STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265508	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legendary Health Care Center	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow professional standards of care for one resident (Resident #2), in a review of six sampled residents, when staff failed to follow physician's orders related to administering Xarelto (blood thinner used to treat and prevent blood clots). The facility census was 37.Review of the undated and untitled facility policy for medication administration showed the following:-The facility shall ensure medications will be administered according to physician's orders;-The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: -Medication administered not in accordance with the prescriber's orders. Examples include, but not limited to: -Incorrect dose, route of administration, dosage form, time of administration; -Medication omission; -Incorrect medication;-If a medication error occurs, the nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible. Review of Resident #2's Face Sheet showed he/she had diagnoses of atrial fibrillation (an irregular and often very rapid heart rhythm) and atrial flutter (a type of heart rhythm disorder). Review of the resident's Physician Orders, dated December 2025, showed an order for Xarelto 15 milligrams (mg) one tablet in the evening (original order dated 6/27/25). Review of the resident's most recent Care Plan, dated 7/7/25, showed the following:-The resident was on anticoagulant therapy related to atrial fibrillation;-Administer anticoagulant medications as ordered. Review of the resident's Medication Administration Record (MAR), dated December 2025, showed staff did not administer Xarelto 15 mg on 12/11/25, 12/12/25, 12/13/25, 12/14/25, 12/15/25 and 12/16/25. Staff documented they were awaiting the medication on all six days. During an interview on 1/12/26 at 4:49 P.M., Licensed Practical Nurse (LPN) I said the following:-Xarelto was not available in the medication cart or in the emergency kit on 12/11/25 to administer to the resident;-He/She reported to the charge nurse, LPN H, that the medication was not available and was not administered to the resident;-He/She did not report to the pharmacy, physician, Director of Nursing (DON), or the administrator the medication was not available or administered to the resident; -He/She was not sure of the pharmacy process to follow when a medication was unavailable. During interviews on 1/6/26 at 5:18 P.M. and 1/12/26 at 4:26 P.M., LPN H said the following:-He/She was the charge nurse on 12/11/25 and usually did not pass medications;-He/She helped LPN I pass medications on the night shift of 12/11/25; -The resident's Xarelto was not available on 12/11/25; -Xarelto was not available in the medication cart or emergency kit for the resident on 12/11/25;-He/She did not usually contact the pharmacy when a medication was not available;-The Certified Medication Technicians (CMTs) were responsible to contact the pharmacy when a medication was not available;-He/She sent a request to the pharmacy to request the medication on 12/12/25;-He/She did not report to the physician or the on-call physician that the medication was not available and not administered to the resident;-He/She should have contacted the physician or physician on call;-The resident did not receive his/her Xarelto from 12/11/25 through 12/16/25. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265508	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legendary Health Care Center	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the communication platform between the facility and the pharmacy, dated 12/12/15 at 2:45 P.M., showed the following:-LPN H requested a refill of the resident's Xarelto;-The pharmacy responded they needed the order for the medication to be updated since the resident's readmission on [DATE]. Review of the resident's progress notes showed no documentation the facility sent an updated order for the resident's medication to the pharmacy on 12/12/25 through 12/15/25. Review of the communication platform between the facility and the pharmacy, dated 12/15/25 at 9:22 A.M., showed the following:-The pharmacy received a refill request for the resident's Xarelto;-The pharmacy could not refill this medication due to the order being over a year old. Can we please have an updated order sent over to us? Review of the communication platform between the facility and the pharmacy, dated 12/16/25 at 9:46 P.M., showed Xarelto should be coming out on the pharmacy's evening delivery run. During an interview on 1/6/26 at 4:55 P.M., the resident said he/she went without his/her blood thinner for five to six days in December. During interviews on 1/6/26 at 5:35 P.M. and 5:47 P.M., 1/7/26 at 9:20 A.M. and 1/13/26 at 11:04 A.M., the DON said the following:-She was not sure why staff did not give the resident Xarelto on 12/11/25, 12/12/25, 12/13/25, 12/14/25, 12/15/25 and 12/16/25; -Staff did not inform her the resident did not receive the Xarelto on 12/11/25 through 12/16/25;-She expected staff to inform her when a medication was not administered to a resident;-Staff ordered the Xarelto from the pharmacy on 12/11/25 and did not receive the Xarelto from the pharmacy until 12/16/25;-The Xarelto was not available because the order needed to be reinstated, which means the facility staff had to delete the order out of the system and restart the order; -The physician did not need to sign for the order to be reinstated since the prescription was still good;-She was not aware of the process for reinstating an order for the pharmacy until this resident;-She expected staff to resubmit the order to the pharmacy if the medication was still not available on 12/12/25;-Staff did not follow up on the resident's medication request until 12/15/25 due to the weekend nurse not following up with the pharmacy or physician;-LPN H notified the physician's office on 12/16/25 to get the medication prescription renewed; -She expected staff to notify the physician or physician on call if a medication was not available or administered;-Staff did not notify the resident's physician or the on-call physician when the resident did not receive the Xarelto from 12/11/25 to 12/16/25. During an interview on 1/8/26 at 2:22 P.M., the resident's physician said the following:-The resident was to receive an anticoagulant daily for atrial flutter and to prevent stroke;-Staff did not notify him/her and he/she was unaware the resident went six days without his/her anticoagulant medication;-He expected staff to notify him when a resident's anticoagulant was not available and not administered, especially if it was for more than a couple of days. Complaint #2702244

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265508	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legendary Health Care Center	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)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation and interview, facility administration failed to implement an effective system for ordering sufficient supplies necessary to meet residents' needs. The facility census was 37.The facility did not have a policy regarding sufficient supplies. 1. Review of Resident #3's Care Plan, dated 6/23/25 and revised on 9/25/25, showed the following:-He/She was able to perform his/her activities of daily living (ADLs) with staff's assistance;-He/She had frequent urinary incontinence; -He/She waited too long to get to the bathroom and voided down his/her legs and on the floor;-He/She wore size five-X incontinence briefs. Observation on 1/6/26 at 12:19 P.M., showed the following: -There were no gloves in the resident's room;-One incontinence brief two sizes too small for the resident was by the resident's bed;-The resident wore pants but did not wear an incontinence brief. During an interview on 1/6/26 at 12:19 P.M., the resident said the following: -There were no gloves in his/her room;-The facility's incontinence supplies had been low for two months;-The facility was out of incontinence briefs in his/her size; -He/She went without wearing incontinence briefs when the facility was out of incontinence briefs;-Staff brought him/her an incontinence brief two sizes too small today; -He/She could not wear the incontinence brief because it was too small;-He/She had three incontinent episodes yesterday and four incontinent episodes today. He/She had to change his/her clothes after he/she was incontinent because he/she did not have incontinence briefs to wear;-He/She felt humiliated when he/she was incontinent when not wearing an incontinence brief. During an interview on 1/6/26 at 1:35 P.M., Certified Nurse Assistant (CNA) B said the following:-The facility often ran out of gloves, incontinence briefs, and wipes;-The facility ran out of the bigger sizes of incontinence briefs;-The facility tried to accommodate when they ran out of incontinence briefs by using smaller size incontinence briefs; -Resident #3 had to go without incontinence briefs;-Resident #3 complained to him/her about not having incontinence briefs; -He/She reported to the charge nurse more than once about Resident #3 not having incontinence briefs. During an interview on 1/6/26 at 2:08 P.M., CNA E said the following:-The facility's supply of gloves, incontinence briefs and wipe had been low since August; -Resident #3 went without incontinence briefs due to the facility not having any incontinence briefs in his/her size. During an interview on 1/6/26 at 2:46 P.M., the Director of Nursing (DON) said Resident #3 had not had incontinence briefs for four days. 2. Review of Resident #2's Care Plan, dated 7/7/25 and revised on 12/8/25, showed the following:-The resident had some incontinence; -He/She needed assistance with toileting hygiene;-Wash, rinse and dry perineum and change clothing after incontinence episodes;-Utilize incontinence briefs as needed and change when soiled. Observation on 1/6/26 at 4:55 P.M., showed there were no gloves or incontinence briefs in the resident's room. During an interview on 1/6/26 at 4:55 P.M., the resident said the following:-He/She wore an incontinence brief when the facility had them; -He/She went without incontinence briefs when the facility ran out;-Staff told him/her today they were out of large incontinence briefs; -He/She did not wear an incontinence brief today, because none were available; -He/She did not have any gloves in his/her room. 3. Review of Resident #4's care plan, dated 11/22/24 and revised on 11/26/24, showed the following:-He/She was frequently incontinent of bowel and bladder;-Provide peri-care with each incontinence brief change. Observation on 1/6/26 at 5:07 P.M., showed there were no gloves or incontinence briefs in the resident's room. During an interview on 1/6/26 at 5:07 P.M., the resident said the following:-The facility ran out of his/her size incontinence briefs two weeks ago; -Staff put an incontinence brief that was too small on him/her because the facility ran out of his/her size; -He/She had an incontinent episode yesterday and had to change his/her clothes because his/her incontinence brief was too small. During an interview on 1/6/26 at 5:10 P.M., Nurse Assistant (NA) G said the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265508	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legendary Health Care Center	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)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following:-The facility ran out of Resident #4's size of incontinence briefs two days ago;-Staff put a smaller brief on the resident when they were out of his/her size. During an interview on 1/6/26 at 1:50 P.M., Certified Medication Technician (CMT) C said yesterday, the resident had to wear an incontinence brief that was much too small because the facility was out of the resident's size. 4. Observation on 1/6/26 at 11:10 A.M of the storage rooms where the incontinence supplies were stored, showed the following:-Four packages of size small pull-on incontinence briefs;-Four packages of size medium pull-on incontinence briefs;-11 packages of size small incontinence briefs;-Five packages of size medium incontinence briefs.(The facility did not have a supply of incontinence briefs larger than size medium.) Observation on 1/6/26 at 11:12 A.M. of the resident list with type of incontinence briefs used and size posted in the incontinent supplies storage rooms showed the following:-No residents required size small;-Five residents required size medium;-Eight residents required size large;-Six residents required size extra-large;-One resident required size triple extra-large;-Two residents required quadruple/quintuple extra-large. 5. Observation on 1/6/26 at 11:00 A.M., showed there were no gloves in Resident #5's room. During an interview on 1/6/26 at 11:00 A.M., Resident #5 said the following:-There were no gloves in his/her room;-Staff had gloves in their pockets when they came in to provide his/her care. 6. Observation on 1/6/26 at 11:06 A.M., showed there were no gloves on the medication cart at the nurse's station. Observation on 1/6/26 at 3:30 P.M., showed there were no gloves in occupied resident rooms 1, 3, 11, 12, 15 19, 20 and 28. Observation on 1/6/26 at 3:30 P.M., showed boxes of gloves at the nurse's station. 7. During an interview on 1/6/26 at 11:06 A.M., Certified Medication Technician (CMT) A said the following:-The facility glove supply was low;-The gloves were kept at the nurse's station when the glove supply was low. During an interview on 1/6/26 at 1:50 P.M., CMT C said the following:-The facility had issues with not having enough supplies since August; -There should be gloves in each resident's room, however, the gloves were kept at the nurse's station when the supply was low. During an interview on 1/6/26 at 1:50 P.M., CNA D said the following:-The facility had issues with not having enough supplies since August; -The facility ran low on incontinence briefs, wipes and gloves;-Residents had to go without wearing incontinence briefs, because the facility did not have incontinence briefs available in the correct sizes. During an interview on 1/6/26 at 2:22 P.M., Registered Nurse (RN) F said the following:-The facility's supply of incontinence briefs, wipes and gloves had been an issue since August; -He/She voiced concern about the low supplies to administration, and administration said the supplies were on order;-There were no gloves in the residents' rooms when the glove supply was low;-The gloves were kept at the nurses station when the glove supply was low;-Staff kept gloves in their pockets when the glove supply was low;-The residents had to go without incontinence briefs or staff used smaller sizes of incontinence briefs on residents when the facility was out of the bigger sizes. During interviews on 1/6/26 at 2:46 P.M., 1/7/26 at 9:20 A.M. and 1/13/26 at 11:04 A.M., the Director of Nursing (DON) said the following:-She expected staff to report to her if a supply of incontinence briefs or gloves was low to prevent running out;-She was to complete an inventory of supplies daily; however, she completed an inventory of supplies every other day;-Staff discussed the supply of incontinence briefs and gloves every day in morning meeting;-She was not aware the facility was completely out of larger sizes of incontinence briefs until 1/6/26 when staff reported this to her; -Staff should have told her the incontinence brief and glove supply were low, so staff could purchase supplies locally and increase the number of these supplies on the next order;-The MDS Coordinator bought gloves and incontinence briefs on 1/6/26 due to running low or being out of these supplies;-She was responsible for ordering supplies and ordered supplies twice a month;-When she ordered supplies, the supply orders were delayed due to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265508	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legendary Health Care Center	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)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the approval process;-She expected gloves to be in every resident room and on every medication and treatment cart;-When the glove supply was low, gloves were kept at the nurse's station. She expected staff to take a handful of gloves with them and to put the gloves in their pockets or to put them on the medication and treatment carts even if this was an infection control issue. During interviews on 1/6/26 at 2:46 P.M., 1/7/26 at 9:20 A.M., and 1/13/26 at 9:34 A.M., the Administrator said the following:-The facility had an issue with running low or out of supplies; -The facility was low on supplies because the facility had not established a sufficient supply due to a higher usage of gloves and incontinence briefs than in the past;-He expected the DON to order more supplies on the next order if an item was low or the facility ran out of the item;-Staff were to notify him or the DON when supplies were low to ensure the facility did not run out of the supplies;-He monitored to ensure there were sufficient supplies by discussing with staff during the morning meeting.-He was aware most of the time when supplies were low; -He was aware gloves and incontinence briefs were low on 1/6/25 and approved for staff to purchase gloves and incontinence briefs. Complaint #2687268