

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ALC000662</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>09/05/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEGACY RIDGE AT MARIETTA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>840 LECROY DRIVE MARIETTA, GA 30068</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
{0000}	<p>Initial Comments.</p> <p>The purpose of this visit was to investigate intake #GA50004215 and #GA50005428. An onsite visit was made 8/27/25 and the inspection was completed 9/5/25.</p>		
{0900} SS= D	<p>111-8-63-.09(1) Workforce Qualifications.</p> <p>Workforce Qualifications, Training and Staffing. The on-site manager and responsible staff persons must be at least 21 years of age and responsible for supervising the provision of care by all other staff. No staff person under the age of 18 is permitted to work in the assisted living community unless there is direct line-of-sight supervision being provided by the administrator, on-site manager or a responsible staff person or the staff member is at least 17 years of age and has successfully completed a vocational technical training track as a nursing assistant through a Georgia high school.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that all staff was at least 17 years of age for 1 of 4 sampled staff (Staff D). Findings included:</p> <p>During a tour of the facility 35 residents and 9 staff were observed. Staff D had resigned and was not observed.</p> <p>A review of the file for Staff D, hired 6/12/25, showed job description as part time server. The file also showed Staff D was 16 years old.</p>		

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<p>{2058}</p> <p>SS= D</p>	<p>During an interview on 8/27/25 at 2:32 p.m., Staff A stated Staff D was hired part time over the summer as a server. Staff A also stated Staff D had resigned.</p> <p>111-8-63-.20(12)(d) Timely Management of Medication Procurement.</p> <p>Timely Management of Medication Procurement. Where the assisted living community procures medications on behalf of the residents, the community must obtain new prescriptions within 48 hours of receipt of notice of the prescription or sooner if the prescribing physician indicates that a medication change must be made immediately. If the pharmacy does not have the medication needed for the immediate change, available and has not obtained further directions from the physician, the community must notify the physician of the unavailability of the prescription and request direction. Refills of prescribed medications must be obtained timely so that there is no interruption in the routine dosing. Where the assisted living community is provided with a new medication for the resident, the MAR must be modified to reflect the addition of the new medication within 48 hours or sooner if the prescribing physician indicates that the medication change must be made immediately.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interviews the facility failed obtain a new prescription on behalf of the resident within 48 hours of receipt of the notice of the prescription for 1 of 3 sampled residents ( Resident #1).</p> <p>Findings included:</p>		

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	<p>During a tour of the facility Resident #1 was observed in memory care sitting in the common area watching television. The medication supply of Resident #1 was observed with all ordered medication available on the cart.</p> <p>A review of the file for Resident #1, admitted 5/1/25 with diagnoses Lewy body dementia, neurocognitive disorder and anxiety disorder.</p> <p>A review of the Medication Administration Record (MAR), for Resident #1, dated 8/2/2025, showed Buspirone 15 mg tablet ordered 1 tablet by mouth 2 times daily for anxiety disorder at 8:00 a.m. and 8:00 p.m. The MAR also showed the resident missed 1 dose of the medication 8/2/25 at 8:00 a.m.</p> <p>During an interview on 8/27/25 at 2:01 p.m., Staff B stated on 8/1/25, Resident #1 returned to the facility from the hospital with a prescription, but no medication. Staff B stated Staff C did not Fax the prescription to the pharmacy on 8/1/25. Staff B also stated Resident #1 missed 1 dose of buspirone prior to having been picked up by AA and taken to the emergency room. Staff B further stated Resident #1 suffered no adverse reaction from not having received the ordered medication.</p>		

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	<p>During an interview on 8/27/25 at 2:32 p.m., Staff A stated the medication error for Resident #1 was reported and corrected as soon as it was brought to the staff's attention.</p> <p>During an interview on 9/2/25 at 8:49 a.m., AA stated Resident #1 returned to the facility 8/1/25 from the hospital. AA also stated he/she gave the prescriptions to the facility 8/1/25 at approximately 1:00 p.m., and the prescription was not filled. AA stated he/she took Resident #1 to the emergency room where medication was administered to the resident . AA further stated he/she kept Resident #1 at home until 8/6/25, the resident returned to the facility, and medication administration resumed.</p>		