STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366418	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Dublin	4075 West Dublin-Granville Road Dublin, OH 43017

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on record review, review of 30-day notice, and resident and staff interview, the facility failed to ensure the 30-day discharge notice documented the location of discharge. This affected one (Resident #90) of two residents revived for 30-day discharge notice. The facility census was 104. Findings include: Review of the medical record for Resident #90 revealed an initial admitted [DATE]. Diagnoses included fracture of left femur, displaced fracture of fourth/fifth metatarsal bone of left foot, chronic obstructive pulmonary disease (COPD), acute respiratory failure, diabetes mellitus, obesity, anxiety disorder, peripheral vascular disease, alcohol abuse, major depressive disorder, chronic pain, and nicotine dependence psychoactive substance abuse. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #90 had moderate cognitive impairment. Review of the 30-day notice issued to Resident #90 dated [DATE] revealed the discharge notice was given due to the safety of other residents was endangered due to Resident #90 was persistent in engaging in illegal smoking. The notice documented the facility was smoke free, including the building and grounds. The 30-day notice did not include an address for the discharge location. On [DATE] at 10:40 A.M., an interview with the Administrator revealed the facility had one 30-day discharge currently for non-complaisance with the facility's smoking policy. The Administrator revealed Resident #90 appealed the notice and the hearing was scheduled for [DATE] at 1:00 P.M. On [DATE] at 1:30 P.M., an interview with Resident #90 revealed he won the appeal due to the 30-day discharge notice was not filled out correctly. On [DATE] at 1:47 P.M., an interview with Licensed Social Worker (LSW) #271 revealed the facility lost the hearing due to no address on for the discharge location was documented on the 30-day discharge notice to the Ombudsman. This deficiency represents non-compliance investigated under Complaint Number OH00155102.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32654 Based on observations and staff interview, the facility failed to ensure resident medications not prepared ahead of administration time and failed to store over the counter (OTC) medications appropriately with name, the original manufacturer's or pharmacy-applied label indicating the medication name, strength, quantity, accessory instructions, lot number, and expiration date when applicable. Additionally, the facility failed to ensure medications were under direct observation of the person administering the medication or locked in the medication storage area/cart. This affected one of four hallways. This affected three residents (#63, #91, and #97). The facility census was 104. Findings include: Observations on 07/12/24 from 8:47 A.M. to 9:47 A.M. revealed Registered Nurse (RN) #216 had two resident's (#91 and #97) morning medications prepared in clear plastic cups sitting on top of the medication storage cart. There were two multi use bottles of Miralax (OTC medication) sitting on top of the medication storage cart. Interview with RN #216 during the time of the observation verified she pre-poured the resident's morning medication in the clear plastic cups with their room name written on the cup. On 07/12/24 at 8:47 A.M., RN #216 entered Resident #97's room leaving Resident #91's medications and the two bottles of multi use Miralax on top of the medication storage cart out of sight. On 07/12/24 at 9:04 A.M., RN #216 prepared Resident #99's morning medication and entered the room leaving two bottles of multi use Miralax and Resident #91's morning medication on top of the medication storage cart out of sight. On 07/12/24 at 9:30 A.M., RN #216 prepared Resident #76's morning medication removing a clear plastic cup with multiple small orange tablets labeled Bisacodyl (OTC medication) on the cup. RN #216 began to remove tablets from the clear plastic cup when the Assistant Director of Nursing (ADON) #247 stopped RN #216 and explained the tablets must remain in the original bottle. RN #216 then entered the room leaving two bottles of multi use Miralax and Resident #91's morning medication on top of the medication storage cart out of sight. On 07/12/24 at 9:47 A.M., RN #216 prepared Resident #63's morning medication dropping one Zoloft (antidepressant) 25 milligram (mg) tablet on the top of the medication storage cart. RN #216 picked the medication up with her bare hands. ADON #247 alerted RN #216 to remove the tablet from the cup as it touched the top of the cart and her bare hands. RN #216 then entered the resident's room and gave Resident #63 her scheduled pain medication. Resident #63 had left Resident #91's medication, the two multi use Miralax bottles and Resident #63's medication cards on top of the medication storage cart. RN #216 then obtained the medication punch cards and laid them on the resident's bedside table. RN #216 exited the room and began preparing another resident's medication leaving the medication cards out of sight. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/12/24 at 10:00 A.M. with RN #216 verified the medications were not always in sight and the medications were not stored properly. RN #216 verified she left Resident #91's medications and two bottles of Miralax on top of the medication storage cart out of sight multiple times. RN #216 verified she left Resident #63's medication carts to top of the medication cart when she went to administer Resident #63 her scheduled pain medication. RN #216 verified she laid the medication cards in Resident #63's room out of sight. This was an incidental finding discovered during the course of the complaint investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32654 Based on observations, staff interview, and facility policy review, the facility failed to maintain the nourishment room's refrigerators in a clean and sanitary manner. This affected two of two nourishment rooms. This had the potential to affect all 104 residents residing in the facility. Findings include: Observation on [DATE] at 10:45 A.M. of the first-floor nourishment room revealed the white reach in refrigerator contained a bag with various foods dated [DATE], several small white bowls with a white food resembling mashed potatoes not dated, several opened containers of drinks undated, and a black bowl containing beans and a brown meat undated. Housekeeping Supervisor #272 verified the outdated food in the refrigerator. Observation on [DATE] at 11:21 A.M. of the second-floor nourishment room revealed the white reach in refrigerator had a brown substance spilled in the bottom of the refrigerator. There were multiple containers of undated and outdated food and an expired carton of milk. Licensed Practical Nurse (LPN) #208 verified the multiple containers of undated and outdated food and an expired carton of milk. Review of the facility's community information and policies dated ,d+[DATE] revealed visitors or friends delivering food and/or beverages to residents must consult with the charge nurse to determine the appropriateness of such food or drink in light of any dietary restrictions that the physician may have put in place. Food must be placed in a sealed plastic container, labeled with resident's name, and date. Beverages must be placed in containers that have a replaceable cap. Food will be discarded after 72 hours. This deficiency represents non-compliance investigated under Complaint Number OH00155460.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 32654 Based on observation, staff interview, and facility policy review, the facility failed to ensure medications were handled and distributed a sanitary manner. This affected two residents (#63 and #99) of four residents observed during medication administration. The facility census was 104. Findings include: Observation of medication administration on 07/12/24 at 9:04 A.M. revealed Registered Nurse (RN) #216 was preparing Resident #99's medication and dropped the Eliquis (blood thinner) on the top of the medication storage cart. RN #216 then picked the medication up with her bare hands and placed the medication into a clear plastic cup. RN #216 then entered Resident #99's room and administered the medication Eliquis to Resident #99. Observation of RN #216 at 9:47 A.M. revealed the RN prepared Resident #63's morning medication dropping one Zealot (antidepressant) 25 milligram (mg) tablet on the top of the medication storage cart. RN #216 picked the medication up with her bare hands and placed it into the cup. ADON #247 alerted RN #216 to remove the tablet from the cup as it touched the top of the cart and her bare hands. RN #216 then entered the resident's room and gave Resident #63 her scheduled pain medication. Interview on 07/12/24 at 9:50 A.M. with RN #216 verified Resident #63 and 99's medication was not distributed in a sanitary manner. Review of the facility's policy titled Medication Administration - General Guidelines dated 12/20/19 revealed the person administering medications adheres to good hand hygiene. This was an incidental finding during the course of the complaint investigation. This deficiency represents continued non-compliance from the survey dated 06/12/24.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 32654 Based on observation and staff interview, the facility failed to ensure the flooring was in good repair and safe in the second floor nourishment room for the residents to use. This affected one of two nourishment rooms. This had the potential to affect the 58 residents residing on the second floor. The facility census was 104. Findings include: Observation on 07/12/24 at 11:21 A.M. of the second floor nourishment room revealed multiple floor tiles with missing pieces resulting in raised edges. Interview with Licensed Practical Nurse (LPN) #208 at the time of the observation verified the missing pieces of tile and verified the raised edges posed a trip hazard to residents utilizing the nourishment room. This deficiency represents non-compliance investigated under Complaint Number OH00155460.