

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/24/2022
NAME OF PROVIDER OR SUPPLIER  Legacy Transitional Care & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  460 Auburn Avenue N.E. Atlanta, GA 30312	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 20958</p> <p>Based on interviews, policy review, and review of Centers for Medicare and Medicaid Services (CMS) guidelines, the facility failed to promote resident rights and allow residents to have visitors at the time of their choosing. Specifically, the facility failed to ensure family members of non-hospice residents were allowed to visit at a time of the residents'/families' choosing without needing to schedule their visits with the facility in advance for seven residents (R) (R#15, R#19, R#27, R#51, R#52, R#89, and R#148) sampled residents reviewed for resident rights.</p> <p>Findings included:</p> <p>Review of CMS Center for Clinical Standards and Quality/Survey and Certification Group (QSO) memorandum #QSO-20-39-NH, revised 3/10/2022, revealed, Facilities must allow indoor visitation at all times and for all residents as permitted under the regulations. While previously acceptable during the PHE [public health emergency], facilities can no longer limit the frequency and length of visits for residents, the number of visitors, or require advance scheduling of visits.</p> <p>Review of the untitled and undated visitation policy, which was included in the facility's admission agreement, revealed, Visitors are permitted within the Facility at the time and choosing of Resident; provided however, that Visitors are required to comply with Facility policies and procedures. Facility reserves the right to remove or deny visitors that impose on the rights of another Resident or for clinical and safety reasons.</p> <p>During a group interview on 8/3/2022 at 10:55 a.m. with R#15, R#19, R#27, R#51, R#52, R#89, and R#148 revealed their family members and friends had had to schedule appointments in advance of their visits to the facility. Per the residents, the practice had been in effect since the beginning of the COVID-19 pandemic. The residents added that visitation was limited to one to two hours during the scheduled visits. The residents stated scheduling visitation in advance of any intended visit was a facility requirement. The residents clarified that if their family/friends were unable to honor their scheduled appointment, they had to wait until they were able to secure another appointment time.</p> <p>1.Review of the clinical record for R#15 revealed diagnoses including epileptic seizures and depression.</p> <p>Review of a quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 115585	If continuation sheet Page 1 of 35

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<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. Review of the clinical record for R#19 revealed diagnoses including cerebral infarction, spinal stenosis, and stage 2 chronic kidney disease.</p> <p>Review of a quarterly MDS, dated [DATE], revealed R#19 had a BIMS score of 15, indicating the resident was cognitively intact.</p> <p>3. Review of the clinical record for R#27 revealed diagnoses including adjustment disorder with mixed anxiety, depressed mood, and dementia without behavioral disturbance.</p> <p>Review of an annual MDS, dated [DATE], revealed R#27 had a BIMS score of 15, indicating the resident was cognitively intact.</p> <p>4. Review of the clinical record for R#51 revealed diagnoses which included chronic pulmonary embolism and primary insomnia.</p> <p>Review of a quarterly MDS, dated [DATE], indicated R#51 had a BIMS score of 15, indicating the resident was cognitively intact.</p> <p>5. Review of the clinical record for R#52 revealed diagnoses including chronic congestive heart failure and essential hypertension.</p> <p>Review of a quarterly MDS dated [DATE] revealed R#52 had a BIMS score of 15, which indicated the resident was cognitively intact.</p> <p>6. Review of the clinical record for R#89 revealed diagnoses including adjustment disorder with mixed anxiety, depressive mood, and essential hypertension.</p> <p>Review of a quarterly MDS, dated [DATE], revealed R#89 had a BIMS score of 11, which indicated the resident had moderately impaired cognition.</p> <p>7. Review of the clinical record for R#148 revealed diagnoses which including cognitive communication deficit, epilepsy, and type 2 diabetes mellitus.</p> <p>Review of an annual MDS, dated [DATE], revealed R#148 had a BIMS score of 9, which indicated the resident had moderately impaired cognition.</p> <p>During an interview on 8/2/2022 at 1:13 p.m., the Social Worker (SW) revealed the facility encouraged scheduled visits, but scheduled visits were not required.</p> <p>During an interview on 8/3/2022 at 11:16 a.m., the SW stated the facility encouraged families to make appointments to visit. She stated the visits were allowed in the main dining room, outside, and in the conference room. The facility tried to encourage social distancing. They did not allow residents to have visitors in their rooms unless the resident was on hospice.</p> <p>During an interview on 8/5/2022 at 8:22 a.m., Certified Nursing Assistant (CNA) NN revealed that visitors had to schedule a visit, and the visits had to occur downstairs in the dining room. CNA NN indicated family members were required to make an appointment to visit the residents.</p> <p>(continued on next page)</p>		

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<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 8/5/2022 at 9:22 a.m., CNA CC revealed visitors had to call the SW to schedule an appointment to visit the residents. CNA CC indicated visitation occurred downstairs in the dining room. During further interview, CNA CC confirmed family members were required to make appointments to visit the residents.</p> <p>During an interview on 8/5/2022 at 10:06 a.m., Licensed Practical Nurse (LPN) Manager AA indicated that due to COVID-19, visitation was conducted downstairs and that visitors had to call and set up an appointment. LPN Manager AA indicated if a visitor did not have an appointment, they could still visit, but visitors were not allowed to come to the floor.</p> <p>During an interview on 8/5/2022 at 10:40 a.m., CNA EE indicated visitors did not come on the floor/unit to visit the residents; they had to stay in the dining room, and appointments were required to visit because of COVID-19.</p> <p>During an interview on 8/5/2022 at 4:08 p.m., the Director of Nursing (DON) stated the facility adopted the idea of scheduling visits in advance during the peak of the COVID-19 pandemic. She acknowledged the CMS directive at that time had since changed and that the new guidance directed the facility be reopened for visitation and not to require residents' family members to schedule visitation in advance. The DON stated the facility did not cease having family members schedule their visits in advance of visitation because they believed COVID-19 was still an issue.</p> <p>40141</p> <p>44243</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44243</b></p> <p>Based on interviews, record review, and policy review, the facility failed to prevent resident-to-resident abuse for one resident (R) (R#225) of four sampled residents, from being physically abused by R#142.</p> <p>Findings included:</p> <p>Review of the policy titled Abuse Prevention Policy, revised 3/1/2018, revealed the resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Physical abuse includes hitting, slapping, pinching, and kicking. Further review of the policy revealed it is the responsibility of all staff to provide a safe environment for the residents.</p> <p>1. Review of the clinical record revealed R#225 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, alcohol abuse, vascular dementia without behavioral disturbance, and essential (primary) hypertension.</p> <p>Review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of three, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was independent with bed mobility, transfer, and walking and required one-person physical assistance for locomotion. Per the MDS, the resident did not exhibit physical or verbal behaviors directed towards others but exhibited other behavioral symptoms not directed towards others (such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds).</p> <p>Review of the care plan revised 6/15/2022, revealed behavioral symptoms were not addressed for R#225.</p> <p>2. Review of the clinical record revealed R#142 had diagnoses including schizoaffective disorder, dementia with behavioral disturbance, and major depressive disorder.</p> <p>Review of a quarterly MDS, dated [DATE], revealed R#142 had a BIMS score of four, indicating the resident was severely cognitively impaired. Per the MDS, the resident did not exhibit physical or verbal behavioral symptoms directed towards others. The MDS indicated the resident was independent with locomotion, walking, transfer, and bed mobility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plan revised 5/13/2021, revealed R#142 was at risk for adverse reactions from behavior disturbances related to dementia with behaviors. The care plan indicated the resident was verbally abusive/yelling out and loud/delusional at times. The care plan further indicated that R#142 became physically/verbally abusive toward staff and others at times when she did not have any more cigarettes during smoke break. According to the care plan, on 2/20/2018, R#142 was observed with initiating physically aggressive behavior toward another resident. In addition, the care plan indicated that on 3/8/2018, R#142 exhibited inappropriate combative behavior toward staff. Interventions included to continue to reinforce positive behavior, administer and monitor effectiveness of medications as prescribed by the physician, anticipate needs and provide them before the resident becomes overly stressed, psychiatric (psych) evaluation as needed, educate resident on other effective coping skills for dealing with feelings, encourage resident/family to increase involvement in activities to eliminate or reduce behaviors, investigate/monitor the need for psychological/psychiatric support, provide services if desired by the resident/family and ordered by the physician, observe and record changes in behavioral symptoms, provide resident with diversional activities when behavioral symptoms arise, and change the resident's room to avoid roommate conflict as needed.</p> <p>Review of progress note dated 6/18/2022 at 10:00 p.m., indicated R#142 and her roommate were observed sitting on the floor in front of the bed holding each other's clothing. R#142 was noted to be hitting and kicking at R#225 and cursing at R#225 for coming into R#142's room. Per the note, R#142 was calm after staff informed her that R#225 lived in the room too. According to the note, R#142 was lying in bed quietly after education was provided.</p> <p>Review of the Police Department Incident Report, dated 6/19/2022, indicated the responding officer was at the facility on 6/18/2022 from 11:40 p.m. through 11:46 p.m. The report revealed that upon the officer's arrival at the facility, the officer met Unit Manager (UM) DD, who stated she witnessed R#142 and R#225 in an argument and grabbing each other. The report noted that both residents suffered from dementia and other complications. The officer reported R#142 and R#225 were asleep when he arrived at the facility. The report concluded that UM DD wanted the incident to be noted for the facility record.</p> <p>Review of the facility's final investigation report and addendum revealed that on 6/18/2022 at approximately 11:00 p.m., UM DD was performing rounds when she heard a commotion in R#225's room. Upon entering the room, UM DD observed roommates R#225 and R#142 in a physical altercation on the floor. Per the report, UM DD called out to a Certified Nursing Assistant (CNA) in the hallway to assist with separating the residents. The report indicated CNA HH entered the room and assisted UM DD. Both residents went back to their respective beds without further incident.</p> <p>Review of psychiatry progress note dated 7/11/2022, revealed R#142's history in the facility included aggressive behaviors in February and March 2022, involving the resident's delusions regarding her dentures being stolen. According to the note, the resident went into other residents' rooms and accused them of stealing her dentures, becoming verbally aggressive with the use of profanity and physically aggressive with shoving, grabbing, and biting staff.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 8/2/2022 at 12:51 p.m., UM DD stated she worked 7:00 p.m. to 7:00 a.m. and was making rounds on 6/18/2022 at approximately 11:00 p.m. when she walked into the room shared by R#142 and R#225. Per UM DD, the residents were sitting on the floor holding each other's clothes and cursing each other out. UM DD stated R#142 thought R#225 was in the wrong room. UM DD stated R#142 was deaf and only read lips. Per UM DD, she guessed R#142 had difficulty reading R#225's lips due to R#225 wearing a mask at the time of the encounter. UM DD stated the residents were separated with the assistance of CNA HH. Per UM DD, R#142 was known to direct physical aggression towards staff and had been involved in a few scuffles with other residents.</p> <p>Interview on 8/2/2022 at 3:41 p.m., CNA HH stated she recalled assisting UM DD with separating R#142 and R#225. Per CNA HH, the two residents were separated and R#225 walked back to her bed. CNA HH stated R#142 was known to physically attack staff but had not had an encounter with another resident to her knowledge.</p> <p>Interview on 8/4/2022 at 12:41 p.m., Licensed Practical Nurse (LPN) KK, who worked the unit during the 7:00 a.m. through 7:00 p.m. shift on 6/19/2022, stated she was not present at the time of the encounter between R#142 and R#225 and was therefore unable to provide any details on the incident. LPN KK stated R#142 was known to be physically aggressive toward staff and had been involved in a few encounters with other residents over the course of the resident's stay at the facility.</p> <p>Interview on 8/4/2022 at 4:08 p.m., the Director of Nursing (DON) stated because R#225 and R#142 lived on the secure unit of the facility, it was not uncommon for there to be a resident-to-resident interactions such as the physical assault perpetrated by R#142 against R#225.</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46194</p> <p>Based on observations, interviews, record review, and policy review, the facility failed to implement the care plan for one resident (R) (R#25) of 24 sampled residents. Specifically, the facility failed to implement the care plan to provide supervision during mealtime for R#25, who was at risk for aspiration (entrance of food, drink, saliva, or vomit into the lungs). R#25 was left unsupervised with his/her meal and was found by the surveyor in respiratory distress.</p> <p>On 9/20/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents.</p> <p>The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 9/20/2022 at 6:49 p.m. The noncompliance related to the IJ was identified to have existed on 8/1/2022.</p> <p>A removal plan (Credible Allegation of Compliance) was received on 9/23/22. The survey team conducted observations, reviewed training records, and interviews with staff and residents to verify elements of the facility's removal plan were implemented. The immediacy of the Immediate Jeopardy was removed on 9/24/22. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures. In-service materials and records were reviewed. Observations and interviews were conducted with staff to ensure they demonstrated knowledge of the facility's policies and procedures.</p> <p>Findings included:</p> <p>Review of the policy titled, Care Plan Policy, reviewed November 18, 2021, revealed each resident will have a plan of care to identify problems, needs, and strengths that will identify how the facility staff will provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Standard of Practice number 7. Areas of concern or potential concern and residents [sic] strengths will be addressed with measurable goals and specific person-centered approaches to promote attainment or maintenance of the goal(s).</p> <p>Review of the clinical record revealed R#25 was admitted to the facility on [DATE] with diagnoses including vascular dementia without behavioral disturbance and chronic obstructive pulmonary disease (COPD).</p> <p>Review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Per the MDS, the resident was totally dependent for eating and did not have signs/symptoms of a possible swallowing disorder.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the care plan reviewed 5/23/2022, revealed resident has a diagnosis of dysphagia and is on a mechanical altered diet. R#25 was on aspiration precautions and had a diagnosis of dysphagia (difficulty swallowing). The care plan indicated on 2/13/2020, the resident was observed choking. On 7/21/2021, a Certified Nursing Assistant (CNA) noted the resident in bed choking while sitting at a 90-degree angle. On 11/26/2021, another choking episode was noted. The care planned interventions/tasks included:</p> <ul style="list-style-type: none"> <li>- 2/13/2020: Aspiration precautions: assistance with all meals with resident sitting upright.</li> <li>- 7/23/2021: up in wheelchair sitting upright during all meals as needed.</li> <li>- 7/23/2021: must be supervised during all meals ensuring small bits, slow pacing.</li> <li>- 11/16/2021: ST [speech therapy] referral completed.</li> </ul> <p>Review of a CNA assignment sheet, dated 8/1/2022, revealed R#25's room/bed number was included on a list of residents who needed to be fed by staff.</p> <p>Review of R#25's Visual/Bedside Kardex Report (a guide used by CNAs to determine the care a resident required) revealed the resident required the following:</p> <ul style="list-style-type: none"> <li>- Aspiration precautions which included assistance with all meals and that the resident needed to sit upright for all meals (dated 2/13/2020).</li> <li>- Have the resident sit upright in a wheelchair during all meals (dated 7/23/2021).</li> <li>- Supervise the resident during all meals/snacks ensuring the resident takes small bites and eats at a slow pace (undated).</li> <li>- Aspiration precautions (undated).</li> <li>- Assist the resident with all meals as needed (undated).</li> <li>- Clinical staff to monitor communal dining or supervised in room as resident can tolerate (undated).</li> <li>- A regular diet, pureed texture, nectar thick liquids consistency (undated).</li> <li>- Monitor the residents' ability to tolerate diet and notify the Medical Doctor (MD) of any problems (undated).</li> </ul> <p>On 8/1/2022 at 1:10 p.m. surveyor observed staff delivering meal trays to residents who ate in their rooms.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 8/1/2022 at 2:54 p.m. surveyor observed R#25 in his room with a meal tray in front of him, with about 50% of the meal consumed. There were no staff members in the room feeding or supervising the resident. R#25 was slumped over to the left side and had thick mucus running out of the side of his mouth. He appeared to be in respiratory distress, using accessory muscles to breathe, and had an audible gurgle in his chest/throat. The surveyor immediately alerted Licensed Practical Nurse (LPN) LL, who entered the room and started to suction the resident. R#25 was deeply coughing and trying to breathe. LPN LL checked the resident's oxygen saturation, which was noted to be 61% (normal range is greater than 90%). LPN LL obtained an oxygen canister and started R#25 on oxygen. R#25 was moaning and trying to catch his breath. After the oxygen was applied, the oxygen saturation increased to only 82%. LPN LL waved for another LPN, Nurse Manager RR, to assist. Nurse Manager RR asked LPN LL if he wanted to send R#25 to the emergency room (ER), since the resident's oxygen saturation would not increase to greater than 82%. Nurse Manager RR left the room and made a phone call to the physician. Nurse Manager RR came back to the room and stated the physician ordered the resident be sent to the ER.</p> <p>Interview on 8/1/2022 at 3:33 p.m. with CNA NN, stated he was watching R#25 eat until the roommate finished his meal, and he left the room and went to pick up trays on the hall. CNA NN stated R#25 would not let him take his meal tray. CNA NN stated R#25 must have eaten part of the meal after he left the room. CNA NN stated he usually left R#25's tray in front of him, and R#25 was usually fine.</p> <p>Interview on 8/1/2022 at 3:41 p.m., LPN LL stated R#25 was usually fed by staff but was not being fed today, according to CNA NN. LPN LL stated the resident required full assistance with feeding and that R#25 should not have been left with the tray in front of him.</p> <p>Interview on 8/2/2022 at 12:04 p.m. with Nurse Practitioner (NP) TT stated R#25 generally fed himself but needed someone nearby during meals. She stated staff should not leave R#25's tray in front of him and leave the room during mealtime. She stated someone needed to be checking on the resident during the meal.</p> <p>Interview on 8/2/2022 at 12:47 p.m., Speech Therapist (ST) SS stated staff needed to remind R#25 to slow down when eating and staff needed to be in the vicinity where R#25 was eating in case the resident was in distress.</p> <p>Interview on 8/2/2022 at 3:44 p.m., the Director of Nursing (DON) stated R#25 could not be left alone while eating for an extended period. She stated if staff left the resident and picked up trays on the hall, that was an extended period, and R#25 should not have been left without supervision.</p> <p>Interview on 8/3/2022 at 12:33 p.m. with CNA WW, stated if the care plan indicated R#25 must be supervised during all meals, ensuring small bites and slow pacing, the resident should be continuously monitored. She stated that would require someone to always be present with resident during meals. She confirmed R#25 was at risk for choking and should not be left alone.</p> <p>Interview on 8/3/2022 at 3:14 p.m. with the Medical Director, stated if the care plan indicated the resident should be supervised during meals, there should be someone in the room with the resident while the resident was eating.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 9/24/2022 at 10:07 a.m., CNA DDD stated she was required to look at the Kardex or care plan to obtain information on residents' care. She stated supervision meant to stay with the resident and not leave the room until the resident was finished eating.</p> <p>Interview on 9/24/2022 at 10:45 a.m., LPN VV stated CNAs went to the Kardex to know how to care for a resident. He stated staff should never leave a tray in front of a resident who was at risk for aspiration.</p> <p>During a follow-up interview on 9/23/2022 at 12:43 p.m., the DON revealed staff should read the Kardex, which would match the care plan, to determine how to take care of residents. She stated following the plan of care ensured safety for the residents.</p> <p>Interview on 9/23/2022 at 9:39 a.m. with the Regional Director of Clinical Operations stated CNA staff were to look at the Kardex to determine what care to provide to residents on aspiration precautions to keep them safe during meals, snacks, and hydration.</p> <p>Removal Plan:</p> <ol style="list-style-type: none"> <li>9/21/22 - Resident #25 continues to reside in the facility, Legacy Nursing and Rehabilitation Center. 8/1/22 - Resident #25 was showing signs of respiratory distress when the surveyor entered the room. A plate of pureed food was left in front of the resident at lunch. The licensed practical nurse suctioned Resident #25 and oxygen was applied. Resident #25 was sent to the emergency room and admitted with a diagnosis of aspiration. Resident #25 returned to the facility 8/4/22.</li> <li>9/21/22 - a root cause analysis was completed and presented to the Ad Hoc QAPI [Quality Assurance Performance Improvement] Committee (Administrator, Chief Clinical Operations (CCO), Medical Director and Regional Director of Clinical Operations. From the root cause analysis, systems were identified that required an immediate action plan to correct deficient practices including the need to follow residents' care plan and provide supervision during mealtimes for residents at risk for aspiration.</li> <li>9/21/22 - an Ad Hoc QAPI meeting was held with the QAPI Committee (Administrator, Chief Clinical Operations, Medical Director, and Regional Director of Clinical Operations) to discuss incident involving Resident #25.</li> <li>9/21/22 - the policies for Care Plan, Incident Report - Documentation, Investigation and Reporting and Respiratory - Aspiration Precautions were reviewed by the Chief Clinical Operations, Medical Director, Regional Director of Clinical Operations, with no revisions made.</li> <li>9/20/22 - the MDS Director, completed a Care Plan/Kardex Audit of care plans and Kardex for all 10 of the 10 residents identified at risk for aspiration. No deficient practices noted in individualized care plans or interventions.</li> <li>9/21/22 - Regional Director Clinical Operations in-serviced the IDT, which consists of Chief Clinical Operations (CCO), MDS Director, and Staff Development Coordinator (SDC) on instructions for care plans (resident centered related to importance of following individualized care plans/ interventions for residents identified at risk for aspiration).</li> </ol> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Legacy Transitional Care & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  460 Auburn Avenue N.E. Atlanta, GA 30312	

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>7. 9/22/22 and 9/23/22 - the Chief Clinical Operations (CCO)and Staff Development Coordinator (SDC) in-serviced 58 of 68 clinical staff on instruction for care plans (resident centered related to importance of following individualized care plans/interventions for residents identified at risk for aspiration:</p> <p>RN: 4 of 5</p> <p>LPN: 21 of 25</p> <p>CMA: 4 of 4</p> <p>C.N.A: 29 of 34</p> <p>Total: 85%</p> <p>8. 9/22/22 and 9/23/22 - the CCO and SDC in-serviced 58 of 68 clinical staff how to access Care Plan/Kardex to identify interventions for residents at risk for aspiration.</p> <p>RN: 4 of 5</p> <p>LPN: 21 of 25</p> <p>CMA: 4 of 4 C.N.A: 29 of 34</p> <p>Total: 85%</p> <p>Those not in-serviced will not be placed in the schedule and/or will not be allowed to return to work until in-services are completed.</p> <p>9. Newly admitted residents or residents newly identified with swallowing disorders or choking episodes will be referred to therapy services for screening. Therapy will communicate any changes in plan of care with Chief Clinical Officer, CCO or Assistant Chief Clinical Officer, ACCO and Unit Managers who will in-service clinical staff of residents at risk of aspiration including care plan and interventions.</p> <p>All corrective actions were completed on 9/23/22. The facility alleges that the IJ is removed on 9/24/22.</p> <p>Onsite Verification:</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The IJ was removed on 9/24/2022 after the survey team performed onsite verification that the Removal Plan had been implemented. Interviews were conducted with staff to ensure they demonstrated knowledge of the facility's policies and procedures. Observations revealed staff were providing the care planned level of supervision to residents during mealtime. Care plans and the Kardex were reviewed to ensure accuracy. The Ad Hoc QAPI meeting minutes were reviewed, and attendance sheets were verified. The Minimum Data Set (MDS) Director's care plan/Kardex audit was reviewed. Sign-in sheets were reviewed for the in-service provided on care plans by the Regional Director of Clinical Operations. The Chief Clinical Operation's audit for ensuring supervision of residents at risk of aspiration was also reviewed. In-service sign-in sheets were reviewed to verify staff education was provided per the removal plan including the importance of following the care plan and how to access care plan. Sign-in sheets were verified, and schedules were reviewed to ensure untrained staff were not working prior to being educated. New admissions were reviewed to ensure newly admitted residents with swallowing disorders were referred to therapy.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46194</p> <p>Based on observations, record review, interviews, and policy review, the facility failed to provide adequate supervision to prevent potential accidents for three residents (R) (R#25, R#167, and R#325) of five sampled residents reviewed for accident hazards. Specifically, the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Provide supervision during mealtime for R#25 of three sampled residents at risk for aspiration (entrance of food, drink, saliva, or vomit into the lungs). On 8/1/22, R#25 was left unsupervised with his meal and was found by the surveyor in respiratory distress. The resident was sent to the emergency room (ER) and subsequently admitted with a diagnosis of subsegmental atelectasis (collapse of a small area of the lung) or aspiration.</li> <li>2. Provide physician ordered thickened liquids for R#167 of three sampled residents at risk for aspiration.</li> <li>3. Thoroughly investigate a fall from a mechanical lift to determine the cause and facilitate development of effective interventions to prevent potential recurrence for R#325 of two sampled residents reviewed for mechanical lift transfers.</li> </ol> <p>On 9/20/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents.</p> <p>The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 9/20/2022 at 6:49 p.m. The noncompliance related to the IJ was identified to have existed on 8/1/2022.</p> <p>A removal plan (Credible Allegation of Compliance) was received on 9/23/22. The survey team conducted observations, reviewed training records, and interviews with staff and residents to verify elements of the facility's removal plan were implemented. The immediacy of the Immediate Jeopardy was removed on 9/24/22. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures. In-service materials and records were reviewed. Observations and interviews were conducted with staff to ensure they demonstrated knowledge of the facility's policies and procedures.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Review of the policy titled, Respiratory - Aspiration Precautions, revised January 2019, revealed the policy statement is to implement and educate patient/caregiver on precautions that prevent aspiration. Considerations 1. Precautions should be taken with all patients who are unable to protect their airway to prevent the involuntary inhalation of foreign substances, such as gastric contents, oropharyngeal secretions, food, or fluids, in the tracheobronchial passages. Procedure 7. Monitor patient when eating/drinking: a. Instruct family or caregiver to do the same. b. Observe adequacy of swallowing.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the clinical record revealed R#25 was admitted to the facility on [DATE] with diagnoses including vascular dementia without behavioral disturbance and chronic obstructive pulmonary disease (COPD).</p> <p>Review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Per the MDS, the resident was totally dependent for eating and did not have signs/symptoms of a possible swallowing disorder.</p> <p>Review of the care plan reviewed 5/23/2022, revealed resident was on aspiration precautions and had a diagnosis of dysphagia (difficulty swallowing). The care plan indicated on 2/13/2020, the resident was observed choking. On 7/21/2021, a Certified Nursing Assistant (CNA) noted the resident in bed choking while sitting at a 90-degree angle. On 11/26/2021, another choking episode was noted. The care planned interventions/tasks included:</p> <ul style="list-style-type: none"> <li>- 2/13/2020: Aspiration precautions: assistance with all meals with resident sitting upright.</li> <li>- 7/23/2021: up in wheelchair sitting upright during all meals as needed.</li> <li>- 7/23/2021: must be supervised during all meals ensuring small bits, slow pacing.</li> <li>- 11/16/2021: ST [speech therapy] referral completed.</li> </ul> <p>Review of a Physician Progress Note, dated 11/19/2021, revealed staff were to assist R#25 with feeding and monitor for aspiration or choking.</p> <p>Review of a Physician Progress Note, dated 12/10/2021, revealed staff were to assist R#25 with meals due to the resident's history of difficulty swallowing.</p> <p>Review of an Order Summary Report revealed R#25 had a physician's order dated 05/07/2020 for a regular, pureed/dysphagia diet with liquids thickened to nectar consistency.</p> <p>Review of a CNA assignment sheet, dated 8/1/2022, revealed R#25's room/bed number was included on a list of residents who needed to be fed by staff.</p> <p>On 8/1/2022 at 2:54 p.m. the surveyor observed R#25 in his room with a meal tray in front of him, with about 50% of the meal consumed. No staff were in the room feeding or supervising the resident. R#25 was slumped over to the left side and had thick mucus running out of the side of his mouth. R#25 appeared to be in respiratory distress, using accessory muscles to breathe, and had an audible gurgle in his chest/throat. R#25 was deeply coughing and trying to breathe. The surveyor immediately alerted Licensed Practical Nurse (LPN) LL, who entered the room and started to suction the resident. LPN LL checked resident's oxygen saturation, which was noted to be 61% (normal range is greater than 90%). LPN LL obtained an oxygen canister and started R#25 on oxygen. R#25 was moaning and trying to catch his breath. After the oxygen was applied, the oxygen saturation increased to only 82%. LPN LL waved for another LPN, Nurse Manager RR, to assist. Nurse Manager RR asked LPN LL if he wanted to send R#25 to the emergency room (ER), since the resident's oxygen saturation would not increase to greater than 82%. Nurse Manager RR left the room and made a phone call to the physician. Nurse Manager RR came back to the room and stated the physician ordered the resident be sent to the ER.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a hospital Radiology Result dated 8/1/2022 at 5:00 p.m. revealed the resident's chest x-ray findings included opacities (white spots on the x-ray) that represented atelectasis or aspiration.</p> <p>Review of a hospital Progress Note dated 8/3/2022, revealed the resident presented to the hospital after an acute aspiration event with acute hypoxemic (low oxygen levels in the blood) and hypercapnic (high carbon dioxide levels in the blood) respiratory failure requiring bilevel positive airway pressure (BiPAP) support on presentation. The resident was now weaned to room air, the oxygen saturation level was 92% at rest, and the respiratory failure had resolved. The resident was started on prednisone (a glucocorticoid medication used to decrease inflammation) and Levaquin (an antibiotic) for possible community-acquired pneumonia versus aspiration pneumonia.</p> <p>A review of the hospital Discharge Summary revealed R#25 was transferred back to the facility on [DATE] with orders to continue prednisone and Levaquin.</p> <p>Interview on 8/1/2022 at 3:33 p.m. with CNA NN, stated he was not sure what happened to R#25. He stated R#25 was fine when he set up the meal tray for the resident. CNA NN stated he usually just kept an eye on R#25 while he provided feeding assistance to the resident's roommate. CNA NN stated he was watching R#25 eat until the roommate finished his meal. He stated R#25 would not let him take his meal tray, so he left and went to pick up trays on the hall. CNA NN stated R#25 must have eaten part of the meal after he left the room. CNA NN stated he usually left R#25's tray in front of him, and R#25 was fine.</p> <p>Interview on 8/1/2022 at 3:41 p.m. with LPN LL, stated R#25 was fine earlier that morning and must have had problems while eating. LPN LL stated R#25 was usually fed by staff but was not being fed today, according to CNA NN. LPN LL stated the resident required full assistance with feeding. LPN LL stated R#25 should not have been left with the tray in front of him. LPN LL indicated he provided CNA NN with an assignment sheet that morning, which indicated who required assistance with feeding, and that the assignment sheet specified that R#25 was to be assisted with feeding.</p> <p>Interview on 8/2/2022 at 12:04 p.m., Nurse Practitioner (NP) TT stated R#25 generally fed himself but needed someone nearby during meals. She stated staff should not leave R#25's tray in front of him and leave the room during mealtimes. She stated someone needed to be checking on him during the meal.</p> <p>Interview on 8/2/2022 at 12:47 p.m., Speech Therapist (ST) SS stated R#25 wanted to eat, but every time the resident was evaluated, he had a poor prognosis. She stated R#25 was at high risk for aspiration. She stated the last time she worked with R#25 she recommended a feeding tube be placed. She stated R#25, and his family declined the tube placement. During further interview, she stated someone should be in the room with R#25 while he ate due to the high risk for aspiration. She stated staff needed to remind R#25 to slow down. She stated someone would need to be in the vicinity where R#25 was eating in case the resident was in distress.</p> <p>Interview on 8/2/2022 at 3:44 p.m. with the Director of Nursing (DON), stated R#25 could not be left alone while eating. She stated if staff left the resident and picked up trays on the hall, that was an extended period, and R#25 should not have been left without supervision.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 8/3/2022 at 12:33 p.m. with CNA WW, stated if the care plan indicated R#25 must be supervised during all meals, ensuring small bites and slow pacing, the resident should be continuously monitored. She stated that would require someone to always be present during meals. She stated R#25 was to be sitting upright at a 90-degree angle. She stated R#25 could feed himself but needed to be continuously monitored and reminded to drink and take small bites. She stated R#25 was prone to choking and should not be left alone during meals.</p> <p>Interview on 8/3/2022 at 12:41 p.m. with CNA UU, stated if the care plan indicated R#25 must be supervised during all meals, ensuring small bites and slow pacing, the resident should be continuously monitored. He stated R#25 should not have a meal tray left in front of him. During further interview, he stated R#25 would reach and get food off the tray. He stated R#25 had a history of taking very large bites and choking.</p> <p>Interview on 8/3/2022 at 9:35 a.m. with the DON stated there were no documented staff in-services that covered aspiration precautions during the past year.</p> <p>Interview on 8/3/2022 at 9:47 a.m. with the Administrator, stated he looked back over the past year and found no staff in-service trainings on aspiration precautions.</p> <p>Interview on 8/3/2022 on 3:14 p.m. with the Medical Director, stated if the care plan indicated the resident should be supervised, there should be someone in the room with the resident while the resident was eating.</p> <p>Removal Plan:</p> <p>1. 9/21/22 - Resident #25 continues to reside in the facility, Legacy Nursing and Rehabilitation Center. 8/1/22 - Resident #25 was showing signs of respiratory distress when the surveyor entered the room. A plate of pureed food was left in front of the resident at lunch. The licensed practical nurse suctioned Resident #25 and oxygen was applied. Resident #25 was sent to the emergency room and admitted with a diagnosis of aspiration. Resident #25 returned to the facility 8/4/22.</p> <p>2. 9/21/22 - a root cause analysis was completed and presented to the Ad Hoc QAPI [Quality Assurance Performance Improvement] Committee. (Administrator, Chief Clinical Operations (CCO), Medical Director and Regional Director of Clinical Operations). From the root cause analysis, systems were identified that required an immediate action plan to correct deficient practices including the need to follow residents' care plan and provide supervision during mealtimes for residents at risk for aspiration.</p> <p>3. 9/21/22 - an Ad Hoc QAPI meeting was held with the QAPI Committee, Administrator, Chief Clinical Operations (CCO), Medical Director, and Regional Director of Clinical Operations, to discuss incident involving Resident #25.</p> <p>4. 9/21/22 - the policies for Care Plan and Respiratory - Aspiration Precautions were reviewed by the Administrator, Chief Clinical Operations, Medical Director, and Regional Director of Clinical Operations, with no revisions made.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>5. 9/20/22 - the MDS Director, completed a Care Plan/Kardex Audit of care plans and Kardex for all 10 of 10 residents identified at risk for aspiration. No deficient practices were noted in individualized care plans or interventions.</p> <p>6. 9/21/22 - The Chief Clinical Operations, CCO, began completing a daily written Resident at Risk for Aspiration Monitoring Audit (Monday through Sunday) for the 10 residents with risk for aspiration and/or Nursing Supervisor designee to perform Quality Improvement Monitoring of residents at risk for aspiration.</p> <p>7. 9/21/22 - Regional Director Clinical Operations in-serviced the IDT [Interdisciplinary Team], which consists of Chief Clinical Operations (CCO) MDS Director, and Staff Development Coordinator (SDC) on instructions for care plans (resident centered related to importance of following individualized care plans/ interventions for residents identified at risk for aspiration).</p> <p>8. 9/22/22 and 9/23/22 - The CCO and SDC in-serviced 58 of 68 clinical staff regarding aspiration precautions and providing supervision during meals for residents who have a history of swallowing disorders and choking episodes and are at risk for aspiration.</p> <p>RN (Registered Nurse): 4 of 5</p> <p>LPN (Licensed Practical Nurse): 21 of 25</p> <p>CMA (Certified Medication Aide): 4 of 4</p> <p>CNA (Certified Nursing Assistant): 29/34</p> <p>Total: 85%</p> <p>9. Those not in-serviced will not be placed in the schedule and/or will not be allowed to return to work until in-services are completed.</p> <p>10. Newly admitted residents or residents newly identified with swallowing disorders or choking episodes will be referred to therapy services for screening. Therapy will communicate any changes in plan of care with Chief Clinical Officer, CCO or Assistant Chief Clinical Officer, ACCO and Unit Managers, who will in-service clinical staff of residents at risk of aspiration including care plan and interventions.</p> <p>All corrective actions were completed on 9/23/22. The facility alleges that the IJ is removed on 9/24/22.</p> <p>Onsite Verification:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The IJ was removed on 9/24/2022 after the survey team performed onsite verification that the Removal Plan had been implemented. Observations revealed staff were providing supervision during mealtime for all residents at risk for aspiration, according to their care plans. Care plans and Kardex were reviewed to ensure accuracy. The facility's root cause analysis was reviewed. The Ad Hoc QAPI meeting minutes were reviewed, and attendance sheets were verified. The Minimum Data Set (MDS) Director's care plan/Kardex audit was reviewed. Sign-in sheets were reviewed for the in-service provided on care plans by the Regional Director of Clinical Operations. The Chief Clinical Operation's audit for ensuring supervision of residents at risk of aspiration was also reviewed. In-service sign-in sheets were reviewed to verify staff education was provided per the removal plan, including the importance of following the care plan and how to access the care plan. Sign-in sheets were verified, and schedules were reviewed to ensure untrained staff were not working prior to being educated. New admissions were verified to ensure newly admitted residents with swallowing disorders were referred to therapy.</p> <p>2. Review of the Transfer/Discharge Report revealed R#167 had diagnoses that included acute kidney failure, dependence on supplemental oxygen, and dysphagia oral phase.</p> <p>Review of the quarterly MDS, dated [DATE], revealed R#167 had a BIMS score of two, indicating severely impaired cognition. The MDS indicated the resident was totally dependent with eating and received a mechanically altered diet.</p> <p>Review of a care plan revised 4/29/2021, revealed resident was at risk for nutritional/hydration problems related to being on a therapeutic diet. The care plan indicated that the resident pocketed food (held food in his mouth without swallowing). A planned interventions was to provide the diet as ordered.</p> <p>Review of the Rehab Services Referral (Nursing Communication) form, dated 7/7/2021, revealed the resident was referred for a swallowing study related to the resident pocketing food. Speech Therapy (ST) was to evaluate the resident and treat as indicated.</p> <p>Review of an Order Summary Report revealed R#167 had a physician's order dated 2/7/2022 for a pureed/dysphagia diet, mechanical soft with pureed meats, and liquids thickened to nectar consistency.</p> <p>Review of the Healthcare Services Dietary assessment dated [DATE], revealed R#167 had orders for a mechanical soft diet, with no added salt, low concentrated sweets, and pureed meat. The assessment indicated the resident was edentulous (without teeth), causing difficulty with chewing.</p> <p>On 8/3/2022 at 12:15 p.m., R#167 was observed lying in bed with the head of the bed elevated. An empty glass with a straw was on the over-bed table, which was positioned across the bed in front of the resident.</p> <p>Observation on 8/3/2022 at 12:45 p.m., revealed R#167 had been served a pureed diet and a glass of lemonade with ice that was not thickened to nectar consistency. The resident was observed to take a drink of the lemonade.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 8/3/2022 at 12:55 p.m., Licensed Practical Nurse (LPN) Unit Manager (UM) DD was asked to observe the resident's liquids for consistency. LPN UM DD observed the lemonade and confirmed it was not thickened. LPN UM DD then went to the computer, reviewed the resident's diet order, and reported the resident was to have nectar thickened liquids.</p> <p>Interview on 8/3/2022 at 1:00 p.m., LPN UM DD confirmed R#167 had received the wrong liquids. She stated the resident was supposed to receive thickened liquids. LPN UM DD reported the dietary department put the thickened liquids on the food trays prior to delivering them to the units to give to the residents. LPN UM DD with the surveyor reviewed the meal card that was on R#167's lunch tray. The card indicated the resident was to receive a pureed diet, no added salt, and low concentrated sugar. The beverage section of the card indicated, NA [not applicable]. The meal card did not address the order for thickened liquids.</p> <p>Interview on 8/3/2022 at 1:14 p.m., LPN UM DD stated Speech Therapy was assessing R#167 to determine whether the resident aspirated the non-thickened liquids.</p> <p>Interview on 8/3/2022 at 1:18 p.m., Speech Therapist (ST) SS verified the current diet order and stated R#167 was to receive nectar-consistency thickened liquids and pureed food. ST SS stated a chest x-ray would be obtained to rule out aspiration.</p> <p>Review of the Rehabilitation Screening Form, dated 8/3/2022 by ST SS, revealed a nurse had reported possible aspiration for R#167. The report indicated R#167 was on a nectar liquid/pureed diet and had no signs or symptoms of aspiration.</p> <p>Review of an Order Summary Report revealed a physician's order was obtained on 8/3/2022 for a chest x-ray to rule out aspiration. An additional order dated 8/3/2022 indicated the resident was to be monitored for signs and symptoms of aspiration pneumonia every 12 hours.</p> <p>Review of an Order Summary Report revealed a physician's order was obtained on 8/3/2022 for a chest x-ray to rule out aspiration. An additional order dated 8/3/2022 indicated the resident was to be monitored for signs and symptoms of aspiration pneumonia every 12 hours.</p> <p>Observation and interview on 8/3/2022 at 2:42 p.m. with Director of Social Work (DSW) JJ was passing drinks to residents during the lunch meal. DSW JJ was passing only regular consistency liquids and reported going by the dietary card to determine who could have regular liquids. DSW JJ denied having passed the regular lemonade to R#167.</p> <p>Interview on 8/6/2022 at 2:19 p.m., Dietary Manager (DM) XX confirmed the resident had an order for thickened liquids, but it was not on the resident's dietary card. DM XX reported the process for changes to diets was that a pink slip would be completed and given to the dietary department, and the card would be updated in the computer. DM XX denied having received a pink slip changing to thickened liquids for R#167. DM XX reported the meal card was updated to reflect thickened liquids, and the thickened liquids would be coming from the dietary department on meal trays.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 8/7/2022 at 8:12 a.m. with the DON, stated the resident should have received the nectar-thick liquids and that the facility would be returning to weekly audits of dietary orders. The DON indicated the unit manager and nurse managers were working the carts and the floor due to being short of nurses, and therefore, processes had been lacking. During further interview, she stated their goal was to get back to auditing.</p> <p>The Administrator was not available for interview.</p> <p>3. Review of a Transfer/Discharge Report revealed R#325 had diagnoses that included chronic respiratory failure, muscle weakness, morbid obesity, left sided hemiplegia, and peripheral vascular disease (PVD).</p> <p>Review of a quarterly Minimum Data Set (MDS), dated [DATE], revealed R#325 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. The MDS indicated R#325 was totally dependent for bed mobility and transfer. According to the MDS, the resident had experienced one fall with no injury since admission, reentry, or prior assessment.</p> <p>Review of the Progress Note, dated 12/28/2021 at 11:08 p.m. revealed R#325 had a fall from the mechanical lift, after which the resident complained of pain to the left leg. Pain medication was administered, and an x-ray was ordered immediately (STAT).</p> <p>Review of the related incident report dated 12/28/2021 at 11:00 p.m. revealed R#325 fell from the mechanical lift. The resident reported suffering a hard fall and was having leg pain. The immediate actions taken included notification of the Director of Nursing and Medical Doctor, administration of pain medication, and obtaining an order for an x-ray. Further review of the incident report revealed the following:</p> <ul style="list-style-type: none"> <li>- The location of the incident was the resident's room. The report indicated there were no witnesses to the fall but also indicated the resident, fell from Hoyer [mechanical] lift while being transferred.</li> <li>- A note dated 12/29/2021 on the report revealed, Resident was lowered to the floor by the assigned CN [Charge Nurse] and CNA [Certified Nursing Assistant] from the Hoyer lift. The BLE [bilateral lower extremities] x-ray revealed no abnormalities.</li> <li>- A handwritten statement with the incident report revealed the staff member was transferring the resident from a Geri chair to bed. When the lift was moved from the hallway to the bed, the staff member was having to hold onto the sling under the resident's bottom, and the lift began to tilt and fall over. The staff member managed to guide [resident's] feet first onto the floor, having hold of the top of the sling. I put my foot under [her] bottom, I eased [her] back down as it was in an upright position and made sure [she] would not hit [her] head, made sure [she] was able to keep [her] head up before I let go to go &amp; [and] get pillows.</li> </ul> <p>Review of an x-ray report, dated 12/29/2021 at 2:15 a.m., indicated the x-ray was completed due to pain in the resident's right and left thighs. The results indicated no fracture or dislocation was seen, and the hip joint was grossly intact.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a Transfer/Discharge Report revealed that on 12/30/2021, R#325 was transferred to the hospital for further evaluation post-fall.</p> <p>Interview on 8/4/2022 at 12:16 p.m. with Licensed Practical Nurse (LPN) Manager AA indicated she recalled the resident and the incident but had no training documents related to the incident.</p> <p>Interview on 8/4/2022 at 12:58 p.m. with the Social Worker (SW) reported incidents were discussed in morning meetings, and nursing investigated the falls.</p> <p>Interview on 8/4/2022 at 1:21 p.m. with the DON stated the CNA involved in the incident gave a statement which indicated the mechanical lift tipped over during the transfer. The DON revealed she did not have a documented investigation of the incident and had not determined the root cause of the mechanical lift tipping. The DON reported it had not been determined how many staff were present during the transfer, or if the mechanical lift had been used properly. The DON reported there had not been any additional training for staff using the mechanical lift since the incident.</p> <p>During a follow-up interview on 8/7/2022 at 8:12 a.m. with the DON, stated she felt it was an isolated incident. The DON reported she expected a thorough investigation be completed and that the findings should be documented.</p> <p>The Administrator was not available for interview.</p> <p>20958</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40141</p> <p>Based on observations, record review, staff interviews, and policy review, the facility failed to maintain an effective infection control program to prevent the spread of COVID-19 on three of three nursing units (second floor, third floor, and fourth floor). Specifically, the following failures were identified:</p> <ol style="list-style-type: none"> <li>1.The facility failed to ensure one resident (R) (R#233) of 11 residents admitted in the last 30 days was promptly tested for COVID-19 and quarantined, which resulted in failure to separate COVID-positive and COVID-negative residents to the extent possible.</li> <li>2. The facility failed to ensure testing of residents and staff for COVID-19 was promptly initiated when a COVID-19 outbreak was identified in the facility.</li> <li>3. The facility failed to ensure staff were fit tested for N95 masks in accordance with Occupational Safety and Health Administration (OSHA) standards and adhered to requirements for the use of personal protective equipment (PPE) during a COVID-19 outbreak in the facility.</li> <li>4. The facility failed to ensure screening for signs and symptoms and/or exposure to COVID-19 was consistently completed for staff upon entering the facility.</li> </ol> <p>On 8/4/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents.</p> <p>The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 8/4/2022 at 5:24 p.m. The noncompliance related to the IJ was identified to have existed on 7/25//2022.</p> <p>A removal plan (Credible Allegation of Compliance) was received on 8/6/22. The survey team conducted observations, reviewed training records, and interviews with staff and residents to verify elements of the facility's removal plan were implemented. The immediacy of the Immediate Jeopardy was removed on 8/6/22. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures. In-service materials and records were reviewed. Observations and interviews were conducted with staff to ensure they demonstrated knowledge of the facility's policies and procedures.</p> <p>Findings included:</p> <p>Review of the facility's policy titled, Pandemic Event Emergency Procedure Coronavirus (COVID-19) Respiratory Disease Infection, revised 3/20/2020, revealed Strategies to prevent the spread of the COVID-19 virus in general are the same strategies to detect and prevent the spread of other respiratory viruses. The facility will make attempts to protect the health and safety of our employees, residents, and visitors by attempting to prevent the spread of this emerging disease. The facility will adhere to recommendations from the Centers for Disease Control and Prevention.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>1. Review of the policy titled, Facility Testing Requirements for Staff and Residents, revised 9/24/2021, revealed Residents will be tested upon admission for COVID-19.</p> <p>Review of the facility's policy titled, Cohorting Residents Guidance, dated 8/2/2020, revealed, Cohorting - The practice of isolating multiple individuals with similar symptoms and conditions together. The policy included a grid, which indicated residents with the same COVID-19 status should be cohorted. The examples included housing two residents with unknown COVID-19 status and no symptoms together or housing two residents with unknown COVID-19 status with symptoms together. For a COVID-positive resident, the options were to place the resident in a private room or COVID unit or to cohort them with another COVID-positive resident.</p> <p>Review R#233's clinical record revealed he was admitted to the facility on [DATE] with diagnoses of cerebral infarction (stroke) due to thrombosis (blood clot) of right posterior cerebral artery and vascular dementia. Review of the resident's immunization history revealed no evidence the resident had been vaccinated against COVID-19.</p> <p>Review of the Resident COVID Line Testing revealed R#233's COVID-19 status was unknown until testing on 7/26/2022 when R#233 tested positive for COVID-19. A concurrent review of the Resident COVID Line Testing and the Detailed Census Report revealed, R#233 had changed rooms three times between 7/21/2022 and 7/26/2022.</p> <p>Further review of the Detailed Census Report dated 8/6/2022 revealed R#233 was admitted to a room on the second floor. On 7/23/2022 and 7/26/2022, the resident was moved to other rooms on the second floor.</p> <p>Review of the Resident COVID Line Testing dated 8/1/2022 revealed four residents (R#14, R#4, R#232 and R#60) who had been roommates of R#233 between 7/21/2022 and 7/26/2022 had tested positive for COVID-19.</p> <p>Interview on 8/4/2022 at 2:26 p.m., the Director of Nursing (DON) confirmed if a resident tested positive for COVID-19 and the roommate tested negative, the facility would leave them in the same room. During continued interview, the DON indicated the facility had been at 180 capacity and, if a resident tested positive, then the roommate was likely positive. The DON stated, We did not move anyone, just in case we had false positives, and to decrease transmission.</p> <p>Interview on 8/7/2022 at 9:35 a.m., the DON indicated her expectation was that new admissions would be tested on admission and room placement would be based on COVID-19 status. She stated Persons Under Investigation (PUI) would be in quarantine for 14 days.</p> <p>2. Review of the policy titled, Facility Testing Requirements for Staff and Residents, revised 9/24/2021, revealed, a table titled, Testing Summary which indicated Newly identified COVID-19 positive staff or resident in a facility that is unable to identify close contacts - Test all staff vaccinated and unvaccinated, facility wide or at a group level if staff are assigned to a specific location where the new case occurred. The policy also indicated, Outbreak Trigger Testing - Test all staff and residents in response to an outbreak (defined [as] any single new infection in staff or any nursing home onset infection in a resident). Continue to test all staff and residents that tested negative every three days to seven days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Interview on 8/1/2022 at 9:59 a.m., the Administrator stated the facility had some COVID-19 positive residents in the building.</p> <p>Review of a Resident COVID Line Testing document, dated 7/25/2022 for the third floor of the facility, revealed 14 residents (R#150, R#76, R#116, R#134, R#54, R#140, R#22, R#135, R#33, R#130, R#93, R#104, R#156, and R#63) tested positive for COVID-19.</p> <p>Review of a Resident COVID Line Testing document dated 7/26/2022 for the second floor of the facility revealed two residents (R#233 and R#275) tested positive for COVID-19.</p> <p>Review of a Resident COVID Line Testing document dated 7/29/2022 for the third floor revealed one resident (R#20) tested positive for COVID-19.</p> <p>Review of a Resident COVID Line Testing document dated 8/1/2022 revealed 11 additional residents on the second floor (R#103, R#165, R#23, R#2, R#137, R#172, R#43, R#14, R#4, R#232 and R#60) tested positive for COVID-19.</p> <p>Review of a Resident COVID Line Testing document revealed testing for the fourth floor of the facility was not completed until 8/2/2022, eight days after the COVID-19 outbreak started. The document for the fourth floor revealed one resident (R#90) tested positive.</p> <p>Interview on 8/3/2022 at 11:04 a.m., the DON and the Assistant DON (ADON) stated they were sharing the Infection Preventionist (IP) role because the Staff Development Coordinator was new. The DON indicated outbreak testing had started on 7/25/2022, when two residents (R#93 and R#320) on the third floor had signs and symptoms of COVID-19. The DON indicated all residents on the third floor were tested and 14 tested positive. The DON indicated unvaccinated staff were tested every Wednesday; however, the DON revealed not all staff had been tested. The DON indicated the facility determined staff testing needs by presence of signs and symptoms and reported none of the staff had symptoms. The DON indicated the second-floor residents were tested on [DATE], and two residents tested positive. The fourth-floor residents were tested on [DATE], and one resident tested positive. The DON indicated the delay in testing the residents on the fourth floor was due to none of the residents on the fourth floor having displayed signs or symptoms of COVID-19. The DON indicated the third-floor residents were retested on [DATE], and four of the 14 residents remained positive. The DON indicated from 7/25/2022 to 8/3/2022, one staff member had tested positive. The ADON added that unvaccinated staff were tested on ce weekly (Wednesday) prior to the outbreak; this did not include existing residents, just unvaccinated employees, and any new admissions. The ADON indicated new admissions were tested on admission and all residents had orders to be tested as needed.</p> <p>Interview on 8/3/2022 at 11:16 a.m., the ADON confirmed the facility only tested unvaccinated staff routinely. Other employees were only tested if they had signs and symptoms.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>3. Review of the Centers for Disease Control and Prevention (CDC) guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, revised 2/2/2022, revealed, Source control options for HCP [healthcare personnel] include: A NIOSH [National Institute for Occupational Safety and Health]-approved N95 or equivalent or higher-level respirator OR a respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators. (Note: These should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated) OR a well-fitting facemask. Further review of the CDC guidance revealed, Source Control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting. Additionally, the guidance indicated, Implement universal use of PPE for healthcare personnel.</p> <p>Review of Occupational Safety and Health Administration (OSHA) Health Standard 1910.134, titled, Respiratory Protection, revealed the following:</p> <p>- 1910.134(c)(1) - In any workplace where respirators are necessary to protect the health of the employee or whenever respirators are required by the employer, the employer shall establish and implement a written respiratory protection program with worksite-specific procedures. The program shall be updated as necessary to reflect those changes in workplace conditions that affect respirator use. The employer shall include in the program the following provisions of this section, as applicable: Procedures for selecting respirators in the workplace; Medical evaluations of employees required to use respirators; Fit testing procedures for tight-fitting respirators; Training of employees in the proper use of respirators, including putting on and removing them, any limitations on their use, and their maintenance.</p> <p>- 1910.134(f) - Fit testing. This paragraph requires that, before an employee may be required to use any respirator with negative or positive pressure tight-fitting facepiece, the employee must be fit tested with the same make, model, style, and size of respirator that will be used.</p> <p>- 1910.134(f)(2) - The employer shall ensure that an employee using a tight-fitting facepiece respirator is fit tested prior to initial use of the respirator, whenever a different respirator facepiece (size, style, model or make) is used, and at least annually thereafter.</p> <p>Observation and interview on 8/3/2022 at 9:22 a.m., Licensed Practical Nurse (LPN) Manager AA, who was wearing an N95 mask, indicated staff had to wear an N95 mask in the hallway and full PPE in rooms that had stop signs on the door, which indicated the residents in those rooms were on isolation precautions. LPN Manager AA indicated this started on Monday, 8/1/2022, because a new admission from the hospital had tested positive. The LPN Manager indicated N95 masks were individually packaged and were obtained at the front desk. LPN Manager AA indicated she had not been fit tested for the mask she was wearing.</p> <p>Interview on 8/3/2022 at 11:04 a.m., the DON indicated N95 masks were required on all floors. When asked about the N95 fit testing for staff, the DON indicated the masks came in a standard size and further stated that no one had complained the masks did not fit.</p> <p>Observation and interview on 8/3/2022 at 1:50 p.m., LPN CCC was passing medications to residents on the third floor of the facility without wearing a face mask. She stated she had taken her mask off and forgot to put it back on.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Interview on 8/7/2022 at 9:35 a.m., the DON indicated her expectation was for all staff to wear PPE appropriately. The DON indicated N95 masks, goggles, gown, and gloves were to be worn on the unit in COVID-positive residents' rooms. The DON indicated face coverings should always be worn in the building, either a 3-ply mask when downstairs (the non-resident-occupied floor of the facility), or an N95 when in patient care areas.</p> <p>20958</p> <p>4. Review of a facility policy titled, Pandemic Event Emergency Procedure Coronavirus (COVID-19) Respiratory Disease Infection, dated as revised 3/20/2020, revealed, Residents, employees, contract employees and visitors should be evaluated daily for symptoms. Employees should self-report symptoms and exposure. Symptoms of Respiratory Infections including COVID-19 are: -Fever -Cough -Shortness of Breath. The policy also indicated, All Employees - Screen all Employees by obtaining temperatures and assessing for coughing, and sore throat symptoms, chest discomfort or shortness of breath. If temperature is greater than 100 degrees Fahrenheit, and/or employee reports respiratory type symptoms the employee will not be allowed to start work duty and will need to follow up with their healthcare provider immediately.</p> <p>Review of the policy titled, Facility Testing Requirements for Staff and Residents, revised 9/24/2021, revealed, Facility staff and individuals entering facility will be screened upon entering the facility for signs and symptoms of COVID-19, vaccination status and potential exposure risk.</p> <p>Observation on 8/2/2022 at 8:00 a.m. revealed signage posted at the facility entrance directing everyone to be screened upon entering the building.</p> <p>Review of the facility's Employee and Essential Worker COVID-19 Screening Log revealed the staff COVID-19 screenings included taking the employee's temperature, as well as determining the following:</p> <ul style="list-style-type: none"> <li>- Whether the employee had any of the following symptoms: loss of smell or taste, nausea, diarrhea, vomiting, fever, cough, shortness of breath, sore throat.</li> <li>- Whether, in the past 14 days, the employee had traveled internationally.</li> <li>- Whether, in the past 14 days, the employee had any contact with any person with known COVID-19 infection or was under evaluation for exposure to COVID-19, or a person with respiratory illness.</li> <li>- Whether, in the past 14 days, the employee had worked in or entered a facility with suspected or confirmed COVID-19 infection (and if so, whether the employee wore appropriate PPE).</li> </ul> <p>Interview on 8/5/2022 at 9:40 a.m., Certified Nursing Assistant (CNA) PP stated the screening process was for each person to check their temperature and answer the screening questions. CNA PP indicated there was a screening form for visitors and a different form for staff. Per CNA PP, she had forgotten to screen and started work before screening but later remembered and went back to complete the screening.</p> <p>Interview on 8/5/2022 at 10:40 a.m., CNA EE stated the screening process included a temperature check and signing the book located at the main entrance to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Interview on 8/5/2022 at 10:55 a.m., Licensed Practical Nurse (LPN) FF stated the screening process included a temperature check and answering questions every time she came to work. LPN FF stated the front entrance was the only entrance to enter the facility.</p> <p>On 8/4/2022, the surveyor reviewed and compared the facility's screening log and time report. The number of staff who had clocked in for work was compared to the number of staff who had completed their COVID-19 screenings. The results were as follows:</p> <ul style="list-style-type: none"> <li>- On 7/20/2022, 68 staff clocked in for work and only 49 staff completed the COVID-19 screening.</li> <li>- On 7/21/2022, 71 staff clocked in for work and only 32 staff completed the COVID-19 screening.</li> <li>- On 7/23/2022, 35 staff clocked in for work, and only 29 staff completed the COVID-19 screening.</li> <li>- On 7/25/2022, 62 staff clocked in for work, and only 29 completed the COVID-19 screening.</li> <li>- On 7/26/2022, 71 staff clocked in for work, and only 37 completed the COVID-19 screening.</li> <li>- On 7/31/2022, 36 staff clocked in for work, and only 16 completed the COVID-19 screening.</li> </ul> <p>Interview on 8/4/2022 at 10:38 a.m., Human Resources (HR) Staff BBB compared the above lists to a daily number of staff on payroll and reported the same results as calculated by the surveyor.</p> <p>Interview on 8/7/2022 at 8:12 a.m., the DON stated she expected staff to continue screening for COVID-19 when entering the building and not just walk through. The DON indicated the Staff Development Coordinator would be responsible for auditing the screening forms.</p> <p>Interview on 8/7/2022 at 10:16 a.m., Receptionist DDD stated when staff and visitors entered the facility, they were to stop at the front desk for screening. She stated there had been occasions when staff sneaked into the facility through a rear entrance.</p> <p>The Administrator was not available for interview.</p> <p>Removal Plan:</p> <p>1. Root cause completed with (DON) Director of Nursing. From the root cause analysis, systems were identified that required an immediate action plan to correct deficient practices. The root cause analysis findings were reported to the Ad Hoc Quality Improvement Performance Improvement Committee. This committee reviewed and approved the (IJ) Immediate Jeopardy removal plan on August 6, 2022. Members of the Ad Hoc QAPI [Quality Assurance Performance Improvement] committee consisted of Medical Director and LNHA [Licensed Nursing Home Administrator] via phone, DON, Regional Director, and Department Heads.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Legacy Transitional Care & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  460 Auburn Avenue N.E. Atlanta, GA 30312	
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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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>2. A Quality improvement tool was developed and initiated which will be monitored weekly by DON or designee to ensure proper N95 [sic] are used, proper PPE are used by staff and residents, and anyone who enters the facility will complete covid-19 screening. Initial audit results were not all employees have been fit tested , some residents and staff not wearing masks to cover nose and mouth, and not all visitors/staff had screened properly. These deficient practices have been reported to the QAPI AD HOC committee and corrective measure taken to ensure compliance has been taken. Future audits will be completed weekly X 8 weeks and then monthly X3 months. DON will report findings in QAPI X 3 months or until a period of compliance is achieved.</p> <p>3. 55 employees participated in N-95 fit (re)testing with the medical clearance forms on 8/5/2022. The DON has been trained to perform the fit tests. Anyone who cannot physically complete the fit testing will have documentation that they cannot medically complete the testing.</p> <p>4. On 8/5/2022 The DON or her designee will educate 124 staff on proper N95 use, proper PPE use by staff and residents. Anyone who enters the facility will complete covid-19 screening. The DON will audit screening process daily by comparing the screening logs to the schedules to verify compliance of the deficient practice. Any staff member who has not completed education and COVID-19 testing will be unable to work until it has been completed. 68 employees out of 124.</p> <p>5. On 8/5/2022 all residents were supplied with a mask for use and explained that the mask was necessary while out of room. Additional face masks available on each nursing unit for clinical and non-clinical staff to distribute to residents.</p> <p>6. On 8/5/2022 regional director educated DON, Infection preventionist and Administrator on proper N95 use, proper PPE use by staff and residents, and anyone who enters the facility will complete covid-19 screening.</p> <p>7. Facility respiratory protection program, PPE utilization and visitor and staff screening procedures per CDC recommended guidelines were reviewed by the Medical Director, Administrator, Director of Nursing and Regional Director of Clinical Operations during an Ad Hoc QAPI meeting on 8/5/2022. The Infection Control and Prevention policy was reviewed on 8/5/2022 and no changes were made.</p> <p>8. All corrections were completed on August 5, 2022.</p> <p>9. The immediacy of the IJ was removed on August 6, 2022.</p> <p>Onsite Verification:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>The IJ was removed on 8/6/2022 after the survey team performed onsite verification that the Removal Plan had been implemented. COVID-19 positive residents were verified to have been moved to the second floor and were not placed with COVID-19 negative residents. Review of sign-in sheets and testing records revealed staff education was ongoing and N95 fit testing was completed. Interviews were conducted with random staff, who correctly verbalized the requirements regarding the need to always wear N95 masks in resident areas, as well as gown, gloves, and face shield/goggles to be worn in the rooms of COVID-positive residents or persons under investigation for COVID-19. The screening process was observed on 8/7/2022, and an audit was completed to verify COVID-19 screening was completed for all staff on duty. The DON's audits were reviewed and verified to have been completed. The DON's education by the Regional Director was verified to have been completed. On 8/7/2022, staff from both shifts were interviewed to confirm education and corrective measures including:</p> <ul style="list-style-type: none"> <li>- Knowledge of the COVID-19 screening process.</li> <li>- When each interviewed staff member was last tested for COVID-19.</li> <li>- Whether each interviewed staff member had been fit tested for an N95 mask.</li> <li>- Knowledge of the proper PPE for entering the rooms of COVID-positive residents or persons under investigation for COVID-19.</li> </ul>		

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<p>F 0886</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Perform COVID19 testing on residents and staff.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40141</b></p> <p>Based on record review, interviews, and policy review, the facility failed to conduct routine and outbreak testing for COVID-19 for all staff and residents in accordance with Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS) requirements, which potentially caused delays in identifying, treating, and isolating COVID-19 positive residents and staff on 3 of 3 resident-occupied floors of the facility (second floor, third floor, and fourth floor). Specifically, the facility failed to quarantine and test one of 11 newly admitted residents (R) R#233; failed to conduct outbreak testing/contract tracing for employees and residents upon identifying a COVID-19 outbreak in the facility; and failed to ensure unvaccinated or staff not up to date with COVID-19 vaccines were routinely tested twice weekly per CDC guidance when the community transmission level was high in the county where the facility was located.</p> <p>On 8/4/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents.</p> <p>The facility's Administrator was informed of the Immediate Jeopardy (IJ) on 8/4/2022 at 5:24 p.m. The noncompliance related to the IJ was identified to have existed on 7/25//2022.</p> <p>A removal plan (Credible Allegation of Compliance) was received on 8/6/22. The survey team conducted observations, reviewed training records, and interviews with staff and residents to verify elements of the facility's removal plan were implemented. The immediacy of the Immediate Jeopardy was removed on 8/6/22. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures. In-service materials and records were reviewed. Observations and interviews were conducted with staff to ensure they demonstrated knowledge of the facility's policies and procedures.</p> <p>Findings included:</p> <p>Review of a CMS Quality/Survey and (&amp;) Oversight (QSO) Group memorandum, Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements, QSO-20-38-NH, revised 3/10/22, indicated, Routine Testing of Staff, Routine testing of staff, who are not up-to-date, should be based on the extent of the virus in the community. Staff, who are up-to date, do not have to be routinely tested . Facilities should use their community transmission level as the trigger for staff testing frequency.</p> <p>Table 2: Routine Testing Intervals by County COVID-19 Level of Community Transmission</p> <p>Level of COVID-19 Community Transmission/Minimum Testing Frequency of Staff who are not up to date+</p> <p>Low (blue) = Not recommended</p> <p>Moderate (yellow) = Once a week</p> <p>(continued on next page)</p>		

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<p>F 0886</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Substantial (orange) = Twice a week</p> <p>High (red) = Twice a week</p> <p>+ Staff who are up to date do not need to be routinely tested .</p> <p>Review of the CDC guidance titled, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 [severe acute respiratory syndrome coronavirus 2] Spread in Nursing Homes, dated 2/2/2022, revealed, In nursing homes, newly admitted residents should be tested immediately.</p> <p>Review of a facility policy titled, Facility Testing Requirements for Staff and Residents, revised 9/24/2021, revealed Residents will be tested upon admission for COVID-19.</p> <p>1. Review of R#233's clinical record revealed he was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy, diabetes mellitus type 2, and cerebral infarction.</p> <p>Review of a Detailed Census Report, revealed R#233 was initially admitted to a room on the second floor. On 7/23/2022, the resident was moved to another room on the second floor.</p> <p>Review of the Resident COVID Line Testing, dated 7/26/2022, revealed R#233 tested positive for COVID-19. The Detailed Census Report indicated the resident was moved to a third room on the second floor on this date. The resident remained in this room at the time of the survey.</p> <p>Review of the Resident COVID Line Testing, dated 8/1/2022, revealed a total of four residents (R#14, R#4, R#232 and R#60) who had been R#233's roommates between 7/21/2022 and 7/26/2022 had tested positive for COVID-19.</p> <p>Interview on 8/3/2022 at 11:04 a.m., the Director of Nursing (DON) and the Assistant DON (ADON) stated they were sharing the Infection Preventionist (IP) role. The DON indicated residents on the second floor were tested on [DATE], and two residents tested positive. The ADON indicated new admissions were to be tested for COVID-19 upon admission and all residents had physician's orders for as-needed (PRN) testing.</p> <p>2. Review of a Resident COVID Line Testing, dated 7/25/2022, revealed 14 residents on the third floor tested positive for COVID-19. There was no evidence outbreak testing was immediately initiated for residents on other floors or for facility staff. No contact tracing efforts were documented.</p> <p>Review of a Resident COVID Line Testing, dated 7/26/2022, revealed two residents on the second floor tested positive for COVID-19.</p> <p>Review of a Resident Covid Line Testing, dated 7/29/2022, revealed four residents on the third floor tested positive for COVID-19. There was no evidence facility staff and residents residing on the fourth floor had been tested as a result of the ongoing COVID-19 outbreak in the facility.</p> <p>Review of a Resident COVID Line Testing, dated 8/1/2022, revealed the same four residents on the third floor tested positive for COVID-19.</p> <p>(continued on next page)</p>		

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<p>F 0886</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Review of a Resident COVID Line Testing, dated 8/1/2022, revealed a total of 11 residents on the second floor tested positive for COVID-19. There was still no evidence facility staff and residents residing on the fourth floor had been tested as a result of the ongoing COVID-19 outbreak in the facility.</p> <p>Review of a Resident COVID Line Testing, dated 8/2/2022, revealed one resident on the fourth floor tested positive for COVID-19. There was no evidence outbreak testing had been initiated for facility staff.</p> <p>Interview on 8/3/2022 at 11:04 a.m., with the DON and the ADON revealed outbreak testing had started on 7/25/2022, when two residents on the third floor had signs and symptoms of COVID-19. The DON indicated all residents on the third floor were tested , and 14 were positive. The DON stated no staff members had been tested . She confirmed that the facility did not test all employees during an outbreak. She stated the facility tested staff based on COVID symptoms, and none of the staff had exhibited symptoms. The DON indicated residents on the second floor were tested on [DATE] and there were two COVID-positive residents. During further interview, the DON stated the residents on the fourth floor were tested on [DATE] and there was one COVID-positive resident. She indicated the facility had not tested the fourth-floor residents prior to 8/2/2022 because there had been no residents on that floor exhibiting signs or symptoms of COVID-19. The DON indicated the third floor had been retested on [DATE], and four of the 14 residents remained positive. The DON indicated from 7/25/2022 to 8/3/2022, one staff (who was tested as part of the weekly testing of unvaccinated staff) had tested positive.</p> <p>Interview on 8/3/2022 at 11:16 a.m., the ADON confirmed unvaccinated staff were tested for COVID-19 routinely, but other employees were only tested if they had signs and symptoms of COVID-19.</p> <p>Interview on 8/4/2022 at 8:50 a.m., the DON stated she did perform contact tracing during the current COVID-19 outbreak. She stated she made a floor grid and looked to see if there were any common factors with the positive rooms. She stated she determined if there were any visitors who visited the positive residents and she looked to determine if the staff who worked with the positive residents had worked with any other residents in the facility. She stated she decided after the first two positive residents were identified to assign designated staff to work on the units and not work on any of the other units during the outbreak. She stated she could not pinpoint any common factors related to the first two positive residents. She stated there were no visitors for the first two positive residents. She also indicated none of the staff who had taken care of the two COVID-positive residents were COVID-positive. When asked how she determined this, since the facility only tested unvaccinated staff or staff who were symptomatic, the DON could not explain and stated, You are right. I would not be able to determine that; we are not testing all staff. The DON confirmed the facility had not effectively implemented and completed contact tracing during the COVID-19 outbreak. She stated she had not documented the contact tracing she had performed. The DON stated the only COVID-positive employee identified to date was an activity aide who had worked on the fourth-floor unit for the past two weeks.</p> <p>Interview on 8/7/2022 at 9:35 a.m., the DON indicated she expected contact tracing to be conducted and for staff and residents to be tested per CDC guidance.</p> <p>The Administrator was not available for interview.</p> <p>(continued on next page)</p>		

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<p>F 0886</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>3. Review of the CDC guidance titled, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 [severe acute respiratory syndrome coronavirus 2] Spread in Nursing Homes, dated 2/2/2022, revealed in nursing homes, HCP [healthcare personnel] who are not up to date with all recommended COVID-19 vaccine doses should continue expanded screening testing based on the level of community transmission. The guidance indicated in nursing homes located in counties with substantial to high community transmission, HCP should have a viral test twice a week.</p> <p>Review of the Centers for Disease Control and Prevention (CDC) Covid Data Tracker for 8/3/2022 revealed the county where the facility was located had a high COVID-19 community transmission level.</p> <p>On 8/3/2022 at 11:04 a.m., the DON and the ADON were interviewed as the Infection Preventionists (IP). The DON indicated unvaccinated staff were being tested on ce per week, every Wednesday.</p> <p>Interview on 8/7/2022 at 9:35 a.m., the DON indicated the facility would follow CDC guidance and expected unvaccinated staff to be tested twice weekly.</p> <p>Removal Plan:</p> <p>1. Root cause completed with (DON) Director of Nursing. From the root cause analysis, systems were identified that required an immediate action plan to correct deficient practices. The root cause analysis findings were reported to the Ad Hoc Quality Improvement Performance Improvement Committee. This committee reviewed and approved the (IJ) Immediate Jeopardy removal plan on August 6, 2022. Members of the Ad Hoc QAPI [Quality Assurance Performance Improvement] committee consisted of Medical Director and LNHA [Licensed Nursing Home Administrator] via phone, DON, Regional Director, and Department Heads.</p> <p>2. A Quality improvement tool was developed and initiated which will be monitored weekly by DON or designee to ensure effective testing procedures COVID-19, appropriate cohorting, and completion of contact tracing staff sign in sheets. An audit was completed on August 5, 2022, on 20 COVID-19 positive residents. Initial audit results where contact tracing employee signature forms were needed on the rooms of those 20 COVID-19 positive residents and have been reported to the QAPI AD HOC committee and corrective measure taken to ensure compliance of COVID19 testing and proper cohorting and isolation precautions have been taken. Daily audits will be conducted on newly admitted residents, or those returning from extended leaves of absences. Future audit will be completed weekly X [times] 8 weeks and then monthly X 3 months. DON will report findings in QAPI X 3 months or until a period of compliance is achieved.</p> <p>3. On 8/5/2022 45 staff tested for COVID-19. 44 of staff test results negative. 1 staff test results positive. Staff members who have not completed COVID-19 testing will be unable to work until COVID19 testing has been completed.</p> <p>4. On 8/5/2022 167 in-house residents were be tested for COVID-19. 147 test results negative. 20 test results positive.</p> <p>5. On 8/5/2022 all new admissions tested . 1 tested with negative test results for COVID-19. Any new admissions/readmissions will be tested for COVID-19 going forward.</p> <p>(continued on next page)</p>		

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<p>F 0886</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>6. On 8/5/2022 (20) Residents tested positive have been cohorted with other residents that tested positive and placed in transmission-based precautions. The following rooms have COVID positive residents in transmission-based precaution isolation. [Room numbers listed].</p> <p>7. On 8/5/2022 (30) residents that tested negative and were in close contact or assigned to the same room as a resident who tested positive will be cohorted with other residents who also tested negative and were in close contact or assigned to the same room as a resident who tested positive and placed on transmission-based precautions as PUIs [Persons Under Investigation]. (30) of residents meet CDC criteria for possible exposure risk and are categorized as a PUI. The following rooms are identified as persons under investigation for COVID19 due to their possible exposure risk. [Room numbers listed].</p> <p>8. On 8/5/2022 all new admissions who are unvaccinated placed with other new admissions who are unvaccinated and placed on transmission-based precautions as PUIs. (1) new admissions were tested and assigned to appropriate rooms based on test results. Any unvaccinated new admissions going forward will be placed in PUI with other unvaccinated new admissions, following CDC guidelines.</p> <p>9. On 8/5/2022 all rooms with any resident that tested positive or were in close contact or assigned to the same room as a resident who tested positive will have a staff contact tracing sign in log attached to their door. [Room numbers listed].</p> <p>10. All residents who have tested positive were notified by the Unit Managers and/or Social Services on the day they tested positive.</p> <p>11. On 8/5/2022 DON or her designee (who has been educated by the DON) will educate 124 staff members on COVID-19 testing policy, cohorting practices, PUI practices, and contact tracing. Any staff member who has not completed education and COVID-19 testing will be unable to work until it has been completed. 68 employees out of 124.</p> <p>12. Contact tracing signage were [sic] placed on the doors of all residents testing positive and all PUI. [Room numbers listed].</p> <p>13. On 8/5/2022 regional director educated the DON, Infection preventionist and Administrator on COVID-19 testing policy, Cohorting practices, PUI practices, and contact tracing.</p> <p>14. Facility COVID-19 testing policy, Facility Respiratory Protection Program, CDC recommendations for transmission-based practices to prevent the spread of COVID-19 including cohorting guidelines, persons under investigation related to possible exposure to COVID-19, Contact Tracing procedures were reviewed with the Medical Director, Administrator, Director of Nursing and Regional Director of Clinical Operations during an Ad Hoc QAPI meeting on 8/5/2022. The Infection Control and Prevention policy was reviewed on 8/5/2022 and no changes were made.</p> <p>15. All corrections were completed on August 5, 2022.</p> <p>16. The immediacy of the IJ was removed on August 6, 2022.</p> <p>Survey Agency validated removal of the Immediate Jeopardy as follows:</p> <p>(continued on next page)</p>		

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<p>F 0886</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>The IJ was removed on 8/6/2022 after the survey team performed onsite verification that the Removal Plan had been implemented. COVID-19 positive residents had been moved to the second floor and were not placed with negative residents. Sign-in sheets for staff were observed to have been placed outside resident room doors as per the removal plan. Implementation of the removal plan was verified through observations, staff interviews, and record reviews. Staff and resident COVID-19 testing was verified through record review and interview. Inservice sign-in sheets were reviewed to verify staff education was provided per the removal plan. The DON audits were reviewed. Review of education records verified the DON's education by the Regional Director was completed. Staff members from both shifts were interviewed regarding when they were last tested for COVID-19 and whether they were aware of the purpose of the sign-in sheets posted on the residents' room doors.</p>		