property (last reviewed 11/30/23) revealed the facility would take reasonable care to prevent loss to or theft of resident's personal property while residing at the facility by establishing the following policies. Residents should label all clothing and personal items with their name, using permanent ink. Residents should report every loss or theft to the facility immediately. Each resident's room was equipped with private closet space that includes clothes racks and shelving that permitted easy access to the resident's clothing. The resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items were replenished. Review of the facility's Grievance/ Concern Log policy (last reviewed on 11/30/23) revealed the disposition of all resident grievances and/ or concerns would be recorded on their resident grievance/ control log. The disposition of all resident grievances and/ or concerns must be recorded on the resident grievance/ concern logs. The social service department would be responsible for recording and maintaining those logs. The following information, as a minimum, must be recorded: the date the grievance/ concern was received, the name of the resident filing the grievance/ concern, the name and the relationship of the person filing the grievance/ concern in behalf of the resident, the date the alleged incident took place, the name of the person investigating the incident, the date the resident, or interested party, was informed of the findings, and the disposition of the grievance/ concern. (continued on next page)

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	10/11/2024

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy on Investigating Grievances/ Concerns (last reviewed on 11/30/24) revealed the facility investigated all grievances/ concerns filed with the facility. The administrator would assign the responsible party of investigating grievances and concerns to the appropriate department. Upon receiving the grievance/ concern report, appropriate department will begin an investigation into the allegations. The grievance/ concern form must be filed with the Administrator within five working days of the incident. The resident, or person acting on behalf of the resident, would 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/ concern.

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	10/11/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47985 Based on observation, record review and interviews, the facility failed to complete comprehensive care plans as required. This affected four residents (#6, #26, #36, and #48) of 21 residents reviewed. The facility census was 61. Findings included: 1. Record review revealed Resident #36 was admitted to the facility on [DATE] with diagnoses including schizophrenia, dementia, and hyperlipidemia. Review of an admission assessment dated [DATE] revealed Resident #36 had some/all natural teeth lost. Review of a care plan dated 07/09/24 revealed no oral/dental care plan was listed. Observation on 09/30/24 at 1:48 P.M. revealed Resident #36 had a broken front tooth which was dark in color. Interview on 10/03/24 at 4:11 P.M. with Director of Nursing (DON) confirmed there was not a dental care plan in place for Resident #36. 2. Record review revealed Resident #48 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, need for assistance with personal care, and anxiety disorder. Review of a minimum data set completed on 07/03/24 revealed Resident #48 required moderate assistance with her personal hygiene. Review of a care plan dated 07/10/24 revealed there was no care plan for Resident #48's personal hygiene. Interview on 10/03/24 at 12:13 P.M. with DON confirmed there was no care plan in place regarding Resident #48's personal hygiene. 28704 3. Medical record review revealed Resident #26 was admitted on [DATE] with diagnoses including bullous pemphigoid (a rare, chronic autoimmune skin disease that causes fluid-filled blisters to form on the skin), hypertensive heart disease with heart failure, anxiety disorder and major depressive disorder. Review of the electronic Physician Orders dated September 2024 revealed benadryl (antihistamine) allergy extra strength (ES) 50 milligrams (mg) every six hours as needed for itching was ordered on 07/06/24 with no stop date. (continued on next page)

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	10/11/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the electronic Medication Record dated July 2024, August 2024 and September 2024 revealed Resident #26 received benadryl ES 50 (mg) on 07/06/24, 07/12/24, 07/13/24, 07/31/24, 08/31/24, 09/16/24 and 09/17/24. Review of the medical record revealed no evidence of a care plan for the use of benadryl. On 10/02/24 at 1:30 P.M., interview with the Director of Nursing verified there was no care plan for Resident #26's use of benadryl. 28923 4. Review of Resident #6's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included adult-onset diabetes mellitus and iron deficiency anemia. Review of Resident #6's physician's orders revealed the resident had an order to receive Aspirin 81 milligrams (mg) by mouth (po) one time a day for heart health. The order had been in place since 05/15/24. Review of Resident #6's comprehensive care plans revealed the resident did not have a care plan in place to address her use of Aspirin (an anti-platelet) or her risk of bleeding/ bruising that could be associated with use of an anti-platelet medication. Findings were verified by the Director of Nursing (DON). On 10/03/24 at 1:49 P.M., an interview with the Director of Nursing (DON) confirmed Resident #6 did have an order to receive Aspirin 81 mg po once daily. She acknowledged the resident's active care plans did not reflect the use of an anti-platelet medication or her risk for bleeding/ bruising associated with it's use. She stated she would have to update the resident's care plans to address that.

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	10/11/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47985 Based on observation, record review, interview, and policy review, the facility failed to ensure residents were offered showers per the shower schedule and failed to provide nail care. This affected three residents (#7, #8, #20) of four residents reviewed for activities of daily living. The facility census was 61. Findings included: 1. Record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including personal history of traumatic fractures, muscle weakness, and rheumatoid arthritis. Review of a care plan dated 01/30/24 revealed Resident #7 had a performance deficit with activities of daily living (ADLs) due to rheumatoid arthritis, limited mobility and shortness of breath. The goal was for Resident #7 to maintain current functional status related to ADLs. Interventions included but were not limited to shower transfers with an assist of one staff and limited assistance with bathing. Review of a quarterly minimum data set (MDS) dated [DATE] revealed Resident #7 required supervision or touching assistance with showers and required set-up or clean-up assistance for shower transfers and her cognition remained intact. Review of task documentation for showers revealed Resident #7 is to receive showers on Tuesdays and Fridays. Resident #7 received one shower on 09/10/24. Review of shower sheets for September 2024 revealed Resident #7 refused a shower on 09/03/24, received a shower on 09/10/24, and refused a shower on 09/27/24. There were no additional shower sheets. Interview on 10/07/24 at 4:19 P.M. with Resident #7 revealed she had not had a shower in three weeks and was tired of this happening because it is inhumane. Interview on 10/08/24 at 8:48 P.M. with Director of Nursing (DON) confirmed there were only three shower sheets completed for Resident #7 in the month of September (2024). The DON stated Resident #7 should be offered showers every Tuesday and Thursday, and confirmed no showers were offered on any other scheduled shower days. 2. Record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including dementia, spinal stenosis, and anemia. Review of a care plan completed on 02/20/24 revealed Resident #20 had a performance deficit with completing ADLs due to decreased mobility related to dementia, spinal stenosis, and generalized muscle weakness. The goal was for Resident #20 to maintain current functional status related to ADLs. Interventions included but were not limited to Resident #20 required extensive assistance with bathing (including nail care). (continued on next page)

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	10/11/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a quarterly MDS dated [DATE] revealed Resident #20 had severely impaired cognition, had no behaviors, and required partial to moderate assistance with personal hygiene and bathing. Observation on 09/30/24 at 4:26 P.M. revealed Resident #20's nails were approximately a quarter inch long. Resident #20 stated she likes her nails long but they did need to be trimmed back. Observations on 10/01/24 at 3:51 P.M. and on 10/02/24 at 7:52 A.M. revealed Resident #20 was sleeping in her recliner chair, and her nails were visible from the doorway. They continued to be longer than her preference. Interview on 10/02/24 at 8:57 A.M. with Registered Nurse (RN) #322 confirmed Resident #20's nails were long. Resident #20 was able to confirm to RN #322 that her preference would be for her nails to be trimmed shorter. 28704 3. Medical record review revealed Resident #8 was admitted on [DATE] with diagnoses including cerebral infarction, diabetes mellitus, hemiplegia and hemiparesis left non-dominant side, aphasia and need for physical assistance with personal care. Review of the 5-day Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #8 was moderately impaired for daily decision-making, required substantial/maximal assist with toileting, shower/bathe self, upper and lower body dressing, was frequently incontinent of urine and always incontinent of bowel with no toileting programs. Review of the 100-400 Hall Shower Schedule revealed Resident #8 was scheduled to receive showers on Wednesday and Saturdays on the 7:00 P.M. to 7:00 A.M. shift. Review of the 100-400 Shower Book revealed state tested nurse aide (STNA) was to complete a body check during showers/baths. Review of the Skin Check sheets dated September and October 2024 revealed showers/baths were documented as given to Resident #8 on 09/04/24, 09/07/24, 09/11/24 and 10/06/24. Review of the medical record revealed no evidence Resident #8 received a shower/bath on 09/14/24, 09/18/24, 09/21/24, 09/25/24, 09/28/24, 10/02/24 or 10/05/24. Review of the care plan: Preferences have been identified (initiated 07/08/24) revealed Resident #8 prefers to choose how often to bathe and satisfied with current schedule and prefers a shower, bed bath or sponge bath. Review of the care plan: ADL Self Care/Mobility/Functional Ability Performance Deficit (initiated 07/18/24) revealed interventions including bathing, upper/lower body dressing and personal hygiene with encouragement to start task and finish if resident becomes tired or unable to complete. On 09/30/24 at 10:20 A.M., observation revealed Resident #8's hair was greasy and his fingernails were long with brown substance under the nails. The resident was observed to have heavy facial hair growth and when asked, the resident stated he was not trying to grow a beard. Resident #8 stated he liked to use a straight razor because he likes a close shave but had a hard time finding anyone to shave him at all. Resident #8 stated he had not received a shower for a while but would like one. (continued on next page)

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	10/11/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/30/24 at 10:31 A.M., interview with STNA #321 verified Resident #8 was not shaved, his hair was greasy, nails were dirty and he was dependent on staff for care. STNA #321 stated he was not familiar with Resident #8's shower scheduled and would have to go look it up. On 10/02/24 at 10:40 A,M., observation revealed Resident #8 was in bed and was shaved. On 10/02/24 at 1:34 P.M., interview with the Director of Nursing (DON) verified Resident #8 was dependent on staff assistance to complete nail care, shaving and bathing. On 10/07/24 at 7:21 A.M., observation of Resident #8 revealed he was sitting in the front lobby in a standard wheelchair with his eyes closed and his head/chin lowered to his chest. The resident had heavy facial hair observed, as well as, a thick V-shaped white-stringy secretion extending from bilateral nares to his chest that measured greater than 12 inches in length. A circular area measuring approximately four inch in diameter of thick, white pooling secretions was observed on the chest of the resident's t-shirt. The Administrator was notified and verified the above at the time of the observation. The Administrator stated he was going to inform the nurse. On 10/07/24 at 7:26 A.M., Resident #8 was observed in the front lobby and the thick white-stringy nasal drainage had been removed; however, the resident was still wearing the same shirt and it remained wet from the nasal secretions. On 10/08/24 at 8:49 A.M., interview with the DON revealed sometimes there was a float aide and they completed resident showers; otherwise, the floor aides were to be completing the showers. The DON verified showers were not provided as scheduled twice a week and there was no evidence of a shower or hygiene for Resident #8 between 09/11/24 and 10/05/24. Review of the policy: Nail Care (reviewed 11/30/23) revealed nails were to be kept clean and trimmed. Review of the policy: State tested Nursing Assistant Bath/Shower (reviewed 11/30/23) revealed the facility was to routinely monitor the skin condition of all residents during bathing activities which will be provided twice a week. A master resident bath/shower schedule approved by the DON will list which shift each resident will be bathed, twice per week. Completed forms will be reviewed by the charge nurse and maintained by the DON, or designee.

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	10/11/2024

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on observations, interviews, and review of the memory care activities calendar, the facility failed to ensure activities were being provided to residents on the secured memory care unit. This affected seven residents (#33, #36, #46, #47, #48, #51, and #259) of seven residents residing on the locked memory care unit. Findings included: Record review revealed Resident #33 was admitted to the facility on admitted to the facility on [DATE] with diagnoses including dementia, senile degeneration of brain, anxiety disorder, hyperlipidemia, and mild neurocognitive disorder. Record review revealed Resident #36 was admitted to the facility on [DATE] with diagnoses including wandering, schizophrenia, and dementia. Record review revealed Resident #46 was admitted to the facility on [DATE] with diagnoses including dementia, schizoaffective disorder bipolar type, and intermittent explosive disorder. Record review revealed Resident #47 was admitted to the facility on [DATE] with diagnoses including dementia, other amnesia, and disorientation. Record review revealed Resident #48 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, anxiety disorder, and anemia. Record review revealed Resident #51 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, depression, and hypertension. Record review revealed Resident #259 was admitted to the facility on [DATE] with diagnoses including acute kidney failure, metabolic encephalopathy, and dementia. Review of the memory care activity calendar for October 2024 revealed activities scheduled for 10/01/24 included music hour (9:45 A.M.), Sittersice (seated exercise) (10:45 A.M.), Water Painting (11:15 A.M.), Lunch Bunch (12:00 P.M.), Daily Chronicle (1:00 P.M.), Serenity Sounds (2:30 P.M.), Trivia (3:30 P.M.), Evening Snack (7:00 P.M.) and Relaxing Video (7:15 P.M.). Activities scheduled for memory care on 10/02/24 included Music Hour (9:45 A.M.), Sports Update (10:45 A.M.), Puzzle Time (11:15 A.M.), Lunch Bunch (12:00 P.M.), Daily Chronicle (1:00 P.M.), Serenity Sounds (2:30 P.M.), Bake with Friends (3:30 P.M.) Evening Snack (7:00 P.M.), and Relaxing Video (7:15 P.M.). Observations were made on the memory care unit in the common area on 10/01/24 from 12:30 P.M. until approximately 3:00 P.M. During that time, residents on the memory care unit ate their lunch. When they were finished with lunch, a visitor began passing out items to play Bingo which continued until 1:52 P.M. A Daily Chronicle was not passed out or read to residents at 1:00 P.M., and Sounds of Serenity did not occur. (continued on next page)

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	10/11/2024

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/02/24 at 10:19 A.M. with Activities Assistant (AA) #344 revealed the activities staff provide all needed items to memory care staff so they can complete activities with the residents, but the activities staff do not directly provide the residents on memory care with activities. Interview on 10/02/24 at 11:16 A.M. with Family Member (FM) #203 revealed the activities staff did not like her because FM #203 does her job for her. FM #203 stated the only activity she had witnessed residents on the memory care unit receive is coloring. FM #203 stated she bought different activities for the residents of memory care out of her own money because they were not being provided with activities on the memory care unit. FM #203 stated the aide who works the unit is supposed to complete the activities, but they also have to do their job as an aide. Observation on 10/02/24 at 2:33 P.M. revealed the 2:30 P.M. scheduled activity of Sounds of Serenity had not been started. There were four residents in the dining room. Two residents (#33 and #36) were dozing off and two residents (#47 and #48) were chatting. A country western was observed to be playing on the television at this time. Observation on 10/02/24 at 2:41 P.M. revealed AA #344 entered the memory care dining room and grabbed the activity calendar to make copies. She then exited the unit. No one started the 2:30 P.M. activity. Interview on 10/02/24 at 2:58 P.M. with STNA #338 revealed she was unsure who was supposed to provide activities on the memory care unit and she had not ever been told she was supposed to provide activities for the residents on memory care. STNA #338 stated if she had to provide activities, help residents with behaviors, help toilet the residents, and be responsible in case of emergency, the job would not be possible to do because she is one person. STNA #338 stated having to provide her normal job duties and activities by herself was too much for one person to do because what if someone falls or a resident beats me up? STNA #338, who also worked on memory care on 10/01/24, confirmed none of the scheduled activities for memory care were completed on 10/01/24 or 10/02/24. During conversation, STNA #338 was noted to place cookies in a small oven for the residents to enjoy. Interview on 10/02/24 at 3:09 P.M. with STNA #332 revealed the facility provides an activities calendar, but she completed activities with the residents when scheduled on memory care based on her own knowledge of dementia care from previous work experience. STNA #332 stated the activities department does bring back supplies to complete activities, but not all the aides working memory care had been trained to know it was their responsibility to provide activities. STNA #332 stated there was no training course to work memory care and there was not an official memory care program. Observation on 10/02/24 at 3:22 P.M. revealed four residents (#33, #47, #48, and #51) were in the memory care dining area with country music playing. Interview on 10/02/24 at 3:35 P.M. with the Director of Nursing (DON) was completed to advise her of concerns on the memory care unit regarding supervision levels and activities not being provided. The DON stated off the record she is only able to provide the amount of staff on the memory care unit that corporate will allow and staff interviews should be taken lightly because if a staff member is mad at the facility, they will say damaging statements in retaliation. The DON acknowledged concerns with activities not being provided. (continued on next page)

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	10/11/2024

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a policy titled Recreation Programs (dated 06/08/22) revealed recreation programs were designed to meet the needs of each resident and were available on a daily basis. The recreation program was designed to encourage maximum individual participation and were geared to individual needs, activities were scheduled seven days a week and included large and small group activities, individual and group activities reflect the schedules and were offered at hours convenient to residents. Review of a policy titled Activities (dated 03/23/21) revealed the facility would provide activities to engage the residents and provide comfort, support, dignity, and meaningful purpose. The activities department would interview the resident and/or family to determine the resident's leisure time pursuits, interests, experiences and beliefs to assess activity needs and desires. A care plan would be developed to provide person-centered activities which will be available 24 hours a day, activities would be scheduled throughout the day to engage residents and could include busy pillows or blankets, folding laundry, rummage room, activity station and skits. Behavioral and psychological symptoms would use non-pharmacological interventions to help alleviate symptoms which could include sensory (aromatherapy, therapeutic touch, music, bright light), psychosocial (validation, reminiscence, music, meaningful activity), and physical (assessing for pain, toileting, temperature). Ongoing training and education would be completed for dementia related topics.

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	10/11/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm 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** 28704 Based on observation, medical record review, policy review and interview, the facility failed to complete treatments and administer insulin as ordered. This affected two residents (#8,#10) of three residents reviewed for skin conditions and of three residents reviewed for pain. The census was 61. Findings include: 1. Medical record review revealed Resident #8 was admitted on [DATE] with diagnoses including cerebral infarction, chronic skin lesion, failure to thrive, diabetes mellitus, hemiplegia and hemiparesis left non-dominant side, aphasia and need for physical assistance with personal care. Review of the 5-day Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #8 was moderately impaired for daily decision-making, did not have a surgical wound and had no skin impairments. a. Review of the Admission Assessment & Baseline Care Plans - V 9 assessment dated [DATE] revealed Resident #8 was at mild risk for skin breakdown and had a surgical incision to the left ear. There was no description or measurement to describe the surgical incision and no treatment had been ordered. Further review of the record revealed no documentation, treatment or assessment of the left ear surgical incision between 07/03/24 and 10/08/24. Review of the care plan: Potential for alteration in skin integrity related to immobility, incontinence, type 2 diabetes (initiated 07/18/24) revealed interventions including monitor for and report any suspicious moles/lesions, following the ABC's: asymmetry, borders (irregular), color (blacks), diameters; weekly skin assessments and when assisting the resident with transfers, positioning or lifting avoid friction and/or skin shear. There was no evidence of the left ear surgical incision/wound in the care plans. Review of the Physician Orders dated September 2024 revealed skin prevention orders including to turn & reposition as tolerated/needed, use a lift pad to minimize friction and shear and low air loss mattress to bed. On 09/30/24 at 10:19 A.M., observation during interview with Resident #8 revealed his left outer ear (helix) was irregularly shaped, black and bleeding. His left ear and pillowcase were bloody. Resident #8 stated he had skin cancer that he had treatments on prior to coming to the facility and when staff dress him or change his clothes, it pulls the scab off. Resident #8 stated he has not had any further treatments or dressings to the area since admission. On 09/30/24 at 10:31 A.M., interview with state tested nurse aide (STNA) #321 verified the above and stated they would notify the nurse. (continued on next page)

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	10/11/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/24 at 4:49 P.M., interview with the Director of Nursing (DON) stated Resident #8 had cancer surgery on his left ear prior to admission and verified there were no treatments or assessment of the area. The DON stated she was unaware the area was black or bleeding and would follow-up with nurse and physician. On 10/02/24 at 7:25 A.M., Resident #8 was observed sitting in a wheelchair in lobby, the left helix was irregular in shape and black. On 10/09/24 at 4:26 P.M., electronic interview with the DON revealed Resident #8 was going to be seen by the wound nurse practitioner the following week but a treatment was being ordered. b. Review of the Physician Orders dated September 2024 revealed to cleanse the left upper arm and right hand/2nd metatarsal area with wound cleanser and pat dry, apply xeroform and foam dressing daily. Review of the Treatment Record dated September 2024 revealed Resident #8's left forearm, left upper arm and right hand treatments were initialed as completed on 09/28/24, 09/29/24 and 09/30/24. On 09/30/24 at 10:19 A.M., observation of Resident #8's left outer forearm and back of the right hand revealed an adhesive dressing dated 09/27/24. On 09/30/24 at 10:31 A.M., the above was verified by STNA #321 who stated the nurse would be notified. On 10/02/24 at 2:50 P.M., interview with Nurse Practitioner (NP) #600 stated it was her expectation the physician orders for dressing changes were to be followed. NP #600 was not aware the dressing had not been changed for three days; however, observation of the treatment areas on the left outer forearm and back of the right hand revealed the areas had both healed. NP #600 stated the resident does heal quickly and had not been notified of any other wounds or skin impairments. 35765 2. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses included diabetes, diabetic retinopathy, atrioventricular block, cerebral infarction, disease of the digestive system, arthritis, major depressive disorder, nail dystrophy, transient ischemic attack, disease of the anus and rectum, anxiety disorder, and hypertension. Review of the October 2024 physician's orders revealed Resident #10 had an order for glargine insulin 25 units once daily for diabetes dated 02/03/24. Review of the Med Pass Note dated 07/26/24 at 10:17 A.M. revealed Resident #10 was only given half his dosage of Humalog insulin per nursing judgment. The physician was notified and awaiting a response. Review of the Med Pass Note dated 07/26/24 at 10:19 A.M. revealed Resident #10 was only given half his dosage of glargine insulin per nursing judgment. The physician was notified and awaiting a response. (continued on next page)

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	10/11/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Narrative Nurse's notes dated 07/26/24 at 7:42 P.M. revealed Resident #10 blood sugars had been running low so the nurse gave half his morning dose of insulin due to his sugar being 72. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #10 had intact cognition and was receiving insulin. On 10/03/24 at 11:48 A.M. an interview with the DON confirmed the nurse should have called the physician or nurse practitioner and received an order prior to only giving Resident #10 half of his ordered insulin dose. She stated the nurse was no longer with the facility. The DON indicated the facility did not have a facility policy on monitoring blood sugars.

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	10/11/2024

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review and interview, the facility failed to ensure resident hearing devices were available and replaced timely. This affected one resident (#17) of two residents reviewed for communication-sensory devices. The census was 61. Findings include: Medical record review revealed Resident #17 was admitted on [DATE] with diagnoses including anxiety disorder, alcohol cirrhosis, gastroesophageal reflux disease, depression, bilateral sensorineural hearing loss and unspecified dementia. Review of the care plan: Communication Problem related to hearing deficit (initiated 09/28/23) revealed resident wears hearing aides, prefers not to wear hearing aides at all times. Interventions included to apply hearing aid(s), assist with application of hearing aid, change hearing aid battery as needed, and encourage use of hearing aid. Review of the electronic Physician Orders (dated 04/16/24) revealed consult audiology services as needed Review of the 360 Care Audiology Visit Note (dated 05/31/24) revealed referred by facility for decreased hearing. Facility staff agreed hearing aides were appropriate for the resident and the resident was interested in a trial with hearing aids. Bilateral ear-mold impressions were completed and a physician statement was left at the facility that would need to be signed by the primary care provider prior to a hearing aid fitting. Ear exam revealed the tympanic membrane was perforated in the left ear. Mild sloping to profound sensorineural hearing loss in both ears and the plan was to return for hearing aid fitting once physician statement was received. Review of the quarterly Minimum Data Set 3.0 assessment (dated 07/08/24) revealed Resident #17 was cognitively intact for daily decision-making and had moderate difficulty hearing with no hearing aid use. Review of the Late Entry Narrative Nurse's Note (dated 07/08/24) revealed the 360 Audiologist was here to see resident today and took broken hearing aide back with her to see if could be fixed. Review of the hospice Client Episode Coordination Notes Report / Social Work Narrative Note (dated 09/17/24) revealed the resident was extremely hard of hearing and utilized a whiteboard to communicate with Resident #17. Patient admitted to facility with two sets of hearing aids, one of which were brand new. Her hearing aids have since been lost and was reported to the facility but there had been no updates on replacing them. On 09/30/24 at 12:05 P.M., interview with Resident #17 stated she used to have two pairs of hearing aids, one cheaper pair broke and they were never returned to her and the second pair were lost over a year ago and were never replaced. Resident #17 stated the hearing aids that the facility lost had cost over $3000. Resident #17 stated she wants to get her hearing aids as they were supposed to be getting her new ones but no one seems to know what was going on. No hearing aides were observed. (continued on next page)

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	10/11/2024

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/30/24 at 12:30 P.M., interview with Licensed Practical Nurse #331 stated the resident does not have hearing aids for use. Review of the Bedside Kardex Report (as of 09/30/24 and 10/08/24) revealed to apply hearing aid(s), assist with application of hearing aid, change hearing aid battery as needed and encourage use of hearing aid. Review of the Client Episode Coordination Notes Report (dated 10/03/24) revealed Resident #17 has communication difficulties due to being hard of hearing (HOH). On 10/07/24 at 11:23 A.M., interview with the Director of Nursing (DON) stated the facility did not have a social service designee or social worker at this time and the corporate social worker was reachable when needed. The DON stated Resident #17's had two sets of hearing aids but one pair was broken and sent for possible repair, and the other pair had been lost. The DON verified the lost pair was not on the missing item list and stated she could not speak to why they were not on the log. The DON verified the resident was alert and oriented, wanted hearing aides, has not had hearing aides since at least May 2024, the resident very (HOH) and the communication care plan had not been revised to reflect current communication needs. On 10/08/24 at 8:20 A.M., interview with the DON stated she thinks it was $79 to get the hearing aids fixed but wasn't sure if it had been done or not, or if the hearing aids were waiting on this payment to be released to the resident. The DON verified there were no notes or follow-up since July 2024 by social services regarding the resident's hearing aids. On 10/08/24 at 12:24 P.M., interview with Resident #17's responsible party (Family #603) revealed the resident had two sets of hearing aids including an expensive pair and a cheaper pair. The expensive pair of hearing aids cost between $2000-$3000 and have been missing for probably a year or so. She states she had not heard from the facility about what was going to happen about the missing hearing aids or if they were going to replace them. She stated the facility told her there was a bill for $69 but was not sure who got that bill or what it was for. Family #603 stated the facility called her earlier today and told her the resident was scheduled for a hearing aid mold fitting on 10/29/24 but did not know if she was going to have to pay for replacements or not. Family #603 stated the resident doesn't want to have surgery or have to travel all the way to Columbus for an audiogram but they definitely want her hearing aids replaced because the resident cannot hear without them. On 10/08/24 at 1:32 P.M., phone interview with Scheduler #604 revealed the Registered Nurse #357 had called earlier today to schedule an appointment for an appointment to get a new pair of hearing aides for Resident #17. Scheduler #604 stated Resident #17's original hearing aids were provided on 02/17/22 and the lost hearing aides were still under Medicaid warranty; therefore, they could have been replaced at anytime at no cost to the resident or facility. Scheduler #604 stated a new pair were being made based off the original hearing aids they made for Resident #17 and should be ready for pick-up on 10/29/24. (continued on next page)

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	10/11/2024

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/08/24 at 1:43 P.M., phone interview with Care Coordinator #605 stated the broken pair of hearing aids were not taken by the audiologist as this was not documented by the audiologist or was it common practice for them to take broken hearing aids for repair. A certified medical necessity form was left at the facility on 06/11/24 for the resident's physician to complete prior to replacing the broken hearing aids. This certified medical necessity form was never returned to the audiologist; therefore, no replacement hearing aids appointments/fittings had been made. Care Coordinator #605 stated on 07/25/24 Resident #17 was sent an invoice for $79 for hearing aid batteries but not sure who had the batteries since the resident's hearing aids had been broken/missing. Review of the policy: Social Services (dated 11/30/23) revealed the facility provides medically-related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental or psychosocial well-being. Medically-related social services is provided to maintain or improve each resident's ability to control everyday physical needs and mental/psychosocial needs. The facility failed to provide a policy regarding ancillary services including audiology when requested.

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	10/11/2024

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 0686 Level of Harm - Minimal harm or potential for 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** 28923 Based on record review, observations, staff interview, and policy review, the facility failed to ensure a resident that was known to have an existing pressure ulcer on her left heel had her heels off-loaded as per her plan of care. This affected one resident (#6) of one residents reviewed for pressure ulcers. Findings include: Review of Resident #6's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included pressure ulcers to multiple sites to include a Stage III pressure ulcer (full thickness tissue loss; subcutaneous fat may be visible, but bone, tendon, or muscle was not exposed; slough may be present but does not obscure the depth of tissue loss; may include undermining and tunneling) to the left heel. The resident's diagnoses also included muscle weakness and the need for assistance with personal care. Review of Resident #6's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was moderately impaired. She was not known to display any behaviors or reject care during the seven days of the assessment period. She was identified to be at risk for pressure ulcers and had unhealed pressure ulcers. Review of Resident #6's active care plans revealed she had a care plan in place for having an alteration in skin integrity related to an Unstageable pressure ulcer (pressure ulcer that was known but not stageable due to coverage of wound bed by slough and/ or eschar) to her left buttock, a Stage III pressure ulcer to her sacrum, and a Stage IV (full thickness tissue loss with exposed bone, tendon, or muscle; slough or eschar may be present on some parts of the wound bed; often included undermining and tunneling) pressure ulcer to her left heel. The care plan was initiated on 03/20/24. The goal was for the resident to demonstrate gradual wound healing as evidenced by a decrease in size and depth of the wound by the next review date. The interventions included encouraging the resident to wear Prevalon boots to her bilateral feet at all times as tolerated. That intervention had been in place since 03/20/24. Further review of Resident #6's active care plans revealed she had a care plan in place for a potential for alteration in skin integrity related to a history of skin breakdown, immobility, and incontinence. The care plan was initiated on 03/31/24. The goal was for the resident to not develop further skin breakdown through the review date. The interventions included the need to offload the resident's heels as tolerated. That intervention had been in place since 03/31/24. Review of Resident #6's physician's orders revealed the resident had an order in place for the use of Prevalon boots to be worn to her bilateral feet at all times as tolerated. They were to be removed for bathing/ hygiene and every shift for skin checks. Her physician's orders also included a current treatment order for a stage IV pressure ulcer to the left heel. (continued on next page)

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	10/11/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/24 at 12:32 P.M., an observation of Resident #6 noted her to be lying in bed in a supine position with the head of her bed elevated. There was a specialty mattress on her bed. Her heels were not offloaded as per her plan of care. The resident's heels were noted to be in direct contact with the mattress. There was a pair of heel protectors sitting on the windowsill near the foot end of her bed. Findings were verified by Licensed Practical Nurse (LPN) #352. On 10/01/24 at 12:34 P.M., an interview with LPN #352 confirmed Resident #6 was known to have an existing pressure ulcer on her left heel. She further confirmed the resident was supposed to have her heels offloaded per her plan of care. She noted the heel protectors were on the resident's windowsill and not on the resident's feet. She also noted there was not a pillow in place to help keep the resident's heels offloaded. Review of the facility's policy on Pressure Ulcer Management (last reviewed on 11/30/23) revealed it was the policy of the facility to assess residents for the potential risk of developing skin breakdown. Residents with skin breakdown would be managed. Pressure reduction strategies would be used as appropriate and care plans would be updated as needed.

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	10/11/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on medical record review, observation, policy review and interview, the facility failed to ensure residents with limited range of motion receive restorative services as indicated to prevent decline. This affected two residents (#8 and #15) of two residents reviewed for positioning. The census was 61. Findings include: 1. Medical record review revealed Resident #8 was admitted on [DATE] with diagnoses including cerebral infarction, diabetes mellitus, hemiplegia and hemiparesis left non-dominant side, aphasia and need for physical assistance with personal care. Review of the 5-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #8 was moderately impaired for daily decision-making, had impairment on one side of upper and lower extremities and had received therapies including physical and occupational therapy during the review period. Review of the Occupational Therapy (OT) Discharge Summary dated 09/30/24 revealed Discharge Recommendations included recommendations to continue with upper body ADL's (activities of daily living), active range of motion (ROM) of bilateral upper extremities (UE). A restorative program was established/trained included an ADL program and range of motion program. The programs established included minimum assist with upper body bathing/dressing and stand by assist with oral care. The ROM program established was active ROM bilateral UE. Review of the Physical Therapy Discharge Summary (dated 09/30/24) revealed recommendations for passive ROM and/or active assist ROM for lower extremities in all planes, and to facilitate hip abduction to reduce the risk of contracture's. Review of the Therapy Recommendation (dated 09/30/24) revealed Resident #8 required minimum assist with upper body dressing and upper body bath, grooming set-up and stand by assist in bed, and bilateral UE active ROM. Review of the medical record revealed no evidence the recommended restorative programs were implemented for Resident #8. On 09/30/24 at 10:17 A.M., observation revealed Resident #8's right knee was in a slight bent position and he was unable to straighten his right knee/leg upon command. Resident #8 stated it had been like that for a while and had been getting therapy but was told he was no longer progressing so they stopped. Resident #8 stated no staff currently performs any type of exercises, range of motion or stretches but sometimes the nurse applies a cream to his knees to help with the pain. On 09/30/24 at 10:30 A.M., interview with state tested nurse aide (STNA) #321 verified Resident #8 was unable to straighten his right knee/leg and verified no restorative programs had been provided. STNA #321 stated he completes what was in the electronic system and there were no restorative programs to date they had to complete. (continued on next page)

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	10/11/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review revealed Resident #15 was admitted on [DATE] with diagnoses included muscle weakness, diabetes mellitus, neuropathy, heart failure, edema, osteoarthritis, need for assistance with personal care and schizophrenia. Review of Resident #15's care plan: ADL self-care performance deficit (initiated 09/12/23) revealed goals to improve current functional status related to ADL's with interventions including limited assistance with bathing, transfers, toilet use oral hygiene and dressing. Review of the annual MDS 3.0 assessment (dated 07/02/24) revealed Resident #15 was cognitively intact for daily decision-making, had no impairment of the upper or lower extremities, and had received both occupational and physical therapy during the review period. Review of the state optional MDS assessment (dated 07/02/24) revealed Resident #15 required extensive assistance with bed mobility, toilet use and transfers. Review of the Occupational Therapy (OT) Discharge Summary dated 07/05/24 revealed discharge recommendations for Resident #15 included to continue with restorative nursing program at this time for ADL's and active ROM bilateral upper extremities. Recommend assist with all ADL's and toilet/functional transfers at this time. Restorative ADL Program established and trained included: Supervision with upper body ADL's and grooming, minimum assist with lower body bathing with use of long handled sponge, moderate assist with lower body dressing, minimum assist with donning socks with use of sock aide, and stand by assist/caregiver assist with toileting. Restorative ROM program established and trained included active ROM to bilateral upper extremities. Resident #15's prognosis was good with consistent staff follow thorough. Review of the medical record revealed no evidence the recommended OT restorative programs were implemented for Resident #15. Review of the Health Documentation - V 4 (dated 10/01/24) revealed Resident #15 required extensive assistance with ADL's including bed mobility and transfers. Review of the Care Assessment -V 8 (dated 10/02/24) revealed Resident #15 self care performance included substantial/maximal assistance with shower/bathe self; partial/moderate assistance with upper body dressing; substantial/maximal assistance with lower body dressing; and was dependent on staff for putting on/taking off footwear. On 10/01/24 at 1:36 P.M., interview with Physical Therapist Assistant Director (PTA Director) #329 revealed therapy will try to do a quarterly screen on all residents and interview of staff for possible resident declines. If any are identified, therapy will complete an evaluation to see if they require any additional therapy services. On 10/01/24 at 3:31 P.M. and 3:38 P.M., interview with the Director of Nursing (DON) stated currently the facility does not have a formal restorative program. ROM was provided during ADL's and if additional services are needed, therapy will screen/evaluate for needs. (continued on next page)

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	10/11/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/24 at 2:06 P.M., observation with Registered Nurse #357 verified there was no sock aid or long handled sponge as recommended by therapy. Interview with Resident #15 at the time of the observation verified he did not have a shower brush stating staff just wash him with a washcloth and he has not had a shoe horn but would like on so he can put on his own shoes. On 10/02/24 at 1:32 P.M., interview with the DON stated when residents are discharged from therapy services she will receive a referral form but it does not say it's a formal restorative program and these are not entered as such. The DON verified recommendations were made for restorative programs for both Resident #8 and #15 but were not implemented. On 10/02/24 at 2:10 P.M., interview with PTA Director #329 stated there was no true restorative program currently at the facility but therapy does make restorative recommendations for nursing in order to keep the residents at their current functional level upon therapy discharge. PTA Director #329 stated she provides the information to the DON and verified both Resident #8 and #15 had restorative recommendations but currently no formal program. PTA Director #329 stated when she makes therapy discharge recommendations, she tries to write them so they can be incorporated into ADL care. On 10/02/24 at 2:30 P.M., interview with STNA #332 verified Resident #8 has difficulty straightening his right leg/knee and some ROM was done with bathing and showers when lifting their arms and legs to wash them but that was it. STNA #332 stated no residents were receive restorative nursing programs and she was unaware Resident #15 had a shower brush or shoe horn. Review of the undated policy: Restorative Nursing revealed the purpose was to increase independence, promote safety, preserve function, increase self-esteem, promote improvement in function and minimize deterioration of residents. Restorative nursing care actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning of residents. The following types of residents should be considered for restorative programming: Residents who experience a decline in functional status; Residents assessed with a potential to benefit from restorative intervention; Residents coming off of skilled therapy with continuing needs for restorative intervention maintaining current level of function per the restorative/functional maintenance program; Residents who are assessed with the potential to benefit from a combination of skilled therapy and restorative nursing services. Residents will be screened on admission/readmission, quarterly and with any significant change in health status to determine whether their level of function has improved, been maintained or has deteriorated. Descriptions used on the restorative screen to identify the resident's abilities will be defined as in their corresponding sections of the MDS 3.0 manual. The designated RN will review the data collected and determine whether the resident would benefit from restorative intervention. The designated RN will then develop the appropriate programs to be provided at least 3 to 6 days per week and at least 15 minutes per day. Programs will incorporate measurable goals, measurable objectives, and measurable interventions and will document them in the plan of care. Restorative activities will be carried out by nursing assistants under the direction and supervision of a licensed nurse. Nursing assistants will be trained in the techniques that involve the resident in the activity and will be responsible for recording the services delivered on the appropriate delivery records.

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	10/11/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on record review, observations, policy review, and interviews, the facility failed to implement immediate fall interventions and complete new fall assessment and failed to provide a safe environment related to unsecured biologicals. This affected two residents (#6, #26) of 11 residents reviewed for accidents and hazards. The facility census was 61. Findings include: 1. Medical record review revealed Resident #26 was admitted on [DATE] with diagnoses including chronic respiratory failure, diabetes mellitus, gout, bullous pemphigoid (a rare, chronic autoimmune skin disease that causes fluid-filled blisters to form on the skin), restrictive lung disease, lymphedema, and polymalgia rheumatica. Review of the Quarterly Fall Review assessment (dated 01/30/24) revealed Resident #26 was at high risk for falls. Review of the record revealed no other fall risk assessments had been completed after 01/30/24. Review of the Therapy Screen dated 04/26/24 revealed Resident #26 required minimum assistance with transfers and ambulation. Review of the Fall report (dated 05/11/24 at 11:30 P.M.) revealed state tested nurse aide (STNA) # 601 was moving Resident #26 from the chair to bed, Resident #26 turned the wrong direction, lost his footing and slid down wall while be assisted by STNA #601. The resident did not hit his head and was sitting up on the floor between the bed and chair. Resident #26 was assisted off the floor and a skin tear was observed to the right lower extremity that measured 2.0 inches by 1.25 inches. Predisposing factors included furniture, gait imbalance, non-compliant with care/care plan. Predisposing Situation Factors included ambulating with assist and a gait belt was not in use and the resident was not using a walker while being transferred to bed. No immediate or new fall interventions were implemented to prevent future falls. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment (dated 7/03/24) revealed Resident #26 had one fall with injury, not major. Review of the care plan: Fall Risk (initiated 02/07/24) revealed Resident #26 had a history of falls, impaired balance, impaired mobility, noncompliance with mobility aide use, noncompliant with fall prevention devices, obesity, and vitamin D deficiency. Interventions included bed in lowest position while in bed (initiated 05/14/24), call light accessible when in room (initiated 02/07/24), fall risk assessment quarterly and PRN (initiated 02/07/24), non-slip footwear (initiated: 02/07/24), reinforce need to call for assistance (initiated 02/07/24). On 09/30/24 at 11:56 A.M., observation revealed Resident #26 was up in his wheelchair and was wearing gripper socks. On 10/01/24 at 11:57 A.M., Resident #26 was observed in his room in a wheelchair wearing gripper socks and call light was within reach. (continued on next page)

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	10/11/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/24 at 2:00 P.M., interview with STNA #332 stated use of gait belt was dependent on how the person was able to stand/pivot. STNA #332 stated Resident #26 was able to transfer to the toilet with one person assist and no gait belt because he can hold onto the grab bar. STNA #332 stated when he was being transferred from chair to bed that was different because he would not have anything to grab onto and would need two staff and the use of a gait belt. STNA #332 stated Resident #26 would not be safe transferring from the chair to bed without the use of two staff and a gait belt. On 10/01/24 at 2:06 P.M., interview with Registered Nurse #357 stated there should be a gait belt behind every door for use as needed and if a gait belt was to be used, it should be in the care plan. On 10/01/24 at 4:49 P.M., interview with the Director of Nursing (DON) stated fall risk assessments should be completed at a minimum with every fall and with all MDS assessments. On 10/01/24 at 5:03 P.M., interview with the DON verified there was no root cause identified for the fall, STNA #601 should have used a gait belt to transfer the resident, there was no immediate intervention to prevent further falls, and no fall risk assessment completed. The DON stated it was her expectation that staff utilize a gait belt during transfers. Review of the policy: Falls - Clinical Protocol (reviewed 11/30/23) revealed staff was to attempt to define possible causes, complete a fall assessment and review/revise the resident's care plan as appropriate. Review of the policy: Bed to w/c (wheelchair) and w/c to bed Transfer (reviewed 11/30/23) revealed the policy was to provide education to staff for a safe bed to w/c and w/c to bed transfer. Procedures included to place a gait belt around the resident's waist to stabilize the trunk, tighten gait belt, grasp gait belt with both hands and bring resident to a standing position. Assist the resident to pivot in a controlled manner that ensures safety, lowers resident onto the bed or w/c, repositions for comfort and safety, and then remove the gait belt. 28923 2. Review of Resident #6's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included multiple pressure ulcers of various stages and at various sites. Review of Resident #6's physician's orders revealed she had treatment orders in place for the treatment of pressure ulcers to the resident's left buttock and sacrum and a boil to the left hip. The treatment orders included the use of Dakin's solution (a diluted solution of bleach and other ingredients including boric acid that was used as a topical antiseptic to treat and prevent infections), in which gauze was to be moistened with the solution and placed in the wound bed. On 10/01/24 at 12:32 P.M., an observation of Resident #6 noted her to be lying in bed conversing with another resident that came over to the 300 hall from the 200 hall to visit with the resident. There was a bottle of Dakin's Full Strength 0.5% solution that was sitting on the top of the resident's dresser next to her bed, along with other treatment/ dressing supplies. The bottle was noted to be open with the cap sitting next to it. No treatment was in the process of being completed at the time the observation was made. Findings were verified by LPN #352. (continued on next page)

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	10/11/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/24 at 12:34 P.M., an interview with the LPN revealed the Dakin's solution that was noted sitting open and on top of Resident #6's dresser was used for her wound care. She confirmed the bottle of the Dakin's solution should not have been left out and with the cap off, when not in use. She stated it should be stored in their treatment cart when not in use. She was not sure how long it had been sitting there, as she did not typically work on that unit and had not completed her dressing change yet. Review of the MSDS for Dakin's Full Strength (Sodium Hypochlorite 0.5%) revealed it was a topical antiseptic and antimicrobial. The solution was not classified as hazardous in the amounts present in the product. Under normal conditions of use, the likelihood of any adverse health effects was minimal. The emergency overview indicated it was a clear, colorless solution with slight chlorine odor. A warning indicated it may be harmful if swallowed or inhaled. Contact with eyes may cause irritation and discomfort, but no permanent damage to eyes. Direct eye contact may cause irritation and/ or burns with symptoms of redness, itching, swelling, but no permanent injury to the eyes. Inhalation of vapors or mists may cause irritation of the mucous membranes and respiratory tract. Symptoms may include coughing, bloody nose, sore throat and sneezing. Ingestion may cause gastroenteritis with any or all the following symptoms: nausea, vomiting. First aide measures for eyes included flushing with water for a minimum of 15 minutes, lifting the lower and upper eyelids occasionally. Get medical attention as needed. For inhalation, if irritation or other symptoms were experienced, get medical attention immediately. If ingested, do not induce vomiting. Otherwise rinse mouth with water and give 8-10 ounces of water, milk, or gelatin solution. Get medical attention as needed. Handling and storage instructions indicated to keep it in a tightly closed, light resistant container, at room temperature. Review of the facility's policy on Receipt and Storage of Supplies and Equipment last reviewed on 11/30/23 revealed supplies should be stored in their designated storage areas. All supplies and equipment must be stored in accordance with the manufacturer's recommendations. Hazardous/ toxic materials must be properly stored and labeled in accordance with current regulations.

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	10/11/2024

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 0690 Level of Harm - Minimal harm or potential for 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** 28704 Based on medical record review, policy review, and interview, the facility failed to implement interventions to restore bladder function. This affected two residents (#8 and #17) of two residents reviewed for bladder and bowel incontinence. The facility identified 28 residents were incontinent of either bowel or bladder. The census was 61. Findings include: 1. Medical record review revealed Resident #8 was admitted on [DATE] with diagnoses including cerebral infarction, diabetes mellitus, hemiplegia and hemiparesis left non-dominant side and benign prostatic hyperplasia. Review of the 5-day Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #8 was moderately impaired for daily decision-making, required substantial/maximal assist with toileting, was frequently incontinent of urine and always incontinent of bowel with no toileting programs. Review of the care plan: At Risk for Urinary Retention and/or Discomfort (initiated 07/18/24) revealed interventions including to administer medications as ordered, assist to stand as needed to void, encourage/remind to empty bladder completely, monitor for frequency, hesitancy, dribbling, bladder distension, and inability to void, and notify physician of changes or concerns. Review of the care plan: Bladder Incontinence: Confusion, Impaired Mobility (initiated 07/18/24) revealed goal to remain free from skin breakdown due to incontinence and brief use. Interventions included: assess bladder continence quarterly and as needed; check resident if he is continent, offer to assist with toileting. If he is incontinent, remove wet or soiled clothing, briefs; provide incontinent care; apply protective barrier after each incontinent episode; maintain resident dignity during incontinent care; monitor for signs and symptoms of an UTI; note any changes in urine: amount, frequency, color or odor; provide incontinence care after each episode, check skin for breakdown and apply protective skin barrier cream. Review of the Task: Bladder Function-12 hr Shifts dated 09/09/24 to 10/08/24 revealed the following continent episodes out of 208 incontinence checks: a. Resident #8 was continent and dry on 44 occasions. b. Resident #8 was dry and voided on 14 occasions. c. Resident #8 was incontinent but was still able to urinate in the toilet/urinal/bedpan on 16 occasions. Review of the Health Documentation - V 4 (dated 10/09/24) revealed Resident #8 required extensive assist of one staff for toileting. (continued on next page)

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	10/11/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Skilled Note - V 3 (dated 10/10/24) Section 2 revealed Resident #8 was always incontinent of bladder. There was no type, description or toileting program identified. Review of the record revealed no interventions or toileting program to restore bladder or bowel function for Resident #8. On 09/30/24 at 10:13 A.M., interview with Resident #8 stated he used to walk to the bathroom with a walker but now they just give him the bedpan. Resident #8 stated staff does not get him up at specific times to go to the bathroom and he puts on his call light when he needs to void. Resident #8 was observed at the time of the interview to be wearing an incontinence product in bed. Resident #8 said they told him it is just the way it is now and he is trying to learn to accept that. On 09/30/24 at 10:31 A.M., interview with state tested nurse aide (STNA) #321 verified Resident #8 was wearing an incontinence product, was checked/changed every two hours, the resident did not get up to go to the bathroom and he was incontinent. STNA #321 verified there was no urinal within reach of the resident and he would need assistance to use it. STNA #321 stated he was not aware of any toileting program to restore continence for Resident #8. On 10/02/24 at 4:26 P.M., interview with the Director of Nursing (DON) verified Resident #8 did not currently have a toileting program to restore function, and had episodes of continence between 09/09/24 and 10/02/24. 2. Medical record review revealed Resident #17 was admitted on [DATE] with diagnoses including anxiety disorder, disorder or kidney and ureter, and non-Alzheimer's dementia. Review of the care plan: Bladder incontinence: Confusion, Dementia (initiated: 04/22/24) revealed a goal to remain free from skin breakdown due to incontinence and brief use. Interventions initiated 04/22/24 included: Check resident if he/she is continent, offer to assist with toileting. If he/she is incontinent, remove wet or soiled clothing, briefs; provide incontinent care; apply protective barrier after each incontinent episode; maintain resident dignity during incontinent care. Monitor for signs/symptoms of an UTI: burning on urination, flank pain, hematuria, difficulty voiding, change in mental status, change in behavior, fever, change in color, clarity & odor of urine. Provide incontinence care after each episode, check skin for breakdown and apply protective skin barrier cream. Use verbal reminders for use of bathroom. No other interventions had been implemented related to incontinence since 04/22/24. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #17 was cognitively intact for daily decision-making, was always continent of bowel and bladder and was not on a toileting program. Review of the Bowel/Bladder Function -12 hour shift report dated 07/08/24 through 10/07/24 revealed Resident #17 was incontinent of urine on 07/16/24, 07/26/24, 07/30/24, 08/20/24, 08/24/24, 08/29/24, 09/01/24, 09/02/24, 09/04/24, 09/06/24, 09/12/24, 09/15/24, 09/17/24, 09/23/24, 09/24/24, 09/30/24 and 10/01/24. Resident #17 was incontinent of bowel on 09/17/24. Review of Resident #17's hospice: Client Episode Coordination Notes Report revealed the following: a. On 08/22/24, resident voiding per usual with occasional stress incontinence. (continued on next page)

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	10/11/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 09/12/24, resident having urinary incontinence and request this nurse to order briefs. c. On 09/19/24, resident has had increased episodes of bowel/bladder incontinence and utilizing incontinence underwear. d. On 09/24/24, occasional bowel/bladder incontinence of and was utilizing incontinence underwear. Review of the record revealed no interventions implemented to restore Resident #17's bowel or bladder continence between 07/16/24 and 10/08/24. On 10/02/24 at 4:00 P.M., interview with Registered Nurse (RN) #359 verified Resident #8 and #17's care plans did not identify the type of incontinence. On 10/07/24 at 10:35 A.M., interview with the DON verified no interventions were implemented to restore Resident #8 or #17's bladder function, no type of incontinence was identified and the care plans were not individualized. On 10/07/24 at 2:28 P.M., interview with the DON stated there were no residents receiving any restorative bowel or bladder retraining programs. Review of the policy: Continence Programs (11/30/23) revealed the purpose of continence programs was to increase independence, dignity and self-esteem, maintain or improve bladder and/or bowel functioning, assist in maintaining skin integrity, and decrease fecal impaction. Residents who may be appropriate for a bladder and/or bowel program upon assessment included a resident who develops a continence problem which may be infrequent and warrants further investigation or a current resident who developed a continence problem when there was no evidence of incontinence concerns when the initial MDS and quarterly reassessments were performed previously. A successful continence program included adequate fluid intake, muscle strengthening exercised at least daily and carefully scheduled elimination times determined by B&B assessments and avoiding the use of incontinence briefs if possible as using briefs may give the resident permission to be incontinent. Bladder retraining programs aim at assisting the resident to regain independence with the entire toileting process. This process includes reaching the toilet, controlling the urge to void until the appropriate time, emptying the bladder and performing hygiene needs. Although every resident may not reach full independence with each step of the toileting process, improvement in any area renders success to the resident. Review of the undated policy: Restorative Nursing revealed the purpose was to increase independence, promote safety, preserve function, increase self-esteem, promote improvement in function and minimize deterioration of residents. Restorative nursing care actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning of residents. Residents will be screened on admission/readmission, quarterly and with any significant change in health status to determine whether their level of function has improved, been maintained or has deteriorated. Continence: define the resident's ability to maintain continence using the response as listed continent, occasionally incontinent, frequently incontinent and always incontinent and any response of incontinence requires a seven day bladder tracking assessment to be completed followed by a decision to proceed or not proceed with a scheduled toileting program -- documented rationale. A check and change every two hours and PRN, and offer toileting every two hours and PRN are part of daily ADL's.

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	10/11/2024

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 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** 35765 Based on record review, facility policy review and interviews, the facility failed to develop and implement an effective pain management program to adequately manage pain for Resident #7 and Resident #156. This affected two residents (#7 and #156) of four residents reviewed for pain management. The facility census was 61. Actual harm occurred beginning on 09/27/24 when Resident #156, with diagnoses of pyogenic and rheumatoid arthritis, myalgia, and chronic back syndrome, did not received ordered pain medication (Methadone) following admission, resulting in unrelieved (per Minimum Data Set (MDS) assessment almost constant pain that affected his sleep, interfered with therapy and affected his day-to-day activities) pain. The resident vocalized the increased unrelieved pain and was subsequently transferred to the hospital for evaluation and admitted with a diagnosis of intractable back pain, requiring hospital treatment. Actual harm occurred on 09/21/24 when Resident #7, with diagnoses of history of traumatic fractures and rheumatoid arthritis, was prescribed Oxycodone (narcotic pain medication) five times a day and the facility failed to ensure the resident received the medication resulting in missed doses of medication. The resident had unrelieved pain with symptoms of withdrawal as evidenced by the resident sustaining irritability, crying/tearfulness, sweating, stomach cramps, and feeling weird. Findings included: 1. Review of the medical record revealed Resident #156 was admitted to the facility on [DATE]. Diagnoses included kidney disease, diabetes, pyogenic arthritis, diabetic foot ulcer, endocarditis congestive heart failure, rheumatoid arthritis of the right shoulder, sepsis, myalgia, and chronic pain syndrome. Review of the baseline care plan dated 09/27/24 revealed Resident #156 had a potential for pain related to a condition or disease process. Interventions were to observe for signs and symptoms of pain, determine the pain intensity with the FACES pain scale, and medicate per physician's order. Review of the restorative note dated 09/27/24 at 7:53 P.M. revealed Resident #156 was totally dependent of two staff for bed mobility, required no assistive devices for bed mobility, he was unable to balance himself for sitting, he was able to turn from his right to the left side while in bed with two staff assist, he was able to turn from the left to the right side while in bed with two staff assist, he was unable to move from lying to sitting in bed, unable to lift his legs off the bed, unable to bend his knees, unable to dangle his feet, and unable to pull self-up in bed. He was alert and oriented to person , place and time. The resident complained of pain with bed mobility. The note revealed the resident was not appropriate for a (restorative) program at this time. Review of the physician's orders dated 09/27/24 revealed Resident #156 had an order for acetaminophen 325 mg every four hours as needed for pain. (continued on next page)

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	10/11/2024

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 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the physician's orders dated 09/28/24 revealed Resident #156 had orders for Oxycodone (pain medication) five milligrams (mg) every six hours as needed, Baclofen (muscle relaxant) 10 mg once daily for muscle spasms, and Methadone (pain medication) five mg give 7.5 mg three times daily for pain. Review of a narrative nurse's note dated 09/28/24 at 5:23 P.M. revealed Nurse Practitioner (NP) #502 ordered to hold the resident's Methadone 7.5 milligrams (mg) until the physician reviewed. Resident notified. Review of the On-Call NP Note dated 09/28/24 at 6:08 P.M. revealed the Director of Nursing (DON) called to clarify that Resident #156 was on Methadone 7.5 mg three times daily prior to hospitalization and he had received the medication from the pain clinic. The DON explained the resident was currently prescribed Lyrica 75 mg twice daily, Oxycodone 5 mg three times daily and Methadone 7.5 mg three times daily. The NP (#502) discussed with the DON about changing the Oxycodone 5 mg from routine to as needed every six hours and Methadone 7.5 mg three times daily in order to prevent over medication. The DON was agreeable to the medication recommendations. Review of the physician's orders dated 09/29/24 revealed Resident #156 had orders for Lyrica (pain medication) 75 mg twice daily and pain scale per [NAME] FACES scale every shift. Review of the Med Pass Note dated 09/29/24 at 2:31 A.M. revealed the Methadone for Resident #156 was not administered and was to be delivered by the pharmacy. Review of the Med Pass Note dated 09/29/24 at 8:08 A.M. revealed the Methadone for Resident #156 was not administered due to waiting delivery from the pharmacy. Review of the Med Pass Note dated 09/29/24 at 1:20 P.M. revealed the Methadone for Resident #156 was not administered due to on order. Review of the Med Pass Note dated 09/29/24 at 2:27 P.M. revealed Lyrica 75 mg was not administered due to on order. Review of the Med Pass Note dated 09/29/24 at 11:00 P.M. revealed the Methadone was not administered due to not being available from the pharmacy. The pharmacy was called regarding the Methadone not being delivered and they stated they do not have it in stock and were looking into getting some from another company to send. They stated they do not have a time or know when they would have it available. Review of the Five-Day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #156 had intact cognition and was dependent on staff for self-care. The assessment revealed the resident received a scheduled and as needed pain medication. His pain frequency was almost constant. The pain affected his sleep, interfered with therapy and affected his day-to-day activities almost constant. His pain was rated a numeric 10 on a scale of one to 10 with 10 being the worst pain. Review of the Skilled Nurse's Note dated 09/30/24 at 3:12 A.M. revealed the pain level for Resident #156 was five to six out of 10. He stated he hurts even more and all over. (continued on next page)

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	10/11/2024

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 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the Med Pass Note dated 09/30/24 at 9:03 A.M. revealed the Methadone was not administered due to they were waiting on delivery from the pharmacy. Review of the September 2024 Medication Administration Record revealed Resident #156 was administered the following: Oxycodone five milligrams on 09/28/24 at 1:40 A.M. with no pain level documented. Tylenol 325 milligrams on 09/28/24 at 11:34 A.M. for pain level six out of 10. Tylenol 325 milligrams on 09/29/24 at 8:08 A.M. for a pain level of four out of ten. Oxycodone five milligrams on 09/29/24 at 11:51 A.M. for a pain level of seven out of ten. Lyrica 75 milligrams on 09/29/24 in the evening, no time documented. Oxycodone five milligrams on 09/29/24 at 9:00 P.M. for a pain level of seven out of ten. Oxycodone 5 milligrams on 09/30/24 at 9:00 A.M. for a pain level of five out of ten. Lyrica 75 milligrams on 09/30/24 in the morning, no time documented. Oxycodone 5 milligrams on 09/30/24 at 5:32 P.M. for a pain level of five out of ten and it was documented to be not effective. Methadone 7.5 milligrams on 09/30/24 in the evening, no time or pain level documented. Tylenol 325 milligrams on 09/30/24 at 8:02 P.M. for a pain level of five out of ten and it was documented as being not effective. Lyrica 75 milligrams on 09/30/24 in the evening, no time documented. On 09/30/24 at 2:07 P.M. an interview with Resident #156 revealed his pain was not controlled and he was not receiving his pain medication as ordered. He indicated his pain was in his lumbar back area. Review of the pharmacy delivery slip dated 09/30/24 revealed Resident #156 received 30 tablets of Methadone 5 milligrams. They were delivered and signed in (by facility staff) at 9:08 P.M. Review of the Narrative Nurse's Note dated 10/01/24 at 11:48 A.M. revealed the family requested Resident #156 be sent to the emergency room (ER) for evaluation of uncontrolled pain. (continued on next page)

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	10/11/2024

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 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the Narrative Nurse's Note dated 10/01/24 at 11:50 A.M. revealed Resident #156 was on scheduled Lyrica and Methadone, which was given as scheduled, he had as needed Tylenol and Oxycodone available as requested at the time of his discharge to the hospital. The note indicated the resident had not requested any as needed medications or notified the nurse that he was in need of them. The family was stating they wanted the resident sent out for ER evaluation at this time. The family was asking if the resident was on Methadone and the nurse explained he had an order for scheduled Methadone. Review of the Narrative Nurse's Note dated 10/01/24 at 4:15 P.M. revealed the nurse spoke to the ER about the resident's status and he was being admitted with intractable back pain. On 10/03/24 at 11:45 A.M. an interview with the DON revealed Resident #156 was on palliative care at the hospital, however he was not on palliative care at the facility and she did not know why. She stated he came to the facility on Lyrica, Oxycodone three times a day routine and and Methadone three times a day routine. She stated she attempted to talk NP #502 out of making the Oxycodone three times daily as needed but NP #502 was concerned about him being on Oxycodone and Methadone at the same time even though he had been on it prior to going to the hospital and was ordered from the hospital to the facility. She stated they could not get the Methadone from their pharmacy so they were trying to get a local pharmacy to send it. She verified the resident had his routine Oxycodone discontinued and changed to as needed. However, he was not receiving his Methadone as ordered for pain due to not being able to obtain it from the pharmacy then he went out to the hospital for severe pain in his back on 10/01/24. She verified there was no documentation or evidence the NP or physician were notified the facility was not able to obtain the Methadone from the pharmacy and Resident #156 had not been receiving it as ordered. On 10/03/24 at 2:14 P.M. an interview with State tested Nursing Assistant #347 revealed the first time she worked with Resident #156 was on 09/30/24. She stated the resident told her he had trouble rolling to his right side due to his shoulder pain. She stated he had told her several times he was in pain and she told the nurse working. She stated she could hear the resident moaning in the hallway from his room a few times when she would walk past his room. Review of the facility policy titled, Pain Assessment and Management, dated 11/30/23 revealed the purpose of the policy was to help the staff identify pain in the resident and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Attempts to reach NP #502 during the survey were unsuccessful as the NP did not return the surveyors calls with three attempts made to reach the NP. 47985 2. Record review revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including personal history of traumatic fractures, muscle weakness, and rheumatoid arthritis. (continued on next page)

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	10/11/2024

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 0697 Level of Harm - Actual harm Residents Affected - Few	Review of a care plan dated 01/30/24 revealed Resident #7 was at risk for pain/discomfort related to rheumatoid arthritis, spondylosis, and shoulder pain. The goal was for Resident #7 to verbalize relief of pain or ability to cope with incompletely relieved pain as evidence by no interruption in normal activities due to pain and no discomfort related to side effects of analgesia through the review date. Interventions included acknowledge presence of pain and discomfort and listen to resident's concerns (01/30/24), assess for pain (01/30/24), encourage non-medicinal interventions to control pain and decrease use of analgesic therapy including repositioning, stretching, exercise, and relaxation techniques to assist with pain control (01/30/24), and report to nurse any change in usual activity attendance patterns or refusal to attend activities related to signs or symptoms or complaints of pain or discomfort (01/30/24). Review of a quarterly MDS assessment completed on 07/05/24 revealed Resident #7's cognition remained intact, had no behaviors, she received a scheduled pain medication regimen, had pain in the last five days frequently which occasionally made it hard to sleep at night and limited day-to-day activities. Review of a quarterly pain assessment completed on 08/27/24 revealed Resident #7 had pain in the last five days frequently, which occasionally interfered with sleeping and day-to-day activities. Resident #7 rated her pain at a seven out of ten. Assessment stated, patient takes scheduled pain medication and is effective most days. Review of a medication administration record (MAR) for September 2024 revealed Resident #7 had a pain level of eight on 09/20/24 at 9:00 P.M. and medication was administered. On 09/21/24, Resident #7 did not receive her 1:00 A.M., 9:00 A.M., or 1:00 P.M. doses of Oxycodone. Her pain was not assessed during those timeframes. Review of a nurse practitioner (NP) note dated 09/20/24 at 11:23 P.M. by NP #502 revealed Oxycodone dose was not available in pyxis (facility back up medication storage) and the correct dose would be available in the morning. The NP gave an order to hold Oxycodone until the correct dose arrived to the facility. Review of a nursing note dated 09/20/24 at 11:31 P.M. by Licensed Practical Nurse (LPN) #312 revealed at 11:11 P.M. NP #502 was made aware Oxycodone for Resident #7 would not be delivered until the early morning and resident would miss one dose. Review of a nursing note dated 09/21/24 at 7:10 A.M. authored by LPN #312 revealed the LPN called the pharmacy and spoke with staff because she had spoken with a representative of the pharmacy last night who had promised the Oxycodone would be sent so it was received in time for the morning dose and it was not. LPN #312 instructed the pharmacy to drop ship this medication this morning, and the pharmacy staff stated they would email the pharmacist to see what she could do to help. There were no additional nursing notes regarding Resident #7's pain medication being delivered, Resident #7's status or pain being assessed, or any new orders being obtained. Review of physician orders revealed Resident #7 had an order in place dated 10/03/24 for Oxycodone oral tablet 10 milligrams (mg) give 10 mg orally five times a day for pain. (continued on next page)

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	10/11/2024

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 0697 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/07/24 at 4:19 P.M. with Resident #7 revealed her pain medications ran out approximately two weeks ago and she missed five doses. Resident #7 stated she began to have withdrawals. Resident #7 was informed she was not able to receive medication out of the pyxis because it contained an incorrect dose (5 mg). Resident #7 stated she began to feel funny, was irritable and yelled at the nurse, was crying and hurting so bad, was sweating and her stomach was cramping and feeling weird. Resident #7 stated she was told the medication would arrive at midnight, then 2:30 A.M., then 10:30 A.M. (the next day) but it still did not come. Resident #7 stated the medication she missed was Oxycodone and stated the nurse (Registered Nurse (RN) #339) told her she was having withdrawals. Resident #7 stated she was asked not to tell the survey team this information. Resident #7 stated the pharmacy was in Kentucky. Interview on 10/08/24 at 12:52 P.M. with LPN #352 revealed she was working the day Resident #7 missed several doses of her medication, but she was not her assigned nurse. LPN #352 stated there was a pyxis/medication bank available and the doctor could be called to get new orders as needed. LPN #352 stated signs of withdrawal included shakiness, sweating, and irritability. Interview on 10/08/24 at 12:57 P.M. with Medical Director (MD) #367 revealed he could not recall if he was notified of Resident #7 running out of Oxycodone and missing several doses. He stated it would have been appropriate for the staff to call him to receive a new order and script for a one-time dose, or limited time dose, of whatever dosage was available of Oxycodone in the pyxis. Interview on 10/08/24 at 1:28 P.M. with the DON confirmed Resident #7's MAR for September (2024) showed at least three missed doses of Oxycodone, with no evidence pain assessments were completed. The DON stated the nurse could have gotten a separate script to use the available dosage in the pyxis until the resident's medication arrived. Interview on 10/08/24 at 1:42 P.M. with LPN #312 revealed the dose available in the Pyxis for the Oxycodone was 5 mg. When she had called the CNP, the medication had not yet been ordered, so LPN #312 ordered the medicine, received the order to hold the medication until the morning dose arrived from the pharmacy, and then the medication did not arrive. LPN #312 stated she called before she left her shift to inquire why the medication hadn't arrived yet and to make sure they drop shipped the medication. LPN #312 stated she worked night shift, so she was not present to see how Resident #7 was doing after missing doses of Oxycodone. LPN #312 stated by the time she worked again, Resident #7 was her normal self, and she did not receive anything in report regarding concerns of Resident #7. LPN #312 stated if she knew the medication would not arrive timely from the pharmacy, she would have requested an order to hold the current dose Resident #7 was prescribed and get a new order for Oxycodone 5 mg two tablets by mouth five times a day until her regular dose came in. Interview on 10/08/24 at 2:56 P.M. with the DON revealed if a resident was sweating, irritable, and feeling weird after being prescribed Oxycodone five times a day for an extended period of time, it was likely she was withdrawing. The DON stated Resident #7 had mentioned the incident to her but only said she received her medication, so the DON stated she believed it was taken care of. (continued on next page)

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	10/11/2024

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 0697 Level of Harm - Actual harm Residents Affected - Few	Interview on 10/08/24 at 3:19 P.M. with RN #339 revealed she was not the nurse who worked on Resident #7's hall but she was working on 09/21/24 and remembered Resident #7 approaching her and telling her she had been without her pain medication; she was in pain and was tired of this happening. RN #339 stated Resident #7's face looked like she could have been in some pain. Resident #7 stated she was starting to sweat. It could have been anxiety, but it could have been withdrawal as often as she takes Oxycodone and as long as she's been taking it. RN #339 stated to her knowledge, there were 5 mg Oxycodone available in the Pyxis, but she stated she was unaware what Resident #7's assigned nurse had tried to do that day. She was able to recall it was LPN #325. Attempts to reach LPN #325 for interview during the survey were unsuccessful.

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	10/11/2024

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 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on observation, review of the facility assessment, review of facility marketing material, medical record review, policy reviews, review of staffing schedules August 2024 through October 2024, and interviews, the facility failed to develop and implement comprehensive and individualized treatment and services to ensure residents, who displayed behaviors and/or were diagnosed with dementia received the appropriate treatment and services to attain or maintain their highest practicable physical, mental and psychosocial well-being. The facility's failure to provide adequate and needed services to residents, admitted to the facility secured memory care unit, resulted in Immediate Jeopardy and included an incident of actual physical and psychosocial harm to Resident #48 that occurred on 09/29/24 at approximately 10:00 P.M. when staff failed to provide adequate supervision/intervention to prevent the resident from being assaulted by Resident #46. The facility's failure to provide adequate and needed services to residents placed all seven residents (#33, #36, #46, #47, #48, #51, and #259) at risk for additional harm, serious injury and death when the facility failed to ensure staff working the secured memory care unit received specialized training for providing care to residents with diagnosis of dementia, the facility failed to provide identified services including medical treatment, specialized care services and social activities to all residents and the facility failed to ensure adequate staffing levels were maintained to provide necessary resident supervision. This affected seven residents (#33, #36, #46, #47, #48, #51, and #259 of seven residents who resided on the facility secured memory care unit. On 10/03/24 at 4:27 P.M., the facility Administrator, Director of Nursing, and Clinical Service Manager (CSM) #357 were notified Immediate Jeopardy began on 09/29/24 when Resident #46 was having aggressive behaviors towards other residents on the memory care unit without evidence of effective and necessary staff intervention. Resident #46's behaviors escalated, and the resident began punching Resident #48 with a closed fist to her head. At the time of the incident, there was one staff member, State tested Nursing Assistant (STNA) #345 on the unit. STNA #345 left the residents/area to find additional staff to assist with the situation. Following the incident, Resident #48 was observed seated in the dining room, leaning forward in her chair with her hands covering her head and sobbing. The Immediate Jeopardy continued due to the facility's failure to provide activities, supervision, and competent staff to address the total care and behavioral health care needs for all seven residents admitted to the facility secured memory care unit. The Immediate Jeopardy was removed on 10/04/24 when the facility implemented the following corrective actions: On 09/29/24 at approximately 10:20 P.M. Resident #46 and Resident #48 were both transported to the hospital for evaluation. On 09/30/24 at 2:04 A.M. Resident #48 returned to the facility from the hospital. The Psychiatric Nurse Practitioner (NP) saw Resident #48 in the facility on 09/30/24. (continued on next page)

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	10/11/2024

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 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/30/24 at 7:45 A.M. head-to-toe assessments were completed for the four non-interviewable residents residing on the Memory Care Unit by the Director of Nursing. Assessments included pain assessment, psychosocial assessments and skin inspections. Five (5) family members were interviewed by phone to identify any care concerns. Two residents were interviewed. On 09/30/24 at 9:00 A.M. Resident #46 returned to the facility from the hospital. On 09/30/24 at 12:00 P.M. Resident #46 was placed on one-to-one supervision with a plan for the one-to-one to continue until the resident was discharged . On 10/02/24 at 7:00 A.M. State tested Nursing Assistant (STNA) staffing was increased to two staff members at all times during the 7:00 A.M. to 7:00 P.M. and 7:00 P.M. to 7:00 A.M shifts for the secured Memory Care Unit. The increase in staffing was to provide activities for the memory care unit and to provide daily care and supervision/safety for the seven residents on the secured memory care unit. The facility plan indicated as the unit census increased (capacity 17) resident needs for care, activities and supervision would be assessed to determine if an increase in staff was needed. On 10/02/24 at 10:50 A.M. Resident #48 was assessed for psychosocial needs and injury by the Licensed Practical Nurse (LPN) and Corporate Licensed Social Worker. Resident #48 would continue monitoring as needed by the Psychiatric NP and nurses for changes in psychosocial status. On 10/02/24 at 12:15 P.M Resident #46 was discharged from the facility to an Inpatient Behavioral Health facility for evaluation, medication review and potential adjustments. On 10/03/24 (no time identified) A root cause analysis of the resident-to-resident altercation on 09/29/24 was completed by the Clinical Service Manager. The facility root cause analysis identified staff were not properly trained in dementia care and there was a lack of activities for residents on the Memory Care Unit. On 10/03/24 at 4:30 P.M an Ad Hoc Policy review was held with the Administrator, Director of Nursing, Regional Clinical Services Manager, Medical Director, Diet Tech, Medical Records/Accounts Payable, Director of Rehab, Staff Development Coordinator, Unit Manager, Business Office Manager, Maintenance Director, Central Supply/Scheduler, and Activity Coordinator to review facility policies for the Memory Care Unit, Staffing and Dementia care training, activities on the Memory care unit, interventions for residents with outburst/behaviors, and the Abuse policy on how to respond to residents with behaviors. The facility identified policies were appropriate but were not implemented daily for the Memory Care unit. On 10/03/24 at 5:00 P.M. the Regional Clinical Services Manager educated the Administrator, Director of Nursing, Unit Manager, and Staff Development coordinator, regarding policies and procedures for the Memory Care Unit, Staffing and Dementia care training, activities on the Memory care unit, immediate interventions for residents with outburst/behaviors and the Abuse policy including how to respond to redirect residents with behaviors. On 10/03/24 at 5:30 P.M. the Corporate Licensed Social Worker (LSC) reviewed the care plans for all residents on the secured Memory Care Unit to ensure appropriate interventions for behaviors, supervision and activities were in place. (continued on next page)

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	10/11/2024

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 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/03/24 at 11:00 P.M. staff education was provided for 23 STNAs, two (2) activities staff, nine (9) therapy staff, 11 LPNs, five (5) RNs, six (6) Dietary staff, six (6) Housekeeping staff on the facility Memory Care Unit policies and procedures, Staffing and Dementia care training, activities and immediate interventions for residents with outburst/behaviors by the Staff Development Coordinator. The facility provided a plan for training to continue on hire, annually and as updates to Memory Care training were available and as necessary to maintain the highest level of care, supervision, quality of life and activities for Memory Care residents. Training would be completed by 10/04/24 at 11:00 P.M. Beginning on 10/04/24 (no time identified) resident referrals for placement on the Memory Care Unit would be screened by the DON and Social Services to determine if residents were appropriate for the unit by reviewing the history of the resident including resident testing that had occurred before acceptance to the Memory Care Unit. Beginning on 10/04/24 (no time identified) the facility implemented a plan for the LNHA/Designee to audit staffing on the Memory Care Unit to ensure two staff members were always present on the Memory Care Unit. Audits would be completed five days a week for four weeks. Beginning on 10/04/24 (no time identified) the facility implemented a plan for the DON/ Designee to audit resident care plans for appropriate interventions for resident behaviors and for the Memory Care Unit supervision. Audits would be completed on three residents three times a week for four weeks. Beginning on 10/04/24 (no time identified) the facility implemented a plan for the LNHA/Designee to audit activities on the Memory Care Unit to ensure activities on the Memory Care Unit based on the Alzheimer's Association recommendations and were being completed. An activity calendar would be hung in the resident lobby on the Memory Care Unit and would be overseen by the Activity director, three times a week for four weeks (beginning on 10/04/24) and (activity) calendar was specialized for the Memory Care Unit, three times a week for four weeks. Beginning on 10/10/24 (no time identified) the facility identified a Quality Assessment and Performance Improvement meeting would be completed every week with the Medical Director to review audits and any additional changes for QAPI plan/modifications or further education for four weeks then monthly for two. Although the Immediate Jeopardy was removed on 10/04/24, 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 was in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings Include: On 09/30/24 at 9:11 A.M. observation during an initial tour of the facility revealed a secured memory care unit with seven residents, Resident #33, #36, #46, #47, #48, #51, and #259 who resided on the unit. At the time of the observation there was one staff member, STNA #343 observed working on the unit. (continued on next page)

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	10/11/2024

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 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility staffing schedules from August, September and October 2024 for the Memory Care unit revealed only one STNA was scheduled to be on the unit at all times with the memory care residents from 08/01/24 through 10/02/24. Interview on 10/02/24 at 9:07 A.M. with STNA #305 revealed she did not receive any type of memory care training and had been employed by the facility for a couple months. STNA #305 stated she was thrown back on the (memory care) unit. Interview on 10/02/24 at 9:14 A.M. with STNA #338 revealed she did not receive any training to work on the memory care unit nor did she receive any dementia care training upon hire to the facility. When asked if she felt comfortable working with aggressive residents, STNA #338 stated, I guess. Interview on 10/02/24 at 9:52 A.M. with Licensed Practical Nurse (LPN) #325 revealed there was only ever one staff member on the unit prior to the one to one being initiated for Resident #46 following an incident on 09/29/24. LPN #325 stated she had not received any training to work the memory care unit. LPN #325 stated in addition, she did not receive a full three-day orientation on hire. During the interview, LPN #325 stated she had never witnessed any organized activities on the unit. Interview on 10/02/24 at 10:19 A.M. with Activities Assistant (AA) #344 revealed the aides who worked on the memory care unit were the staff who were responsible to provide activities to the residents. AA #344 said the staff were provided items needed to complete the activities, and sometimes the residents got to attend activities off the memory care unit such as church, prayer group, or musical guests. AA #344 stated she documented their activities once she was made aware they participated. Interview on 10/02/24 at 11:16 A.M. with Resident #46's family (FM #203) revealed the facility does not provide activities on the memory care unit so she took it upon herself to purchase Bingo and additional games to do activities with the residents because there was only one aide on the unit, and the aide can't provide care and activities to the residents. Interview on 10/02/24 at 12:12 P.M. with Certified Nurse Practitioner (CNP) #361 revealed she was unaware of a (staff) training program for the memory care unit. CNP #361 stated she had concerns about the facility only having one staff member on the unit because even if there were only seven residents currently on the unit, if there was an emergency or someone was having behaviors, other residents may be left alone while staff were addressing the resident in need of care, or if they were providing showers to residents, the other residents would be unsupervised. CNP #361 stated in case of an emergency, one staff member should stay with the affected resident, and another should go for help. Observation on 10/02/24 at 2:33 P.M. revealed the memory care activity for this time was Sounds of Serenity. During observation, there were no staff in the dining area to provide the activity. There was a country western on the television, two residents were sleeping, and two were talking. There were no Sounds of Serenity at this time. Observation on 10/02/24 at 2:41 P.M. revealed AA #344 entered the unit, took the memory care activity calendar and then left the unit. The 2:30 P.M. activity was still not started. (continued on next page)

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	10/11/2024

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 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 10/02/24 at 2:58 P.M. with STNA #338 revealed she did not know she was responsible for providing activities while working on the memory care unit. STNA #338 stated she had not ever been told she was supposed to provide activities, but if she had to do activities, help residents with behaviors, help take residents to the bathroom, or help during an emergency by herself, her job would not be possible to complete. STNA #338 stated it was too much work for one person to complete and stated, what if someone falls or I get beat up? STNA #338 confirmed Sounds of Serenity did not happen, and stated none of the scheduled activities for 10/01/24 or 10/02/24 were completed for the residents. Interview on 10/02/24 at 3:09 P.M. with STNA #332 revealed she did not receive any type of training to work the memory care unit and there was no formal memory care program. STNA #332 stated she used her own work experience and knowledge to complete activities with the residents. STNA #332 stated there was only ever one aide working at a time on the unit for a 12-hour shift and felt it was unsafe because if something happened, she would not be able to contact the nurse for help. STNA #332 stated when she had an incident happen on the unit a while back, she had to leave the resident and run to the door of the memory care unit to call for help and felt she was potentially delaying care or leaving other residents unsupervised when she had to care for just one individual's needs. During an interview on 10/02/24 at 3:35 P.M. with the DON, the concerns related to the lack of resident supervision and activities on the memory care unit were shared. The DON indicated she was only allowed to staff the unit with what corporate told her she should staff. The DON also stated she had concerns with the supervision levels on the unit. During the interview, the DON revealed the secured memory care unit had first opened in February 2024. The unit had a total capacity for 17 residents. Interview on 10/02/24 at 3:58 P.M. with STNA #345 revealed she did not have any type of dementia care training specific to the memory care unit. Interview on 10/02/24 at 4:14 P.M. with LPN #323 revealed she did not receive any type of memory care training while working at the facility. LPN #323 stated she did not believe having only one staff member on the memory care unit was sufficient. Interview on 10/02/24 at 5:36 P.M. with the DON revealed she was unable to provide documented evidence any type of memory care training or specialized training was completed for the staff who worked on the memory care unit. Interview on 10/08/24 at 12:57 P.M. with Medical Director (MD) #367 revealed he was not sure of the facility policies regarding staffing the memory care unit. MD #367 said there should always be someone on the unit to supervise the residents. MD #367 was not sure about what type of education he would expect for staff working the memory care unit. (continued on next page)

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	10/11/2024

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 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of pamphlet titled Legacy [NAME] Skilled Nursing & Rehabilitation: Cognitive Spa Memory Care Program dated 2023 revealed a secured memory care unit was provided at the facility and memory care was provided by specially trained professionals dedicated to the unique and ever-changing needs of those living with Alzheimer's and related dementia. The unit utilized a Secure Care System which allowed individuals a safe, secure and homelike environment. The memory care program was to provide compassionate staff specially trained using HealthCare Interactive's CARES training (innovative set of training products for online training and qualifies individuals for Alzheimer's Association essentiALZ certification), daily social activities that use visual aids and functional routines to promote independence and well-being personalized to residents, a safe and secure cheerful homelike setting, and additional services including hospice, palliative care, and respite care if needed. Review of a pamphlet titled Legacy [NAME] Skilled Nursing & Rehabilitation: Services Guide dated 2024 revealed the facility's memory care unit had care provided by specially trained professionals dedicated to the unique and ever-changing needs of those living with Alzheimer's and related dementia. Utilizing a SecureCare system allows each individual a safe, secure and homelike environment. The secured dementia unit provides patients with daily social activities and routines, an enclosed courtyard, CARES trained staff, psychological services, and other care services including hospice, palliative care and respite care if needed. Review of a policy titled Memory Care Unit dated 11/30/23 revealed memory care would be offered to residents with a diagnosis of dementia and a Global Deterioration Scale Stage 4-6 who would benefit from a secured, person-centered care setting with activity-based programming. If a resident was identified as a potential candidate for the memory care unit, an assessment would be completed and the physician would be notified and if he agreed, an order would be obtained. If family or guardian agree, the resident would be admitted to the memory care unit and quarterly assessments would be completed. Review of the facility assessment dated [DATE] revealed no evidence of the facility having a secured memory care unit, services provided on said unit, or staffing plan for a memory care unit. The following incident and care for Resident #48 and Resident #46 were investigated during the annual survey with concerns identified related to the lack of comprehensive and individualized dementia care/services to meet both residents total care needs and to provide supervision to prevent the assault of Resident #48: a. Record review revealed Resident #48 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, anxiety disorder, unspecified psychosis, and disorientation. The resident was admitted to the facility secured Memory Care unit. Review of an assessment titled Memory Care Unit Criteria dated 06/18/24 revealed Resident #48 had a diagnosis of Alzheimer's and inappropriate behaviors including wandering, exit seeking, and she was easily redirected. The assessment revealed Resident #48 would benefit from a structured environment with specialized activities and was appropriate for memory care unit. Record review revealed there was no physician order for placement on the facility secured memory care unit. (continued on next page)

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	10/11/2024

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 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a care plan dated 06/25/24 and revised on 09/11/24 revealed Resident #48 required a special memory care unit related to a diagnosis of dementia with behaviors and at risk of elopement and cognitive loss with poor safety awareness. Goals included participation in activities, socializing with others appropriately, and her quality of life being maintained at an optimal level while on the special memory care unit. Interventions included assessing Resident #48 for appropriate placement on the unit upon admission, quarterly, and as needed (06/25/24); engage resident in simple, structured activities that avoid overly demanding tasks (06/25/24); escort off unit for walks in or outside facility if appropriate for a change of scenery (06/25/24); introduce to peers on the unit with similar interests and cohesive temperament to assist in establishing common bonds (06/25/24); provided one to one intervention as needed (06/25/24); and provide diversional activities for resident (06/25/24). Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #48 had severe cognitive impairment, disorganized thinking, mild depression, no behaviors, and required supervision for activities of daily living. Review of a nursing note dated 09/29/24 at 10:13 P.M. by Licensed Practical Nurse (LPN) #323 revealed Resident #48 was sitting in the dining room when another resident came up behind her and began hitting her with fists on both sides of her head several times. Resident #48 was shaken up and crying, no injuries were noted, neurological checks were within normal limits, and the nurse practitioner was called and gave orders to send to the emergency department (ED) to be evaluated. Resident #48's family was notified of the incident. Review of a Certified Nurse Practitioner (CNP) #360 note dated 09/29/24 at 10:15 P.M. revealed Resident #48 was hit hard on both sides of her head by another resident. No immediate injuries were noted but Resident #48 was sent to the hospital for evaluation and treatment. Review of a nursing note dated 09/29/24 at 10:20 P.M. by LPN #323 revealed an (emergency) squad was at the facility to transport Resident #48 to the ED, report was called, and the DON was notified of the incident. Review of a nursing note dated 09/30/24 at 2:04 A.M. by LPN #323 revealed Resident #48 returned to the facility from the ED. She was alert, denied pain, neuro checks were resumed, and family was updated. Review of a nursing note dated 09/30/24 at 9:50 A.M. by Registered Nurse (RN) #359 revealed Resident #48 had been sent to the ED, no injuries were noted, and psychosocial effects (of the assault by Resident #46) were to be followed up by social services. b. Record review revealed Resident #46 was admitted to the facility on [DATE] (admitted from the hospital where he received treatment and services on the psychiatric unit) with diagnoses including schizoaffective disorder bipolar type, Alzheimer's disease, intermittent explosive disorder, other conduct disorder, and type A behavior pattern. The resident was admitted to the facility and then moved to the secured Memory Care unit on the same day of admission; however, record review revealed no Memory Care Unit assessment was completed for the resident. (continued on next page)

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	10/11/2024

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 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a hospital note dated 07/22/24 (prior to admission) revealed Resident #46 was admitted to the hospital for intermittent explosive disorder from a long-term care nursing facility, where he was noncompliant with medications, had auditory and visual hallucinations, was aggressive, going after female staff, and urinating everywhere. Resident #46 was admitted to the hospital to adjust medications at the psych unit. Review of a hospital note dated 07/23/24 (prior to admission) revealed Exelon (cognition enhancing medication used in the treatment of Alzheimer's related dementia) and Namenda (central nervous system medication used in the treatment of dementia and Alzheimer's disease) were implemented to attempt to impact positively on activity of daily living (ADL) maintenance, behaviors, and cognition. Medications would be tapered upwards as needed and tolerated. Medications would be utilized to decrease impulsivity and aggression to return to the least restrictive environment. Review of a hospital note dated 07/24/24 revealed Resident #46's Namenda was increased. Review of a hospital note dated 07/25/24 revealed Resident #46 had a paradoxical effect to Ativan (benzodiazepine used in the treatment of anxiety) and to make sure he does not take Ativan. Medications were adjusted. Review of a hospital note dated 07/26/24 revealed Resident #46 was exit-seeking, fighting and hitting another patient, and had taken a napkin and tried to feed it to another patient. A dose of Geodon (anti-psychotic medication used in the treatment of mental and mood disorders) was administered and was ineffective. He did eventually calm down and slept approximately six hours. Medication adjustment was made to discontinue Risperdal and start Seroquel (anti-psychotic medication) due to the completion of GeneSight testing (a test to see how a patient's genes may affect their response to certain medications). A hospital note dated 07/27/24 revealed Resident #46 had behaviors of trying to shove a paper towel down another resident's throat, he also tried to climb in bed with a female patient but did not exhibit sexual behaviors. Resident #46 was given a dose of Ultram (narcotic medication used to treat pain), which was effective, and he slept six hours. Review of a hospital note dated 07/28/24 revealed Resident #46 was pacing the halls, exit seeking and attempting to go into other resident rooms. When attempting to redirect, Resident #46 because agitated and aggressive, attempted to hit one of the nurses, and Vistaril (antihistamine used in the treatment of anxiety) 50 mg was ordered. Resident #46 was mumbling and yelling at staff, he did have a urinary tract infection and was waiting for culture and sensitivity reports. Resident #46 slept approximately nine hours after having medication. Review of discharge orders dated 08/06/24 from the hospital included orders for Seroquel 50 mg by mouth three times daily, Namenda 10 mg by mouth twice daily, Exelon patch 13.3 mg every morning, and Ultram 50 mg by mouth twice daily. Review of Resident #46's facility medical record revealed a physician order for Seroquel 50 milligrams (mg) one tablet by mouth three times a day for schizophrenia (08/06/24); memantine (Namenda) oral tablet 10 mg one tablet by mouth two times a day for dementia (08/06/24); and rivastigmine (Exelon) transdermal patch 24-hour 13.3 mg/24 hours apply one patch transdermal one time a day for dementia (08/07/24). There was no evidence the order for Ultram 50 mg by mouth was carried over from the hospital discharge orders to the resident's facility orders. (continued on next page)

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	10/11/2024

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 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a nursing note dated 08/06/24 at 4:41 P.M. by LPN #331 revealed Resident #46 was admitted to the facility from the hospital and had behaviors while being taken for his weight. The note did not specify what type of behaviors. Review of a provider note dated 08/07/24 at 1:00 A.M. by Medical Director (MD) #367 revealed Resident #46 admitted to the facility after being admitted to the hospital for inpatient psychiatric services related to aggression, visual hallucinations, and behaviors. At a previous facility, Resident #46 was non-compliant with medications. Resident #46 did have exit seeking behaviors during inpatient stay, so he was admitted to the secured dementia unit and had a wanderguard in place. Staff were to monitor for behaviors. Review of a care plan dated 08/07/24 and revised on 09/11/24 revealed Resident #46 required the special memory care unit related to a diagnosis of dementia with behaviors and at risk of elopement and cognitive loss with poor safety awareness. His goal was to maintain current level of cognitive function through the review date. Interventions included do not rush or show annoyance/impatience (08/07/24); encourage family involvement (08/07/24); encourage resident to make routine, daily decisions and coach through process if decisions are not forthcoming (08/07/24); engage resident in simple, structured activities that avoid overly demanding tasks (08/07/24); keep resident's routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion (08/07/24); limit choices, use cueing, task segmentation, written lists, instructions that will maximize involvement in daily decision making and activity (08/07/24); and monitor, document, and report to the doctor any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty in expressing self, difficulty understanding others, level of consciousness and mental status (08/07/24). Review of a care plan dated 08/07/24 and revised on 09/11/24 revealed Resident #46 was at risk for changes in mood related to disease process, new admission, stating he was fidgeting or restless, having trouble falling and staying asleep, having little pleasure in doing activities, schizophrenia, and trouble concentrating on things. Goals included having mood improved evidenced by happier, calmer appearance, no signs or symptoms of depression, anxiety, or sadness through next review. Interventions included administer medications as ordered, monitor for side effects and effectiveness (08/07/24); allow time and encourage to express feelings (08/07/24); arrange for clergy or spiritual leader of choice to visit as requested (08/07/24); assist in developing a program of activities that is meaningful and of interest and encourage and provide opportunities for exercise and physical activity (08/07/24); assist to identify strengths, positive coping skills and reinforce them (08/07/24); behavioral health consult as needed (08/07/24); encourage activities of choice, give reminders and escort as needed (08/07/24); encourage, assist, and support to maintain as much independence and control as possible to ask for help and express feelings (08/07/24); monitor and record mood to determine if problems seem to be related to external causes such as medications, treatments, or concern of diagnoses (08/07/24); and monitor, record and report to physician as needed risk for harm to self, suicidal plan, past attempt at suicide, risky actions, intentionally harmed or tried to harm self, refusing to eat or drink, refusing medications or therapy, sense of hopelessness or helplessness, impaired judgement or safety awareness (08/07/24). (continued on next page)

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	10/11/2024

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 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a care plan dated 08/07/24 revealed resident #46 was at risk for behavior symptoms related to mental illness, schizophrenia, and explosive disorder. Goals included maintaining involvement with ADL performance and social activities, accepting care and medications as prescribed, and reducing risk of behavioral symptoms. Interventions included administer medications as ordered, monitor and document side effects and effectiveness (08/07/24); analysis of key times, places, circumstances, triggers and what de-escalates behavior and document (08/07/24); assess for causes of behavior and alter environment as needed (08/07/24); assess resident's coping skills and support system (08/07/24); escort to a private area if unable to divert resident's attention (08/07/24); provide diversional activities as appropriate (08/07/24); provide positive feedback for good behavior, emphasize the positive aspects of compliance (08/07/24); and refer to psych as needed (08/07/24). Review of a nursing note dated 08/10/24 at 6:30 A.M. by LPN #312 revealed Resident #46 wandered during the night without direction or purpose, required much redirection and attempted to wander into other resident rooms. Resident #46 had also taken off his brief and was rinsing it in the sink, plugged up the sink and water overran onto the bathroom and bedroom floor and was playing in the water, swishing it around. Review of an admission MDS completed on 08/13/24 revealed Resident #46 had severely impaired cognition, inattention, disorganized thinking, had moderate depression, wandered one to three days, and required supervision for transfers and walking. Review of a care plan dated 08/16/24 revealed Resident #46 required use of psychotropic medications with potential for adverse reactions related to behaviors associated with dementia. The goal was to perform to highest level of ADLs, have regular elimination pattern, and communicate appropriately with others. Interventions included administer medic [TRUNCATED]

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	10/11/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record, review of pharmacy recommendation, National Library of Medicine drug review, and interview with staff the facility failed to ensure pharmacy recommendation were addressed timely for residents and failed to address extended antibiotic use for a resident. This affected four residents (#6, #10, #17, and #26) of five reviewed for unnecessary medications. Findings included: 1. Review of the medical record revealed Resident #26 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, dysphagia, hypomagnesemia, diabetes iron deficiency, hyperlipidemia, gout, bullous pemphigoid, (a rare, chronic autoimmune disease that causes fluid-filled blisters to form on the skin), lymphedema, dysphonia, anxiety, major depressive disorder, and benign prostatic hyperplasia. Review of the October 2024 physician's orders revealed Resident #26 had an order for sertraline 25 milligrams once daily for depression dated 01/24/24. Review of the pharmacy recommendation dated 02/24/24 revealed Resident #26 was on sertraline 25 milligrams every day. The physician did not review the recommendation until 04/18/24. On 10/03/24 at 4:30 P.M. an interview with the Director of Nursing (DON) revealed she was not the DON at the time of the recommendation, however she confirmed the pharmacy recommendation for Resident #26 was not addressed timely. She stated the facility did not have a policy on medication reviews or pharmacy recommendations. 2. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses included diabetes, diabetic retinopathy, atrioventricular block, cerebral infarction, disease of the digestive system, arthritis, major depressive disorder, nail dystrophy, transient ischemic attack, disease of the anus and rectum, anxiety disorder, and hypertension. Review of the October 2024 physician's orders revealed Resident #10 had an order for mirtazapine 7.5 milligrams once daily for depression dated 02/09/24. Review of the pharmacy recommendation dated 02/24/24 revealed Resident #10 was on mirtazapine 7.5 milligrams every day. The physician did not review the recommendation until 04/18/24. On 10/03/24 at 4:30 P.M. an interview with the DON revealed she was not the DON at the time of the recommendation however, she confirmed the pharmacy recommendation or Resident #10 was not addressed timely. She stated the facility did not have a policy on medication reviews or pharmacy recommendations. 28704 (continued on next page)

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	10/11/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Medical record review revealed Resident #17 was admitted on [DATE] with diagnoses including anxiety disorder, alcohol cirrhosis, gastroesophageal reflux disease, depression, bilateral sensorineural hearing loss and unspecified dementia. Review of the Hospice IDG Comprehensive Assessment and POC Update Report dated 05/23/24 neomycin 500 milligrams (mg) twice a day for management of disease symptoms. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #17 was cognitively intact for daily decision-making, had no infections and was receiving antibiotics. Review of Resident #17's medical record revealed no documentation or appropriate indication of continued use for neomycin (broad spectrum antibiotic). Review of the electronic Physician Orders (dated 04/04/24) revealed Resident #17 was administered neomycin 500 milligrams twice a day for an infection. Review of the 360 Care Audiology Visit Note (dated 05/31/24) revealed referred by facility for decreased hearing. Facility staff agreed hearing aides were appropriate for the resident and the resident was interested in a trial with hearing aids. Bilateral ear-mold impressions were completed and a physician statement was left at the facility that would need to be signed by the primary care provider prior to a hearing aid fitting. Ear exam revealed the tympanic membrane was perforated in the left ear. Mild sloping to profound sensorineural hearing loss in both ears and the plan was to return for hearing aid fitting once physician statement was received. Review of the electronic Physician Order (dated 09/30/24) revealed neomycin 500 mg was being administered twice a day as a prophylactic. Review of the electronic Physician Orders revealed a Black Box Warning for Neomycin. The warning indicated a systemic absorption of neomycin occurs following oral administration, and toxic reactions may occur. Patients treated with neomycin should be under close clinical observation because of the potential toxicity associated with the use of neomycin. Neurotoxicity (including ototoxicity) and nephrotoxicity following the oral use of neomycin sulfate have been reported, even when used in recommended doses. The potential for nephrotoxicity, permanent bilateral auditory ototoxicity, and sometimes vestibular toxicity, is present in patients with healthy renal function when treated with higher doses of neomycin or for longer periods than recommended. Serial, vestibular and audiometric tests, as well as tests of renal function, should be performed (especially in high-risk patients). The risk of nephrotoxicity and ototoxicity is greater in patients with impaired renal function. Ototoxicity is often delayed in onset, and patients developing cochlear damage will not have symptoms during therapy to warn them of developing eighth nerve destruction, and total or partial deafness may occur long after neomycin has been discontinued. Other factors which increase the risk of toxicity are advanced age and dehydration. Review of Resident #17's medical record revealed no care plan for the use of neomycin. On 10/01/24 at 8:40 A.M., interview with Resident #17 stated she was sure why she was taking an antibiotic. (continued on next page)

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	10/11/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/07/24 at 4:09 P.M., interview with the Director of Nursing (DON) verified Resident #17 had been receiving neomycin 500 milligrams twice a day since 2022. The DON stated she believed the resident was receiving it due to cirrhosis but was not sure. The DON verified there was no evidence the continued use of the antibiotic was addressed by the physician for an appropriate use of the medication or indication for use. Review of the policy: Antibiotic Stewardship Program (dated 11/30/23) revealed the facility will establish and maintain a multi-disciplinary stewardship program that defines and provides guidance for optimal antimicrobial use. The purpose was to monitor the use of antibiotics and the facility will establish and maintain an antibiotic stewardship program that will establish guidelines for appropriate identification of and assessment of infection and treatment guidelines. 28923 4. Review of Resident #6's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included adult-onset diabetes mellitus, presence of an artificial left hip, and chronic pain. Review of Resident #6's medication regimen reviews revealed the consulting pharmacist had reviewed the resident's medications monthly for irregularities for the past 12 months. As a result of those medication regimen reviews, pharmacy recommendations were made on 01/22/24 and again on 02/24/24. Review of Resident #6's pharmacy recommendation for the medication regimen review completed on 01/22/24 revealed the pharmacist recommended the physician specify the dose/ amount of Voltaren Gel (Diclofenac Sodium) that should be used in the directions of the resident's current order. A second pharmacy recommendation was made on 02/24/24, with the same recommendation regarding the Voltaren Gel as was made on 01/22/24. The pharmacist's recommendation dated 01/22/24 was not addressed by the physician or advanced level provider until it was addressed by a nurse practitioner on 04/17/24. She indicated under the physician/ prescriber response that the order had been updated. The second pharmacy recommendation regarding the Voltaren Gel made on 02/24/24 was not addressed by an advanced level provider until 04/18/24. The advanced level provider addressing that recommendation indicated it was noted under the physician's/ prescriber's response. On 10/03/24 at 12:45 P.M., an interview with the facility's Director of Nursing (DON) revealed she was not the facility's DON, when Resident #6's pharmacy recommendations were made on 01/22/24 and again on 02/24/24. She confirmed the recommendations made on 01/22/24 and 02/24/24 were not responded to timely, as they were not addressed until 04/17/24 and 04/18/24 respectively. She stated, since she has been the DON, she gave the pharmacy recommendations to the physician or nurse practitioner within two days when they visited. If she did not see them within two days of the pharmacy recommendation being made, she would call them on the phone to ensure they were addressed timely. (continued on next page)

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	10/11/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy on Consultant Pharmacist Reports (dated November 2021) revealed the consultant pharmacist worked with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' medication therapies were communicated to those with authority and/ or responsibility to implement the recommendations, and were responded to in an appropriate and timely fashion. Comments and recommendations concerning medication therapy were to be communicated in a timely fashion. The timing of those recommendations should enable a response prior to the next medication regimen review. If the prescriber that did not respond was also the Medical Director, the DON and the Administrator would address the requirements with the Medical Director and/ or pursue more formal actions if necessary to facilitate compliance.

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	10/11/2024

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 0757 Level of Harm - Minimal harm or potential for 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** 28704 Based on medical record review, National Library of Medicine drug review and interview, the facility failed to ensure residents were free from unnecessary medications. This affected one resident (#17) of five residents reviewed for unnecessary medications. The census was 61. Findings include: Medical record review revealed Resident #17 was admitted on [DATE] with diagnoses including anxiety disorder, alcohol cirrhosis, gastroesophageal reflux disease, depression, bilateral sensorineural hearing loss and unspecified dementia. Review of the electronic Physician Orders (dated 04/04/24) revealed Resident #17 was administered neomycin 500 milligrams twice a day for an infection. Review of the Hospice IDG Comprehensive Assessment and POC Update Report dated 05/23/24 neomycin 500 milligrams (mg) twice a day for management of disease symptoms. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #17 was cognitively intact for daily decision-making, had no infections and was receiving antibiotics. Review of Resident #17's medical record revealed no documentation or appropriate indication of continued use for neomycin (broad spectrum antibiotic). Review of the 360 Care Audiology Visit Note (dated 05/31/24) revealed Resident #17's tympanic membrane was perforated in the left ear and she had mild sloping to profound sensorineural hearing loss in both ears. Review of the electronic Physician Order (dated 09/30/24) revealed neomycin 500 mg was being administered twice a day as a prophylactic. Review of the electronic Physician Orders revealed a Black Box Warning for Neomycin. The warning indicated a systemic absorption of neomycin occurs following oral administration, and toxic reactions may occur. Patients treated with neomycin should be under close clinical observation because of the potential toxicity associated with the use of neomycin. Neurotoxicity (including ototoxicity) and nephrotoxicity following the oral use of neomycin sulfate have been reported, even when used in recommended doses. The potential for nephrotoxicity, permanent bilateral auditory ototoxicity, and sometimes vestibular toxicity, is present in patients with healthy renal function when treated with higher doses of neomycin or for longer periods than recommended. Serial, vestibular and audiometric tests, as well as tests of renal function, should be performed (especially in high-risk patients). The risk of nephrotoxicity and ototoxicity is greater in patients with impaired renal function. Ototoxicity is often delayed in onset, and patients developing cochlear damage will not have symptoms during therapy to warn them of developing eighth nerve destruction, and total or partial deafness may occur long after neomycin has been discontinued. Other factors which increase the risk of toxicity are advanced age and dehydration. (continued on next page)

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	10/11/2024

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #17's medical record revealed no care plan for the use of neomycin. On 10/01/24 at 8:40 A.M., interview with Resident #17 stated she was sure why she was taking an antibiotic. On 10/07/24 at 4:09 P.M., interview with the Director of Nursing (DON) verified Resident #17 had been receiving neomycin 500 milligrams twice a day since 2022 as ordered by the hospice physician. On 10/10/24 at 1:32 P.M., electronic interview with the DON revealed she was not sure if the physician was aware of Resident #17's diagnosis of left ear perforated tympanic membrane and mild sloping to profound sensorineural hearing loss in both ears. Review of the National Library of Medicine : Neomycin drug guidance (dated 11/12/23) revealed Neomycin is primarily used to treat and manage hepatic coma and perioperative prophylaxis. Neomycin belongs to the aminoglycosides group of antibiotics, which functions by inhibiting bacterial protein synthesis, resulting in a bactericidal effect primarily against gram-negative bacteria. FDA-Approved indications of use include hepatic coma or portal-systemic encephalopathy: Neomycin is used to manage hepatic encephalopathy, including hepatic coma. This drug is typically indicated for treating acute cases of hepatic encephalopathy, as opposed to chronic cases, due to its adverse effect profile. Colorectal surgical (perioperative) prophylaxis. Off-Label Use to treat constipation-predominant irritable bowel syndrome When administered orally, neomycin exhibits limited absorption into the systemic circulation. Neomycin use carries a significant risk of hearing loss due to ototoxicity. This complication is usually bilateral and associated with cochleotoxicity, resulting in high-frequency sensorineural hearing loss. At the earliest indication of changes in hearing, healthcare providers should promptly cease neomycin therapy to mitigate the extent of cochlear damage. Contraindications included according to the American Academy of Otolaryngology guidelines, neomycin otic formulation should be avoided in patients with a perforated tympanic membrane. Audiometric assessments should be conducted in patients undergoing neomycin treatment. Any indications of renal or otologic impairment necessitate the prompt cessation of the medication.

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	10/11/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704 Based on observation, medical record review, policy review, manufacturer guideline review and interview, the facility failed to ensure medication administration error rates are not 5 percent or greater. The facility had 30 opportunities for error with three observed errors resulting in a medication error rate of 10%. This affected one resident (#12) of two residents observed for medication administration. The census was 61. Findings include: Medical record review revealed Resident #12 was readmitted to the facility on [DATE] with diagnoses including hypertensive heart disease with heart failure, type 2 diabetes mellitus, ulcerative colitis, and rheumatoid arthritis. Review of Resident #12's electronic Physician Orders dated October 2024 revealed morning medications to administer included: aspirin chewable 81 milligrams (mg) daily, colace (stool softener) 100 mg one capsule daily and basaglar insulin 17 units via kwikpen. On 10/02/24 at 7:31 A.M., observation revealed Licensed Practical Nurse (LPN) #325 prepared medication for Resident #12 including aspirin EC (enteric coated) 81 milligrams (mg), colace 100 mg two capsules and basaglar insulin via kwikpen 17 units subcutaneous. During the observation, LPN #325 verified the above including not priming the insulin kwikpen. On 10/02/24 at 9:20 A.M., interview with the Director of Nursing verified medications were to be administered as ordered including the resident was ordered aspirin chewable 81 milligrams and was administered aspirin EC and the insulin kwikpen required priming and the kwikpen was not primed before administering the medication. Review of the policy: Preparation and General Guidelines (dated November 2021) revealed medications were to be administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Right resident, right drug, right dose, right route and right time are applied for each medication being administered. Review of the manufacturer Basaglar kwikpen insulin glargine injection, solution (revised November 2022) revealed it was important to prime the pen before each injection so that it will work correctly. If you do not prime before each injection, you may get too much or too little insulin.

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	10/11/2024

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review and staff interview, the facility failed to ensure laboratory tests were completed as ordered. This affected one resident (#6) of five residents reviewed for unnecessary medications. Findings include: Review of Resident #6's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included adult-onset diabetes mellitus. Review of Resident #6's physician's orders revealed the resident had an order to have a Hemoglobin A1C (a blood test that measures a person's average blood sugar level over the past two to three months) every three months. The order originated on 06/25/24. The order was to start on the 25th with directions to make sure, after it was obtained that time, that it was back in the orders to be done again in three months. The resident was receiving Metformin (an oral hypoglycemic) 500 milligrams (mg) by mouth twice a day. She was also receiving Novolog (fast acting insulin to lower blood glucose levels) per a sliding scale. Resident #6's medical record was absent for evidence of a Hemoglobin A1C being obtained on 09/25/24. The last Hemoglobin A1C was obtained on 06/26/24 and was elevated at 6.8% (normal ranges 4 to 5.6%). Findings were verified by the Director of Nursing (DON). On 10/03/24 at 1:49 P.M., an interview with the DON revealed she could not find any evidence of Resident #6 having a Hemoglobin A1C done on 09/25/24 as ordered. She confirmed a physician's order was written on 06/25/24 for a Hemoglobin A1C to be done every three months on the 25th. She further confirmed the last one that had been done was on 06/26/24 and there should have been another Hemoglobin A1C done on 09/25/24, but was not. She indicated the Hemoglobin A1C was not drawn as it did not get put into their lab book for it to be drawn by the lab technician. She contacted the physician and made him aware it was not done and they were just going to get it drawn in the morning.

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	10/11/2024

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on record review, observations, and interviews, the facility failed to acquire dental services for a resident with a broken, dark colored tooth. This affected one resident (#36) of one resident reviewed for dental services. The facility census was 61. Findings included: Record review revealed Resident #36 was admitted to the facility on [DATE] with diagnoses including wandering, schizophrenia, and dementia. Review of an admission minimum data set completed on 06/07/24 revealed Resident #36 had severely impaired cognition, had no behaviors, and had no dental concerns. Review of guardianship paperwork revealed Resident #36 has had a guardian of person since 08/24/21. Review of an admission assessment dated [DATE] revealed Resident #36's oral status was within normal limits. Review of a care plan dated 07/09/24 revealed there was no oral/dental care plan. Review of a social services note dated 06/12/24 at 11:09 A.M. by Corporate Social Worker revealed she attempted to contact Resident #36's guardian who did not answer. A voicemail was left offering ancillary services, but no call back was received. Resident #36 was spoken with and offered ancillary services and stated she was not in need of services. Resident #36 was made aware she can request services at any time if needed. Observation on 09/30/24 at 1:48 P.M. revealed Resident #36 had a broken front tooth which appeared to be dark in color. Interview on 10/01/24 at 1:33 P.M. with Resident #36 revealed she lost a tooth but doesn't know what happened. Resident #36 was confused at the time of the conversation. Interview on 10/02/24 at 4:52 P.M. with Director of Nursing (DON) confirmed the guardian was not contacted to offer dental services and if Resident #36 had a legal guardian in place, she would not be able to consent to or decline services. Interview on 10/03/24 at 11:01 A.M. with Resident #36 revealed her teeth do not bother her or cause her pain. Interview on 10/03/24 at 4:11 P.M. with the DON revealed Resident #36's guardian was court appointed, and the guardian was not contacted again to offer ancillary services until the survey team brought the concern to their attention. The DON also confirmed Resident #36 did not have a dental/oral care plan.

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	10/11/2024

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985 Based on review of the facility assessment and interviews, the facility failed to have a comprehensive facility assessment to address the care needs of all units in the facility. This had the potential to affect seven residents (#33, #36, #44, #46, #48, #51, and #259) of seven residents residing on the secured memory care unit. The facility census was 61. Findings included: Review of a facility assessment dated [DATE] revealed there was no specific memory care staffing plans, training programs (apart from the required annual 12 hours of training), or mention of the facility containing a secured memory care unit. Interview on 10/08/24 at 4:19 P.M. with Director of Nursing (DON) confirmed there was no mention of the facility having a secured memory care unit, specialized staffing requirements or training for memory care on the facility assessment.

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	10/11/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, interview with staff, and review of the facility policy, the facility failed to wear personal protective equipment (PPE)in the room of a resident that required enhanced barrier precautions (EBP), failed to ensure the infection control log was updated, and failed to follow appropriate infection control practices during a pressure ulcer dressing change for a resident. This affected two residents (#6 and #15) of six residents reviewed for infection control. This had the potential to affect all 61 residents in the facility. Findings included: 1a. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE]. Diagnoses included respiratory failure, diabetes, chronic heart failure, atherosclerotic heart disease, urinary tract infection, hypertension, allergic rhinitis, schizophrenia, edema, benign prostatic hyperplasia, neuromuscular dysfunction of the bladder, and retention of urine. Review of the October 2024 physician's orders revealed Resident #15 had an order for a Foley (urinary) catheter and enhanced barrier precautions: use a gown and gloves for high-contact resident care including dressing, bathing, showering, transfers, hygiene care, changing linens, changing briefs, assisting with toileting, dressing changes, and care of any device. Review of the modification to the Annual Minimum Data Set assessment dated [DATE] revealed Resident #15 had intact cognition and had an indwelling catheter. Observation of catheter care on 10/07/24 at 2:20 P.M. revealed State tested Nursing Assistant (STNA) 305 put on gloves and provided catheter care to Resident #15 without putting an isolation gown on. There was a sign on the wall and an isolation cart outside of the room in the hallway indicating Resident #15 was in EBP. On 10/07/24 at 2:21 P.M. an interview with STNA #305 confirmed she had not worn an isolation gown while providing catheter care for Resident #15 who required EBP. Review of the facility policy titled, Enhanced Barrier Precautions, (dated 11/30/23) revealed EBP was an infection control intervention designed to reduce the transmission of multi-drug resistant organisms (MDRO). EBP were used for residents with wounds, indwelling medical devices like central lines, urinary catheters, feeding tubes, tracheostomies and ventilators. Gowns and gloves were to be used for high contact resident care activities for residents known to be colonized or infected with MDRO as well as those with increased risk of MDRO acquisition. b. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE]. Diagnoses included respiratory failure, diabetes, chronic heart failure, atherosclerotic heart disease, urinary tract infection, hypertension, allergic rhinitis, schizophrenia, edema, benign prostatic hyperplasia, neuromuscular dysfunction of the bladder, and retention of urine. Review of the physician's orders revealed Resident #15 had orders for cefdinir 300 milligrams twice daily for seven days for urinary tract infection dated 05/18/24. (continued on next page)

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	10/11/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the May 2024 infection control tracking log revealed no documentation of Resident #15 having an infection or being on an antibiotic on 05/18/24. Review of the physician's orders revealed Resident #15 had orders for Rocephin one gram intravenously for one dose dated 06/06/24, Rocephin one gram intramuscularly once daily for two days for elevated white blood cells, change in mental status and sepsis dated 06/07/24, and ampicillin 500 milligrams three times daily for five days for a urinary tract infection dated 06/12/24. Review of the June 2024 infection control tracking log revealed no documentation of Resident #15 having an infection or being on an antibiotic 06/06/24 and 06/12/24. Review of the modification to the Annual Minimum Data Set assessment dated [DATE] revealed Resident #15 had intact cognition and had an indwelling catheter. On 10/07/24 at 11:18 A.M. an interview with Registered Nurse (RN) #350 revealed she just started as the Infection Preventionist in September 2024 and she did not know why Resident #15 was not on the infection control tracking log for May and June 2024 but she would look into it. On 10/07/24 at 11:48 A.M. an interview with RN #350 revealed Resident #15 not being placed on the May and June 2024 infection control tracking log was an oversight. She confirmed the infection control tracking log was not accurate with complete infection control documentation. Review of the facility policy titled, Infection Criteria, (dated 11/30/23) revealed the infection log would be updated regularly to identify clusters, outbreaks, and other unusual infection patterns. A review would be initiated by the Infections Control Preventionist or designee when an antibiotic was initiated. 28923 2. Review of Resident #6's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included multiple pressure ulcers of various stages to multiple sites of her body. She also had the presence of a left artificial hip joint and a history of Methicillin Staphylococcal Aureus (MRSA) and severe sepsis with septic shock. Review of Resident #6's physician's orders revealed she had treatment orders in place to her pressure ulcers on her left buttock, sacrum, and left heel. She also had a treatment order in place for a boil to her left hip. The order for the left buttock and sacral pressure ulcer was to cleanse the wounds with wound cleanser, pat dry, clean with soap and water, apply Prisma (a collagen and silver dressing) first, then apply Dakin's moist gauze second, cover with an ABD pad and secure with hypafix one time a day and as needed (prn). The treatment order for the left hip was to cleanse the boil with wound cleanser, pat dry, apply Prisma then Dakin's soaked gauze and cover with bordered gauze every day and prn. On 10/07/24 at 2:28 P.M., an observation was made of Resident #6's wound care to the pressure ulcers she had to her left buttock, sacrum, and left heel, as well as to the boil she had on her left hip. The treatment was completed by Licensed Practical Nurse (LPN) #315 and she was assisted by Certified Nursing Assistant (CNA) #340. Resident #6 was under enhanced barrier precautions due to her wounds. (continued on next page)

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	10/11/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse and the CNA donned a gown before entering the resident's room. Treatment supplies had already been set up on the resident's bedside table prior to the observation being made. The resident was lying in bed and was assisted to a right side lying position by CNA #340, after the aide donned gloves. The nurse was observed to wash her hands and donned gloves prior to removing the old dressings the resident had over her left hip boil and a large ABD dressing the resident had over the two pressure ulcers on her left buttock and sacrum. She used the same gloved hands to remove both those dressings over the three different areas without removing her gloves and performing hand hygiene. The outer dressings and the packing were removed from all three of those areas. She then proceeded to cleanse the wounds to the sacrum and left buttock with wound cleanser before moving on to cleansing the area to the left hip. She was then observed to go into the resident's bathroom with washcloths she was carrying in her same gloved hands that were used to remove the resident's old dressings. She used the sink in the bathroom to get the washcloths wet. Upon returning to the resident's bedside, she used soap from a bottle to apply to the wet wash cloths and proceeded to clean the resident's pressure ulcers to her sacrum and left buttock. She then used another wet wash cloth with soap applied to clean the resident's left hip wound (boil). She then rinsed all three areas using wound cleanser, after she washed them with the soap and water. She then pat dried the left hip wound before she moved on to pat dry the sacrum and the left buttock. She was noted to remove her gloves for the first time donning a new pair of gloves without performing any type of hand hygiene. She did not wash her hands nor did she use hand sanitizer before she put her new disposable gloves on. She was then observed to apply Prisma to the wound beds of the pressure ulcers on the resident's sacrum and left buttock. She then soaked a gauze dressing with Dakin's solution and placed it over top of the Prisma that had been placed in the wound bed of the sacral wound and the left buttock wound. She applied a large ABD pad over top of both the sacral wound and the left buttock wound. As she was securing the edges of the ABD pad to the resident's skin with hypafix tape, the moistened gauze that was over the Prisma had fallen out onto a towel she had placed under the resident's right hip to catch any of the drainage from the wounds when she was washing and rinsing them. The nurse picked the moistened gauze back up and re-applied it to the wound bed. She then held the ABD over the wounds on the sacrum and left buttock while she secured the bottom edge of the ABD pad with the hypafix tape. She then proceeded to apply the Prisma to the left hip wound. She followed that by a gauze that had been moistened with Dakin's solution. She then covered the left hip wound with a border dressing and then dated the two dressings using a Sharpie. (continued on next page)

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	10/11/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The left heel was the last area that she performed a treatment on. She removed the gloves she had on when she completed the treatments to the resident's left hip boil and the pressure ulcers to the sacrum and the left buttock. She donned a new pair of disposable gloves without performing any type of hand hygiene when changing gloves. She cleansed her scissors she had previously used to cut the Prisma to fit in the resident's other three areas using wound cleanser. She removed the old dressing the resident had over her left heel and laid the dressing and the Kerlix wrap on the bed as she picked the packing from the wound bed. She then disposed of the old dressing she had previously removed and laid on the resident's bed along with the packing that had just been pulled out into a small plastic bag she had on the floor at the bedside. A small piece of packing that had been in the left heel wound and had some serosanguineous drainage on it was overlooked and was left on top of the resident's bed sheet. The nurse was then observed to touch hardware on front of the dresser to obtain additional dressing supplies using her same contaminated gloved hands that she previously used to remove the old dressing and packing. She cleansed the wound to the left heel with wound cleanser. She then went to the resident's bathroom to use the sink to get the washcloth wet. She returned to the resident's bedside and added soap from a bottle onto the wet washcloth so she could wash the resident's wound. She used the wet wash to wash the resident's wound on her left heel. The nurse then rinsed the resident's left heel using saline wound wash and then patted it dry. The left heel pressure ulcer was unstageable as the wound bed was covered with eschar. She cut out a piece of Prisma and Meglisorb AG to apply to the wound bed. A non-woven gauze was then put over the left heel and then she wrapped it with Kerlix. The nurse was noted to lean down and over the resident's bed to better visualize the resident's wound on her left heel when she was applying the Prisma and the Meglisorb AG. Her head and her hair was noted to be in contact with the resident's bed sheet in the same area where she had previously been noted to lie the wrap and old dressing on the bed as she removed the packing. She then put her wound supplies away in the resident's drawers to her dresser that was next to the bed. The CNA assisted the resident with placing her heels up on a wedge cushion and putting heel protectors on her. The CNA then covered the resident up with the small piece of packing still in her bed that had been previously overlooked by the nurse when she discarded the rest of the old dressing supplies. She then removed her personal protective equipment (PPE) before leaving the room and went down to the hall to the central bath to dispose of her plastic bags. She did not wash her hands until she arrived at the central bath to dispose of her trash from the treatments she had completed. On 10/07/24 at 2:56 P.M., an interview with LPN #315 confirmed she provided wound care to all three areas Resident #6 had on her left hip, left buttock, and sacrum at the same time. She acknowledged by doing all three wound treatments at the same time, it could cause cross contamination if one of the three wounds had been infected. She also confirmed she did not change her gloves at appropriate times throughout the treatment process and did not perform hand hygiene between glove changes. Review of the facility's policy on Clean Dressing Changes (last reviewed on 11/30/23) revealed the purpose of the policy was to protect the wound, prevent irritation, prevent infection and the spread of infection, and to promote healing. The procedure included the need to removing the soiled dressings and discarding them in a plastic bag. They were then to dispose of their gloves in the plastic bag and wash their hands or use hand sanitizer. They were then to put on a second pair of gloves before cleaning the wound. After cleaning the wound, they were then instructed to dispose of the second pair of gloves in the plastic bag, perform hand hygiene and put on a third pair of disposable gloves. They were then to apply the dressing and secure with tape. They were then to remove their gloves and discard with all unused supplies in a plastic bag. They were then directed to wash hands or use hand sanitizer before assisting the resident to a comfortable position with the call light left in reach.