

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265508	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Legendary Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 809 East Gordon St Marshall, MO 65340	

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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42594</p> <p>Based on interview and record review, the facility failed to thoroughly assess one resident (Resident #1) and notify the physician after the resident sustained an unwitnessed fall that resulted in increased pain, dizziness, vomiting, and a fractured hip, in a review of 10 sampled residents. After the fall, staff transferred the resident from the floor to the toilet, to a wheelchair, and then to his/her bed. During the transfer, staff said the resident yelled and screamed out in pain. The resident complained of his/her head hurting and feeling dizzy. Registered Nurse (RN) A and Licensed Practical Nurse (LPN) B did not perform neurological checks (assessing level of consciousness, visual fields, pupil constriction and dilation, upper and lower limb strength or limitation, speech and vital signs) with the resident after the unwitnessed fall. RN A and LPN B did not report the resident's pain or changes of condition to the physician and did not send the resident to the hospital. After the resident's fall, RN A ordered an x-ray of the resident's hip without a physician order. The resident began vomiting, lost consciousness, and died at the facility. The facility census was 32.</p> <p>The Administrator was notified on [DATE] at 4:00 P.M. of the Immediate Jeopardy (IJ), which began on [DATE]. The IJ was removed on [DATE], as confirmed by surveyor onsite verification.</p> <p>Review of the facility's policy Falls - Clinical Protocol, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -The nurse shall assess and document and report vital signs, injury, especially fracture or head injury, musculoskeletal function, observing for changes in normal range of motion, weight bearing, neurological status, and pain; -The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. <p>Review of the facility's policy Assessing Falls and Their Causes, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -The purpose of this procedure is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall; -If a resident has just fallen, or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities; <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
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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Obtain and record vital signs as soon as it is safe to do so;</p> <p>-If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately;</p> <p>-Notify the resident's attending physician and family in an appropriate time frame. When a fall results in a significant injury or condition change, notify the practitioner immediately by phone.</p> <p>Review of the facility's policy Change in a Resident's Condition or Status, dated February 2021, showed the following:</p> <p>-The facility promptly notifies the resident, physician, and the resident's representative of changes in the resident's medical/mental condition and/or mental status;</p> <p>-The nurse will notify the resident's attending physician or physician on call when there has been an accident or incident involving the resident, significant change in the resident's physical, emotional, or mental condition, and need to transfer the resident to a hospital or treatment center;</p> <p>-The nurse will record in the resident's medical record information relative to changes in the resident's medical or mental condition or status.</p> <p>Review of the facility's policy Pain - Clinical Protocol, dated [DATE], showed the following:</p> <p>-The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition and when there is onset of new pain or worsening of existing pain;</p> <p>-The staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity;</p> <p>-The nursing staff will identify any situation or interventions where an increase in the resident's pain may be anticipated; for example, wound care, ambulation, or repositioning;</p> <p>-The physician will perform or order appropriate tests as needed to help clarify sources of pain. For example, an x-ray may help to identify the cause of joint pain.</p> <p>1. Review of Resident #1's undated Face Sheet showed the following:</p> <p>-The resident had diagnoses that included Alzheimer's disease (a progressive, neurodegenerative disorder that affects memory, thinking, and behavior), mild cognitive impairment, muscle wasting and atrophy (the loss of muscle mass and strength), muscle weakness, unsteadiness on feet, abnormal posture, need for assistance with personal care, history of falling, overactive bladder, osteoporosis (a condition that weakens bones, making them fragile and prone to fractures, often going unnoticed until a bone breaks, particularly in the hip, spine, or wrist), collapsed vertebra (causes a vertebral compression fracture that can be caused by trauma or osteoporosis), difficulty in walking, and cognitive communication deficit;</p> <p>-The resident had a code status of do not resuscitate.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -The resident's cognition was severely impaired; -The resident had diagnoses that included Alzheimer's disease and osteoporosis; -The resident required substantial/maximum assistance from staff for lying to sitting and sitting to lying repositioning, and chair to bed transfers. <p>Review of the resident's Care Plan, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -The resident had chronic pain in his/her back from past falls and prior fractures of his/her spine; -The resident was able to voice discomfort; -The resident had a history of several falls as he/she takes self to the bathroom frequently. He/She has osteoporosis which put him/her at risk for further injuries; -The resident required assistance with part of his/her activities of daily living (ADLs). <p>Review of the resident's nursing note, dated [DATE] at 3:50 P.M., entered by RN A showed the following:</p> <ul style="list-style-type: none"> -The resident hollered for help; -Staff approached the bathroom and found the resident on the floor; -The resident had an unwitnessed fall trying to get himself/herself to the toilet; -Two staff members assisted the resident off the bathroom floor, then assisted with changing the resident's clothes; -Staff transferred the resident to his/her wheelchair, vital signs taken, the resident complained of right hip pain; -The physician, Director of Nursing (DON), and administrator notified; -A portable x-ray was ordered. <p>Review of the resident's nursing note, dated [DATE] at 3:52 P.M., entered by RN A showed the following:</p> <ul style="list-style-type: none"> -A fall occurred on [DATE] at 2:16 P.M. that was not witnessed; -The resident attempted to toilet himself/herself and the reason for the fall was not evident; <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-An injury did not occur as a result of the fall and the fall did not result in an emergency room visit;</p> <p>-The physician was notified on [DATE] (no time documented) of the resident's fall with new order received (see order sheet for new order);</p> <p>-The resident's blood pressure was ,d+[DATE] (reference range is ,d+[DATE] to ,d+[DATE]), pulse was 73 (reference range is 60 to 100 beats per minutes), respirations were 18 (reference range is 12 to 20 breaths per minute, (all within normal limits), oxygen level was 90% on room air (reference range is 92% to 100%), and temperature was 97.7 degrees Fahrenheit (reference range is 97.8 degrees Fahrenheit to 99.1 degrees Fahrenheit);</p> <p>-The resident voiced complaints of sharp pain in his/her right hip, rating it a 6 out of 10 on a scale of 1 to 10 with 10 being the worst pain;</p> <p>-The resident had a change in mobility status;</p> <p>-The resident had recent pain and blood pressure medication changes.</p> <p>Review of the resident's physician order sheet, dated [DATE], showed the following:</p> <p>-No evidence of a standing order for x-rays;</p> <p>-RN A entered an order at 4:03 P.M. for a two view portable x-ray of the resident's right hip for a fall, pain in hip, unable to bear weight, and non-ambulatory;</p> <p>-RN A entered the Medical Director as the ordering physician;</p> <p>-The communication method was marked as prescriber written.</p> <p>Review of the resident's nursing note, dated [DATE] at 7:00 P.M., entered by LPN B showed the following:</p> <p>-The resident's blood pressure was ,d+[DATE], pulse 74, respirations 18, oxygen level 90% on room air and temperature 97.7;</p> <p>-The resident said his/her hip was still hurting and would not let LPN B assess it;</p> <p>-The resident's hand grips were of equal strength;</p> <p>-The resident's pedal (foot) pulses were strong;</p> <p>-The resident refused his/her evening meal but did take a few sips of water and drank a cup of coffee.</p> <p>Review of the resident's nursing note, dated [DATE] at 9:26 P.M., entered by LPN B showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-At approximately 8:00 P.M. staff notified LPN B the resident was unresponsive;</p> <p>-LPN B immediately called 911;</p> <p>-Upon entering the resident's room, the resident was noted to be gray in color with his/her head slumped on his/her chest;</p> <p>-Staff tried to rouse the resident but were unsuccessful and LPN B was unable to find a pulse or heartbeat.</p> <p>During interviews on [DATE] at 2:47 P.M. and [DATE] at 10:46 A.M., RN A said the following:</p> <p>-The resident fell about 3:15 P.M. The resident hollered for help and he/she went to the resident's room and found the resident sitting on the bathroom floor;</p> <p>-The resident's wheelchair was in the doorway and the footrests were down;</p> <p>-The resident said he/she did not hit his/her head. RN A felt the back of the resident's head and there were no cuts, bleeding, or bumps;</p> <p>-RN A assessed the resident by moving his/her leg up and down and the resident said no;</p> <p>-The resident complained his/her right hip hurt;</p> <p>-Two aides came in the bathroom and assisted the resident to the toilet, cleaned the resident up and changed his/her incontinent brief;</p> <p>-When the aides stood the resident, the resident did not have any shortening of either leg (this would be an indication of a hip fracture). The resident could only put weight on his/her right toes and put most of his/her weight on his/her left side. Staff transferred the resident to his/her wheelchair;</p> <p>-RN A took the resident's blood pressure, pulse, respirations, and temperature;</p> <p>-RN A said he/she talked to the physician. RN A then responded that he/she called the physician's office and no one answered and RN A said based on his/her best nursing judgement, he/she put in a standing order for an x-ray;</p> <p>-He/She called the mobile x-ray company and ordered a stat (immediate) x-ray of the resident's right hip;</p> <p>-He/She only did an initial assessment when finding the resident on the bathroom floor;</p> <p>-RN A did not complete neurological assessments (assessing level of consciousness, visual fields, pupil constriction and dilation, upper and lower limb strength or limitation, speech and vital signs) on the resident. RN A did not know what the protocol was for neurological assessments for an unwitnessed fall at the facility;</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-RN A checked on the resident two or three times after the fall and before the end of his/her shift, but did not complete neurological assessments;</p> <p>-RN A did not call the on-call physician and did not feel like the resident needed to go to the hospital;</p> <p>-RN A did not feel it was an emergent situation;</p> <p>-RN A did not think the resident had broken his/her hip;</p> <p>-Staff never told RN A the resident felt dizzy, had a headache, or wanted to go to the hospital after the fall.</p> <p>During an interview on [DATE] at 1:31 P.M., LPN B said the following:</p> <p>-He/She came on duty at 6:00 P.M. on [DATE];</p> <p>-He/She got report from RN A and was told Resident #1 fell in the bathroom and had an x-ray of his/her right hip. The results had not come back yet and LPN B was to watch for them;</p> <p>-He/She saw the resident for the first time on his/her shift at 7:00 P.M., the resident said his/her right leg hurt;</p> <p>-He/She felt strong pulses in both feet. He/She did not do a push/pull leg strength assessment because the resident's right leg hurt;</p> <p>-The resident was not able to give a number on a scale of one to 10 (with 10 being the worst pain) to rate his/her pain;</p> <p>-LPN B did not notify the physician of the resident's pain. The resident had opioid pain medication scheduled at 8:00 A.M., 1:00 P.M., and 6:00 P.M. that Certified Medication Technician (CMT) E administered to the resident at 7:00 P.M.</p> <p>-The resident refused his/her evening meal but did take a few sips of water and then drank a cup of coffee;</p> <p>-About 8:00 P.M., Nursing Assistant (NA) C, NA D, and CMT E were all in the resident's room. One of them yelled out that the resident was vomiting and was unresponsive;</p> <p>-He/She called 911 at 8:00 P.M.</p> <p>During an interview on [DATE] at 3:37 P.M., NA C said the following:</p> <p>-He/She entered the resident's room after the fall occurred on [DATE] at approximately 2:20 P.M.;</p> <p>-He/She helped transfer the resident from the toilet to the wheelchair;</p> <p>-RN A took the resident's vital signs after the resident was in the wheelchair;</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The resident stayed in his/her wheelchair until about 5:00 P.M. when the mobile x-ray company arrived;</p> <p>-NA C heard the resident screaming down the hallway and went to his/her room to see if the resident needed help, staff had just transferred the resident to his/her bed to get the x-ray;</p> <p>-NA C and Certified Nurse Aide (CNA) I helped the resident roll to his/her side for the x-ray technician could. When staff rolled the resident, he/she said, Stop, pain, it's hurting;</p> <p>-The resident continued to yell out in pain off and on after the x-ray was completed as NA C and other staff assisted other residents on the hall;</p> <p>-NA C went to the resident's room after the x-ray was completed and the resident wanted his/her family called but the facility did not have a number for the requested family member. The resident kept asking for that particular family member;</p> <p>-NA C and CNA I told RN A a little while after the x-ray was completed the resident asked to go to the hospital. RN A said there was nothing he/she could do until the x-ray results came back;</p> <p>-LPN B came on duty at 6:00 P.M., but did not go see the resident until about 7:00 P.M.;</p> <p>-NA C sat with the resident in between answering call lights and the resident would randomly scream out in pain. If NA C left to answer a call light the resident would yell out, Come back, help me!;</p> <p>-The resident told NA C he/she was waiting for the ambulance and NA C said the ambulance was not coming. The resident told NA C he/she wanted to go to the hospital;</p> <p>-The resident complained of his/her head hurting really bad and asked for pain medication;</p> <p>-NA C was not in the resident's room the first time the resident vomited, but about 7:45 P.M. the resident vomited again and it looked like coffee grounds. The head of the bed was at a 45 degree angle and staff raised it to a 90 degree angle;</p> <p>-The resident complained of being dizzy and said his/her head hurt;</p> <p>-CMT E checked the resident's oxygen level and it was 48%. They told LPN B and he/she said to get oxygen for the resident;</p> <p>-The resident vomited for the third time, mumbled incoherently and then became unresponsive;</p> <p>-Staff told LPN B and he/she called 911;</p> <p>-CMT E checked the resident's pulse and it was very faint. The pulse oximeter (device used to measure oxygen levels) would not read the resident's oxygen level;</p> <p>-Emergency Medical Services (EMS) arrived and took over.</p> <p>During an interview on [DATE] at 4:08 P.M., NA D said the following:</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-When he/she arrived in the resident's room the resident was ashen, unresponsive and if he/she was breathing it was minimal;</p> <p>-The resident was placed on the cardiac monitor and there was no pulse.</p> <p>During an interview on [DATE] at 1:10 P.M. and [DATE] at 11:16 A.M., the DON said the following:</p> <p>-She expected staff to follow the policy as written and complete neurological checks and reassess the resident as needed;</p> <p>-She expected the physician/on-call physician to be notified if a resident had a fall;</p> <p>-She would not expect a nurse to place an order for an x-ray without a physician's order;</p> <p>-The facility did not have standing orders for x-rays.</p> <p>During an interview on [DATE] at 11:16 A.M., the Administrator said the following:</p> <p>-RN A should have called the on-call physician;</p> <p>-He would have expected staff to complete neurological assessments on Resident #1 because it was an unwitnessed fall;</p> <p>-He would not expect a nurse to order an x-ray without a physician's order.</p> <p>During an interview on [DATE] at 4:37 P.M. the On-Call Physician said the following:</p> <p>-He/She had missed a call on [DATE] at 9:53 P.M. from the facility;</p> <p>-At 10:00 P.M. he/she got a call from LPN B and was told Resident #1 passed away and the body had been released;</p> <p>-He/She did not receive any calls prior to 9:53 P.M. on [DATE] from the facility.</p> <p>During an interview on [DATE] at 1:29 P.M. and [DATE] at 11:40 A.M., the Medical Director said the following:</p> <p>-She was not notified of Resident #1's fall on Sunday, [DATE];</p> <p>-She did not order a mobile x-ray for the resident;</p> <p>-She would have expected the nurse to call the on-call physician on a Sunday;</p> <p>-She would expect neurological checks to have been completed every 15 minutes for at least the first hour and further assessments of the resident should have been completed after his/her fall;</p> <p>-The resident may have had a different outcome if staff had sent the resident to the hospital;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265508	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Legendary Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 809 East Gordon St Marshall, MO 65340	
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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The nurse should have called the physician and gotten the resident sent to the hospital.</p> <p>MO250114</p> <p>MO250199</p> <p>NOTE: At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.</p> <p>At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s).</p>		