

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER Legacy Centerville		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Alex Bell Road Centerville, OH 45459	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on observation, staff interview, record review, and policy review, the facility failed to ensure a resident was being transported in a wheelchair in a dignified manner. This affected one (#34) of four residents sampled for dignity. The facility census was 96. Findings include: Review of the medical record revealed Resident #34 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, type II diabetes, stage II chronic kidney failure, unspecified bipolar disorder, and paranoid schizophrenia. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 had moderately impaired cognition, had no behaviors, did not wander , and did not reject care. Review of care plan dated 12/10/23 revealed Resident #34 had an Activities of Daily Living (ADL) Self-care/mobility/functional ability/performance deficit. Interventions included limited to extensive assistance with bathing, and additional staff assistance with ADL's as needed to ensure needs were met. Observation on 03/24/25 at 2:14 P.M., revealed Certified Nurse's Assistant (CNA) #8 pulled Resident #34 backwards in a shower chair in the hallway from the resident's room to the shower room. Interview on 03/24/25 at 2:14 P.M., with CNA #8 verified she pulled Resident #34 backwards in shower chair and stated she was unaware it was a dignity issue. Review of policy titled Dignity dated February 2021, revealed demeaning practices and standards of care that compromised dignity were prohibited.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on medical record review, staff interview, and policy review, the facility failed to assess residents with new diagnoses and medications to treat serious mental illness for eligibility for Level II pre-admission screening and resident review (PASARR) services. The affected four (#19, #34, #55, And #63) of five residents sampled for PASARR. The facility census was 96. Findings include: 1. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, type II diabetes, stage II chronic kidney failure, unspecified bipolar disorder, and paranoid schizophrenia. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident # 34 had moderately impaired cognition, had no behaviors, did not wander , and did not reject care. Review of care plan dated 12/10/2023 revealed Resident # 34 had an Activity of Daily Living (ADL) Self-care/mobility/ functional ability/performance deficit. Interventions included limited to extensive assistance with bathing, and additional staff assistance with ADL's as needed to ensure needs were met. Review of PASARR dated 01/09/23 revealed Resident #34 was assessed and had anxiety and depression and had no antipsychotic. antidepressant, anti-anxiety, or mood stimulator medications ordered. Review of the medical record revealed Resident #34 was diagnosed with paranoid schizophrenia and borderline personality disorder on 01/06/23 and unspecified bipolar disorder on 11/28/22. Review of the medical record revealed Resident #34 had active orders for psychotropic medications including Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 1 capsule by mouth two times a day for depression; buspirone HCl Oral Tablet 10 milligrams (mg), Give 1 tablet by mouth one time a day for anxiety; buspirone HCl Oral Tablet 15 mg, Give 1 tablet by mouth one time a day for anxiety; Quetiapine Fumarate Oral Tablet 100 mg, Give 1 tablet by mouth one time a day for depression and Give 2 tablet by mouth at bedtime for depression: and Sertraline HCl Oral Tablet 100 mg (Sertraline HCl) Give 1 tablet by mouth one time a day for anxiety. Interview on 03/26/25 at 10:18 A.M., Business Office Manager (BOM) #138 verified she had not completed a significant change PASARR after Resident #34 had new diagnoses and medications were initiated to treat serious mental illness. BOM #138 stated she was not clinical and did not attend clinical staff meetings where this information was shared. 2. Review of the medical record revealed Resident #55 was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, unspecified chronic kidney disease, unspecified anxiety disorder, unspecified convulsions, and delusional disorders. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent Minimum Data Set (MDS) assessment dated revealed Resident #55 had moderately impaired cognition, had occasional verbal behaviors, did not wander, and did not reject care. Review of PASARR Screening dated 01/22/21 revealed Resident #55 had no diagnoses or active medications orders which indicated Serious Mental Illness (SMI). Review of the medical record revealed Resident #55 was diagnosed with delusional disorders on 03/08/21, Major depressive disorder, single episode, severe with psychotic features on 11/12/24, and unspecified anxiety disorder on 02/23/21. Review of the drug summary revealed Resident #55 had active orders for psychotropic medications including: Ativan 0.5 mg by mouth twice daily (03/08/2025), Buspirone 10 mg one tablet once daily and two tablets once daily (10/30/24), Duloxetine 60 mg by mouth once daily (05/13/24), and Duloxetine 20 mg by mouth once daily (10/30/24). Interview on 03/26/25 at 9:56 A.M., with BOM #138 stated if nursing told her there had been a change in diagnosis or new medications she would do a new PASARR, but she was not clinical and would not otherwise know to do one. BOM #138 verified Resident # 55 had no new PASARR completed since admission. 37447 3. Review of the medical record for Resident #19 revealed she was admitted [DATE] with diagnoses to include type 2 diabetes, vascular dementia, chronic obstructive pulmonary disease, hyperlipidemia, hypertension, hypothyroidism, gastro-esophageal reflux disease, dysphagia, delusional disorder and schizoaffective disorder. Review of her Minimum Data Set (MDS) annual assessment dated [DATE] revealed her Brief Interview of Mental Status (BIMS) score was 10 indicating she was moderately cognitively impaired. She required set-up for eating and moderate assistance for her activities of daily living (ADLs). Review of her Pre-Admission Screening and Resident Review (PASARR) dated 07/21/18 revealed a diagnosis of mood disorder. Review of her current diagnosis list revealed a diagnosis of delusional disorder dated 07/15/22. Interview on 03/26/25 at 10:00 A.M., with the Business Office Manager (BOM) #138 verified the diagnosis of delusional disorder was not documented on the PASARR for Resident #19 and an updated PASARR should have been completed to include the delusional diagnosis. BOM #138 stated she was not a clinical staff person so did not attend the clinical meetings and new diagnosis were not relayed to her. 4. Review of the medical record for Resident #63 revealed she was admitted [DATE] with diagnoses to include chronic obstructive pulmonary disease, encephalopathy, mood disorder, schizoaffective disorder, anxiety disorder, morbid obesity, hypertension, carpal tunnel syndrome, gastro-esophageal reflux disease, peripheral vascular disease, and bariatric surgery status. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of her Minimum Data Set (MDS) quarterly dated 01/24/25 revealed her Brief Interview of Mental Status (BIMS) score was 15 indicating she was cognitively intact. She required set-up with eating and supervision with activities of daily living (ADLs). Review of her Pre-Admission Screening and Resident Review (PASARR) dated 10/31/23 revealed she took anti-psychotic and anti-depressant medication. Review of her current physician list revealed an anti-anxiety medication Buspar 5 milligrams (06/03/24) and a mood stabilizer Depakote 125 milligrams twice daily (05/12/24) which were not documented on her PASARR. Interview on 03/26/25 at 10:00 A.M., with the Business Office Manager (BOM #138) verified the anti-anxiety and mood stabilizing medication was not reflected on her PASARR and should have been added. BOM #138 stated she was not a clinical staff person so did not attend the clinical meetings, and new medications were not relayed to her. Review of the undated policy titled, PASARR (Pre-Admission Screening and Resident Review) revealed the policy was to ensure each resident was screened for a mental disorder or intellectual disability prior to admission and that residents identified with those diagnoses are evaluated and received care and services in the most integrated setting appropriate to their needs. If a resident's condition changed significantly after admission and there was reason to believe the resident may now have newly developed symptoms of a mental disorder or intellectual disability, the facility must reassess and if appropriate, re-submit the screening and coordinate with the state-designated authority to ensure a Level II PASARR is completed in a timely manner.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492 Based on record review, staff interviews; resident interviews, and policy review, the facility failed to ensure quarterly care conferences were conducted with residents and resident representatives. This affected three (#16, #41, and #73) of three residents sampled for care planning. The facility census was 96. Findings include: 1. Review of the medical record revealed Resident # 41 was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, major depressive disorder, morbid obesity, unspecified gout, and chronic pain syndrome. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #41 was cognitively intact, had no behaviors, did not wander, and did not reject care. Review of care conference note dated 03/07/23 revealed Resident #41 and his father (via telephone) had a care conference with the social worker, dietary, and activity staff in attendance. Interview on 03/24/25 at 2:02 P.M., with Resident #41 stated he had not had a care conference in at least six months. Interview on 03/26/25 at 4:48 P.M., with the Director of Nursing (DON) verified Resident #41 has not had a care conferences since 03/07/24. 2. Review of the medical record revealed Resident #16 was admitted to the facility on [DATE]. Diagnoses included type II diabetes, obesity, and end stage renal disease with dependence on dialysis. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was cognitively intact, did not wander, and did not reject care. Interview on 03/24/25 at 11:48 A.M., with Resident #16 stated it had been at least four to five months since his last care conference. Review of Care Conference Note dated 10/23/24 revealed Resident #16 met with Social Worker #180 and discussed care plans, dietary orders, and concerns with care. Interview on 03/26/25 at 4:48 P.M., with the DON verified Resident #16 has not had a care conferences since 10/23/24. 25908 3. Review for Resident #73's medical record revealed an admitted [DATE]. Diagnoses included aphasia, diabetes, anxiety and stroke. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was severely cognitively impaired. The resident required extensive assistance for dressing, toileting, and personal hygiene. Review of the care conference notes revealed care conferences were held 03/14/24, 05/23/24 and 08/06/24 with family in attendance. No further care conferences were noted. Interview on 03/26/25 at 4:48 P.M., with the Director of Nursing (DON) revealed Resident #73 did not have any more care conferences. Review of the policy titled, Resident Participation - Assessment/Care Plans, dated 02/2021, revealed the facility staff held quarterly care planning meetings at times when residents were functioning at their best and family members/representatives could attend.		

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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** 46613 Based on medical record review, observation, staff interview, and family interview, the facility failed to ensure gastrostomy tube dressings were changed as ordered. This affected one (#301) residents of four residents reviewed for wound care. The facility census was 96. Findings include: Review of the medical record for Resident #301 revealed an admitted [DATE], with medical diagnoses of aftercare following surgery for neoplasm, squamous cell cancer of skin on face, encounter for attention to gastrostomy, malignant neoplasm of mouth, dysphagia, and anemia. Review of the medical record for Resident #301 revealed an admission evaluation, dated 03/11/25, which indicated Resident #301 was cognitively intact and admitted with cancer biopsy site to right jaw, and a gastrostomy tube (g-tube). Review a physician order dated 03/12/25 revealed to cleanse g-tube site with normal saline and cover with a t-drain dressing daily. Review of the March 2025 Treatment Administration Record (TAR) which had documentation to support Resident #301's g-tube care was completed 03/12/25 to 03/25/25. Interview with observation on 03/24/25 at 2:23 P.M., with Resident #301's family stated staff were not changing Resident #301's g-tube dressing as ordered. Observation revealed Resident #301's family pulled up Resident #301's t-shirt and revealed a dressing to Resident #301's g-tube site dated 03/21/25. Interview on 03/24/25 at 2:26 P.M., with Licensed Practical Nurse (LPN) #206 confirmed the g-tube dressing for Resident #301 was dated 03/21/25 and that the dressing had not been changed daily as ordered. This deficiency represents non-compliance investigated under Complaint Number OH00162757.		

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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** 42492 Based on medical record review, observation, staff interview, resident interview, and review of policies, the facility failed to accurately assess a wound and timely initiate a treatment for new skin area. This affected one (#41) residents of four residents reviewed for wound care. The facility census was 96. Findings include: Review of the medical record revealed Resident # 41 was admitted to the facility on [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, major depressive disorder, morbid obesity, unspecified gout, and chronic pain syndrome. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident # 41 was cognitively intact, had no behaviors, did not wander, and did not reject care. Review of care plan dated 06/17/24 revealed Resident # 41 had potential for alteration in skin integrity related to incontinence. Interventions included diet as ordered, lotion for dry skin, Braden scale quarterly and as needed, avoid elevating head of bed greater than 30 degrees when in bed, keep lines dry and wrinkle free, monitor skin folds for signs of irritation, pressure redistributing devices as indicated, offload heels as tolerated, monitor nutritional status, turn and reposition as needed, and position with pillows as needed for support. Review of progress note dated 03/23/25 at 11:50 A.M. revealed Resident #41 asked Licensed Practical Nurse (LPN) #21 to check his upper thigh under his buttocks and noted a wound which measure 0.1 cm x 0.1 cm. The nurse cleansed the area with soap and water, applied cream, and applied a 3 x 3 gauze pad. Review of Wound assessment dated [DATE] revealed Resident #41 had a new abrasion in-house acquired, no location documented, which measured 0.4 cm x 1 cm x 0.6 cm with 100% granulation. Review of the medical record revealed Resident #41 had an order dated 03/25/25 to start 03/27/25 for wound care to the left gluteal fold: clean and cover with bordered foam three times a week and as needed every day shift every Tuesday, Thursday, and Saturday. Interview on 03/24/25 at 2:07 P.M., with Resident #41 stated he had an open area on back of his left thigh that had been there one week. He was not sure when or how he got it. Resident #41 stated it felt like something was pinching his thigh. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/26/25 at 7:04 A.M., with LPN #21 stated she was giving medications and Resident #41 stated he felt something back there. The nurse rolled him over and saw a reddened area on the left thigh that looked like shearing, like a rug burn, where the skin was starting to break. The nurse stated when a new area was found, the nurse measured it and put a note in risk management for the wound team to check it out. LPN #21 stated she notified the wound manager and left a note in the book for the nurse practitioner. The LPN #21 stated she did not call the on-call practitioner to get a new order for wound care because she had looked at it, and the wound was not bleeding or deep. Interview on 03/26/25 at 7:55 A.M., with the DON stated when a nurse finds a new area, it goes into risk management, call the provider, get a new order, place new order in, and the wound nurse would see on next wound round day. Interview on 03/26/25 at 11:05 A.M., with Resident # 41 stated after the nurse put a dressing on it Sunday night, no one came and looked at the wound or changed the dressing placed on 03/23/25, until Tuesday morning, 03/25/25, when the wound team came in. Resident #41 stated he was unaware of any dressing currently in place. Observation on 03/26/25 at 1:03 P.M., revealed LPN #26 performed incontinence care. Resident #41 had an open area to left buttock/anterior thigh with no dressing in place approximately the size of a nickel. The skin surrounding the wound was covered with white paste. LPN #26 cleansed the peri-area with wipes, applied zinc paste to the skin surrounding the wound, placed a clean brief, positioned the resident in bed with pillows for comfort, doffed her gloves, and sanitized her hands before leaving room. During a concurrent interview, LPN #26 stated she normally did not have this hall. LPN #26 stated she was unaware Resident #41 had an open area or had a wound treatment in place. Interview on 03/26/25 at 2:44 P.M., with Registered Nurse (RN) #173 stated Resident # 41 was seen on weekly wound rounds for vascular ulcers on his lower extremities. There was a new wound on his buttocks. RN #173 verified the team became aware of the wound on Monday 03/24/25, but did not see it until wound rounds on Tuesday, 03/25/25. The RN stated for any new wound, nurses were expected to fill out a risk management and call the on-call to notify and receive new orders. RN #173 verified staff identified Resident #41 had a wound on 03/23/25 and the wound did not have an active treatment order placed until 03/25/25. Review of policy titled, Pressure Injury Risk Assessment, dated March 2020, revealed if a new skin alteration was noted, staff documented characteristics of the wound, provider notification, new orders for wound care, revision(s) to the care plan, and family notification. Review of the policy titled, Pressure Ulcers/Skin Breakdown- Clinical Protocol, stated the physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressing, (occlusive, absorptive, etc.) and application of topical agents if indicated for type of skin alteration. This deficiency represents non-compliance investigated under Complaint Number OH00163742 and OH00162757.		

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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** 46613 Based on medical record review, staff interviews, and policy review, the facility failed to investigate a resident elopement. This affected one (#22) of one resident reviewed for elopement. The facility census was 96. Findings included: Review of the medical record for Resident #22 revealed an admitted [DATE] with medical diagnoses of major Depression, diabetes mellitus, congestive heart failure, history of suicidal ideations, and hypertension. Review of the medical record for Resident #22 revealed a Minimum Data Set (MDS) assessment, dated 01/27/25, which indicated Resident #22 had severely impaired cognition and required set-up assistance with eating, toileting, bathing, bed mobility and transfers. The MDS did not indicate Resident #22 had behaviors. Review of the medical record for Resident #22 revealed a physician order dated 02/18/25 for wanderguard to check placement to left ankle and function every shift. Review of the medical record for Resident #22 revealed an elopement care plan dated 01/10/25 which stated Resident #22 was at risk for elopement/exit seeking/wandering related to altered cognitive status, exit seeking behaviors, expresses feeling unhappy with placement, and unsafe wandering. An intervention was to check wanderguard placement every four hours. Review of the medical record for Resident #22 revealed an elopement assessment dated [DATE] which indicated Resident #22 was at risk for elopement. Review of the medical record for Resident #22 revealed documentation on 01/10/25 Resident #22 was hospitalized at a psychiatric hospital for suicidal ideation, on 02/07/25, Resident #22 was hospitalized due to increased aggressive behaviors, exit seeking and cutting off his wanderguard, and on 02/19/25, Resident #22 was hospitalized for verbalizing suicidal ideations. Review of the medical record revealed a nurses note dated 03/02/25 at 11:33 A.M., stated Resident #22 voiced he was wanted to leave the facility and threatened to go play in traffic. The note stated the police were notified and deemed not suicidal by the police. The note continued to state Resident #22 later went on leave of absence (LOA) with his sister and upon return Resident #22 would continue one-on-one supervision. Review of the nurses note, dated 03/02/25 at 7:33 P.M. stated Resident #22 returned from LOA with sister at 6:00 P.M. The note stated Resident #22 attempted to get out of the facility and was redirected several times. The note stated the nurse went to assist another resident and upon return to the nurse's station noted Resident #22 was not sitting there any longer. The note stated the aide that was sitting with Resident #22 had gone to assist another resident also. The note indicated the nurse went to look for Resident #22 he was found being brought back into the facility through the front door by the night shift nurse and another aide. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/26/25 at 9:15 A.M., with Registered Nurse (RN) #51 confirmed she was the nurse who took care of Resident #22 on day shift 03/02/25. RN #51 stated the aide on the unit went to assist another resident and left Resident #22 alone at the nurse's station. RN #51 stated when she returned to the nurse's station Resident #22 was no longer sitting there. RN #51 stated she went to look for Resident #51 and found the night shift nurse and aide bringing Resident #22 in the building through the front door. RN #51 stated Resident #22 was found in the front parking lot and had not gotten off the facility property. RN #51 stated she could not confirmed if Resident #22 had a wanderguard in place or if the door alarm was sounding. Interview on 03/26/25 at 1:59 P.M., with Administrator, Director of Nursing (DON), and Regional Director of Clinical Operations (RDCO) #241 confirmed the facility had not completed an investigation into how Resident #22 got out of the building, if Resident #22 had his wanderguard in place, or if the front door alarm was sounding upon Resident #22's exit from the facility. Administrator confirmed Resident #22 is at risk for elopement and has been on one-on-one supervision 24 hours per day since 03/04/25. Review of the policy titled, Elopement, revised December 2007, stated staff shall investigate and report all cases of missing residents. The policy stated staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or DON. The policy stated when a departing individual returns to the facility, DON or Charge Nurse shall: examine the resident for injuries, notify the attending physician, notify the resident's legal representative of the incident, complete and file Report of Incident/Accident and document the event in the resident's medical record.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER Legacy Centerville		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 Alex Bell Road Centerville, OH 45459	
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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613 Based on observation, staff and resident interviews, and policy review, the facility failed to provide mechanically alter diet as ordered. This affected one (23) of the two residents reviewed for food texture. The facility identified seven residents on a pureed diet. The facility census was 96. Findings include: Review of the medical record for Resident #23 revealed an admitted [DATE] with medical diagnoses of hypertensive heart disease with heart failure, chronic kidney disease, congestive heart failure, diabetes mellitus, and dysphagia. Review of the medical record for Resident #23 revealed a quarterly Minimum Data Set (MDS) assessment, dated 02/07/25, which indicated Resident #23 was cognitively intact and was independent with transfers, toileting, and set-up assist with eating. The MDS indicated Resident #23 received a mechanically altered diet. Review of the medical record for Resident #23 revealed a physician order dated 03/24/25 for carbohydrate control, no added salt, pureed texture diet with thin liquids. Observation and interview with Resident #23 on 03/24/25 at 11:50 A.M., stated he does not receive meals as ordered at times and it is difficult to swallow some items. The observation of Resident #23's lunch tray revealed mashed potatoes, pureed vegetable, and pork loin. The observation of the lunch tray revealed individual shreds of pork loin were visible and the pork was easily flaked apart. Interview on 03/24/25 at 11:56 A.M., with Licensed Practical Nurse (LPN) #35 confirmed Resident #23's pork loin appeared minced and was not a pureed consistency. LPN #35 confirmed the mashed potatoes and vegetables on Resident #23 had a texture consistent with a pureed diet. Interview on 03/27/25 at 9:34 A.M., with Dietary Technician (DT) #191 stated she was notified on 03/24/25 that Resident #23 did not want his lunch tray. DT #191 stated she went to Resident #23's room and confirmed the pork loin that was provided on his lunch tray was not a pureed texture and she went to the kitchen and brought him a bowl of pureed pork loin. Review of the undated policy titled, Therapeutic Diets and Mechanically Altered Diets, stated puree foods are blenderized to a pudding-like texture that clings together and does not require chewing.		