

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2025
NAME OF PROVIDER OR SUPPLIER Legacy Barberton		STREET ADDRESS, CITY, STATE, ZIP CODE 85 Third Street SE Barberton, OH 44203	

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 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771</p> <p>Based on closed medical record review, review of the Notice of Medicare Non-Coverage form, review of the durable medical equipment order summary, policy review and interviews, the facility failed to implement a discharge plan to ensure needed services and equipment were available upon discharge for Resident #80. This affected one resident (Resident #80) of three residents reviewed for discharges.</p> <p>Findings include:</p> <p>Review of the closed medical record for former Resident #80 revealed an admitted [DATE] with diagnoses of fracture of shaft of left tibia, fracture of shaft of left fibula, chronic obstructive pulmonary disease, acute on chronic heart failure, diabetes, muscle weakness and atrophy, and anxiety disorder. Review of the Minimum Data Set (MDS) 3.0 admission assessment dated [DATE] revealed Resident #80 was cognitively intact, used a wheelchair for mobility, required substantial/maximal assistance with toileting, bathing, and toilet/bathing transfers and was dependent for lower body dressing and putting on/taking off footwear. Resident #80 discharged home on 04/05/25.</p> <p>Review of the Notice of Medicare-Non-Coverage form revealed Resident #80's skilled nursing services would end on 04/04/25. Resident #80 signed the form on 04/02/25.</p> <p>Review of the discharge orders dated 04/05/25 revealed Resident #80 was okay to discharge with HHA [home health agency], palliative [care], physical therapy/occupational therapy and a specialty bed. The discharge orders were silent to a wheelchair.</p> <p>Review of the nurses note dated 04/05/25 timed 11:06 A.M. revealed Resident #80 was discharged homegoing. Sent with discharge paperwork, medication list, medications except Tramadol (narcotic pain medication). Medication list reviewed with resident. Aware of follow-up with primary care physician within one week of discharge. Aware of upcoming Orthopedic appointment. No questions or concerns. Transported by son.</p> <p>Review of the Post-Discharge Plan of Care assessment dated [DATE] revealed Resident #80 was discharged home on 04/05/25 with a HHA however the HHA's contact information was not provided. The Post-Discharge Plan of Care was silent to durable medical equipment (DME) provider name, contact information and the equipment needed. Resident #80's signature and the date of 04/05/25 was on the paper assessment in the hard medical record.</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
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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Discharge Notice sheet dated 04/05/25 in the hard medical record revealed Resident #80 was discharged home with HHA [name of agency provided] and DME [company name provided] including hospital bed and a wheelchair. The delivery date of the wheelchair was listed as 04/04/25 and delivery date of the hospital bed was 04/05/25.</p> <p>Interview on 04/22/25 at 2:00 P.M. with Resident #80's son revealed he was upset that Resident #80 was sent home without a hospital bed or wheelchair being delivered yet from the DME company. Resident #80's son stated that since the DME company's phone number was not listed on the resident discharge summary, he had to search for the phone number to call to follow up with the DME company. The DME company reported to Resident #80's son that they (the DME company) had received all the paperwork regarding Resident #80's discharge however the equipment had not been approved yet. Resident #80 was supposed to have a HHA. However, the HHA did not show up so Resident #80's son had to call the HHA. The HHA stated that the HHA order was sent to the HHA but the services had not been approved yet. Resident #80's son stated Resident #80 couldn't stand at all so that first week home was rough and the resident mostly stayed on the couch. Resident #80 son stated it was a week [after discharge] that the HHA came to the resident's house and that the hospital bed and wheelchair got delivered to the house. Resident #80 had a community primary care physician appointment scheduled for a week after discharge, however Resident #80 had to cancel the appointment because she was having a hard time getting around. Resident #80 son's verified Resident #80 was not provided with a phone number on the discharge summary for the DME company or the HHA. Resident #80's son revealed Resident #80 had remained at home with family members staying with her at house and the resident was still receiving HHA physical and occupational therapy. Resident #80's son stated Resident #80 was not interested in returning to the facility.</p> <p>Interview on 04/22/25 at 2:35 P.M. with Social Services Designee (SSD) #1 revealed SSD #1 assisted with discharge planning however the two former Medical Records Assistants (MRAs) set up DME and HHA and filled out the Discharge Notice sheet for the hard chart to let the nurses know the discharge plan. SSD #1 usually filled out the sections of the Ombudsman number and contact information, the resident's community primary care physician and contact information, and the resident's community pharmacy and contact information on the Post-Discharge Plan of Care assessment. For Resident #80's discharge though, SSD #1 was not working that day because it was a weekend so Licensed Practical Nurse (LPN) #1 (a floor nurse) filled out the Post-Discharge Plan of Care. SSD #1 was aware Resident #80 was discharging home on 04/04/25 because Resident #80 was given and signed a Notice of Medicare Non-Coverage (NOMNC) on 04/02/25 and the resident's last covered date was 04/04/25. SSD #1 revealed SSD #1 found out after Resident #80 discharged that Physician #3's (Resident #80's primary care physician) office staff refused to notify Physician #3 to sign the DME and HHA order because Physician #3's office staff did not realize Physician #3 had seen Resident #80 at the facility so there was a lot of back and forth trying to figure it out. SSD #1 verified the HHA name and contact information and the DME company's name and contact information was not provided on Resident #80's Post-Discharge Plan of Care assessment.</p> <p>Interview on 04/22/25 at 3:40 P.M. with the Administrator, with the Administrator-in-Training (AIT) present, verified the HHA name and contact information and DME company name and contact information was not provide on Resident #80's Post-Discharge Plan of Care.</p> <p>Interview on 04/28/25 at 12:30 P.M. with Medical Records Assistant (MRA) #4 revealed she requested Resident #80's hospital bed on 04/02/25 and requested Resident #80's wheelchair on 04/03/25 and sent a fax to Physician #3 on 04/02/25 and 04/03/25.</p> <p>(continued on next page)</p>		

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A follow-up interview on 04/28/25 at 10:50 A.M. with the Administrator verified the facility to not follow up to ensure Physician #3 approved the DME and HHA orders prior to Resident #80 discharging home.</p> <p>Review of the DME Order Summary for Resident #80's hospital bed revealed MRA #4 created the hospital bed order and requested signature from Physician #3 on 04/02/25, Physician #3 approved the order on 04/10/25, and the hospital bed was delivered on 04/11/25.</p> <p>Review of the DME Order Summary for Resident #80's wheelchair revealed MRA #4 created the wheelchair order and requested Physician #3's signature on 04/03/25, Physician #3 approved the order on 04/10/25, and the wheelchair was delivered on 04/11/25.</p> <p>Review of the facility's Resident-Initiated Transfer or Discharge policy dated 2001 revealed for resident-initiated discharges, the medical record would contain a discharge care plan. The comprehensive care plan would contain the residents' goals for admission, desired outcomes, which would be aligned with the discharge if it was resident-initiated.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00164784.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771</p> <p>Based on closed medical record review, policy review and interviews, the facility failed to provide a discharge summary to Resident #81 and failed to provide a complete discharge summary to Resident #80. This affected two residents (Resident #80 and #81) of three residents reviewed for discharges.</p> <p>Findings include:</p> <p>1. Review of the closed medical record for former Resident #81 revealed an admitted [DATE] with diagnoses of acute respiratory failure, pneumonia, chronic obstructive pulmonary disease (COPD), diabetes, chronic embolism and thrombosis of left popliteal vein, sleep apnea, kidney failure, and neuromuscular dysfunction of bladder. Resident #81 discharged home on 03/24/25.</p> <p>Review of the nurse practitioner discharge evaluation progress note dated 03/24/25 revealed Resident #81 was admitted to the hospital on 02/23/25 due to increase shortness of breath, previously tested positive for influenza A seven to 10 days prior to admission. He was found to have severe pneumonia with a COPD exacerbation. He was placed on a BiPap (a type of non-invasive ventilation therapy used to assist with breathing difficulties), given intravenous (IV) steroids and IV antibiotics. He was then discharged on [DATE] to the facility for physical and occupational therapy due to increased weakness and decreased mobility.</p> <p>Review of the physician orders from March 2025 revealed Resident #81 was ordered Warfarin sodium (a blood thinning medication) oral tablet 2.5 milligrams (mg) give one tablet by mouth one time a day for chronic embolism of the left popliteal vein, Humalog (an insulin) injection solution 100 unit/milliliter(mL) inject six units subcutaneously before meals for diabetes, Insulin NPH subcutaneous suspension 100 unit/mL inject 14 units subcutaneously one time a day for diabetes, Insulin NPH subcutaneous suspension 100 unit/mL inject five units subcutaneously one time a day for diabetes, Ipratropium-Albuterol inhalation solution (an inhaler) three mL inhale orally three times a day for wheezing/shortness of breath, Metoprolol tartrate oral tablet 25 mg give one tablet by mouth two times a day for hypertension, Pramipexole dihydrochloride oral table 1 mg one time a day for restless leg syndrome, Ranolazine extended release oral tablet 500 mg give one tablet by mouth two times a day for angina (chest pain) due to congestive heart failure, Sodium chloride inhalation (an inhaler) solution 3% 4 mL inhale orally one time a day for COPD, Atorvastatin (a cholesterol lowering medication) calcium oral tablet 20 mg give one tablet by mouth for hyperlipidemia, and Guaifenesin (used to clear mucus) extended release oral tablet 12 hour 600 mg give one tablet by mouth two times a day for COPD.</p> <p>Further review of the physician orders from March 2025 revealed Resident #81 had orders to cleanse buttocks with Hibiclens, rinse with normal saline, pat dry, apply Magic Butt Paste to buttocks and leave open to air two times a day for moisture associated dermatitis (MASD); cleanse left heel with soap and water, pat dry, apply Skin Prep to left heel and leave open to air once a day and as needed, and cleanse right toe with soap and water, pat dry, apply Betadine to right second digit and leave open to air daily and as needed. Resident #80 also had an order to obtain a PT INR (measures how long it takes blood to clot) every Monday and Thursday for Warfarin (anticoagulant) therapy. Resident #80 was ordered discharge home with physical and occupational therapy on 03/24/25.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Notice of Medicare-Non-Coverage form revealed Resident #81's skilled nursing services would end on 03/23/25. Resident #81 signed the form on 03/21/25.</p> <p>Review of the nurses note dated 03/21/25 revealed labs obtained and reviewed with nurse practitioner. New order to increase Coumadin (Warfarin) to 2.5 mg. Recheck PT on Monday (03/24/25).</p> <p>Review of the lab results report dated 03/24/25 revealed Resident #81's PT value was 15.6 seconds (9.8 to 12.2 normal) and INR was 1.5 (2.0 to 3.0 standard anticoagulant).</p> <p>Review of the nurse's note dated 03/24/25 timed 10:04 A.M. revealed per daughter, she advised Resident #81 contacted her overnight and stated he wanted medical transport home today. Transport was notified and they would arrive to pick up the resident at 5:00 P.M. and resident would be discharged home.</p> <p>Review of the nurse's note dated 03/24/25 timed 7:06 P.M. authored by Assisted Director of Nursing (ADON) #3 revealed Resident #81 discharged home at 6:55 P.M. via transport. Resident voiced no complaints.</p> <p>Review of the Discharge Notice sheet dated 04/05/25 in the hard medical record revealed Resident #81 would receive physical therapy and occupational therapy via a home health agency (HHA). Resident #81's community primary care physician and contact information and community pharmacy and contact information was listed on the sheet.</p> <p>Review of the Evaluations tab in the electronic medical record revealed there was no Post-Discharge Plan of Care for Resident #81.</p> <p>Review of Resident #81's hard medical record revealed there was no Post-Discharge Plan of Care for Resident #81.</p> <p>Interview on 04/22/25 at 2:35 P.M. with Social Services Designee (SSD) #1 revealed Resident #81's was given the NOMNC form on 03/21/25. Resident #81's family called on the morning of 03/24/25 requesting the resident to be transported home via transport company rather than his family picking him up from the facility. SSD #1 verified there was not a signed Post-Discharge Plan of Care in Resident #81's hard medical record.</p> <p>Interviews on 04/22/25 at 3:20 P.M. and 4:10 P.M. with Resident #81's family members revealed the family was blindsided and clueless and not given anything upon Resident #81's discharge. Resident #81 was not sent home with a medication list, medications, information about HHA or wound care orders for his heel and buttocks. Resident #81's family had to call his primary care physician for assistance. Resident #81 was at home and had been receiving hospice care for the past two weeks. Resident #81's family members stated Resident #81 was not interested in returning to the facility at this time.</p> <p>Interview on 04/22/25 at 3:40 P.M. with the Administrator verified Resident #81 was not provided with a Post-Discharge Plan of Care or any information regarding his care upon discharge.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/22/25 at 4:55 P.M. with Assistant Director of Nursing (ADON) #3 revealed ADON #3 observed Resident #81 exit the facility via transport squad and did not remember seeing paperwork provided to the resident. An Agency Nurse was working on the unit Resident #81 resided when he was discharged which was why ADON #3 wrote the nurses' note about the resident exiting the building.</p> <p>Review of the facility's Resident-Initiated Transfer or Discharge policy dated 2001 revealed for resident-initiated discharges, the medical record wound contain a discharge care plan. The comprehensive care plan contained the residents' goals for admission, desired outcomes, which would be aligned with the discharge if it was resident-initiated.</p> <p>2. Review of the closed medical record for former Resident #80 revealed an admitted [DATE] with diagnoses of fracture of shaft of left tibia, fracture of shaft of left fibula, chronic obstructive pulmonary disease, acute on chronic heart failure, diabetes, muscle weakness and atrophy, and anxiety disorder. Review of the Minimum Data Set (MDS) 3.0 admission assessment dated [DATE] revealed Resident #80 was cognitively intact, used a wheelchair for mobility, required substantial/maximal assistance with toileting, bathing, and toilet/bathing transfers and was dependent for lower body dressing and putting on/taking off footwear. Resident #80 discharged home on 04/05/25.</p> <p>Review of the nurses note dated 03/31/25 timed 10:34 A.M. revealed notified by therapist that resident had a new skin tear to left shin. Stated she wrapped left knee dressing with bag due to resident received shower. When she removed tape to left shin it caused a skin tear. Cleaned with normal saline, patted dry, TAO (triple antibiotic ointment) applied, padded with ABD (large bulky gauze pad), wrapped with Kerlix, and secured with tape. Dressing order put in place to change nightly with left knee dressing change. Resident aware.</p> <p>Review of the skin/wound note dated 04/01/25 timed 11:29 A.M. revealed area to left lateral knee improving, measuring 2.8 centimeters (cm) by 1.1 cm by 0.2 cm. Small amount of tan-colored drainage (10 percent of 4 by 4 gauze). Peri wound area intact, normal skin tone. Area to left knee (anterior) unstageable improving measuring 1.0 by 1.0 by unable to determine (UTD) and 100% yellow-white slough. Periwound area intact, normal skin tone.</p> <p>Review of the Notice of Medicare-Non-Coverage form revealed Resident #80's skilled nursing services would end on 04/04/25. Resident #80 signed the form on 04/02/25.</p> <p>Review of Resident #80's discharge orders dated 04/05/25 revealed to cleanse left knee and left lateral shin with Dakins, apply nickel thick Santyl to wound bed followed by adaptic and cover with ABD and Kerlix one time a day and as needed. Resident #80 was also ordered wound care for left skin tear including cleansing with normal saline, applying TAO, padding with ABD pad, wrapping with Kerlix and securing with tape every night shift and as needed until resolved. The orders also indicated Resident #80 was okay to discharge with HHA [home health agency], palliative [care], physical therapy/occupational therapy and a specialty bed. The discharge orders were silent to a wheelchair.</p> <p>Review of the nurses note dated 04/05/25 timed 11:06 A.M. revealed Resident #80 was discharged homegoing. Sent with discharge paperwork, medication list, medications except Tramadol (a narcotic pain medication). Medication list reviewed with resident. Aware of follow-up with primary care physician within one week of discharge. Aware of upcoming Orthopedic appointment. No questions or concerns. Transported by son.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Post-Discharge Plan of Care assessment dated [DATE] revealed Resident #80 was discharged home on 04/05/25 with a HHA however the HHA's phone number and address were not provided. The Ombudsman's name or phone number were not provided. Resident #80 had a daily wound care orders to her to left knee and left shin however N/A (not applicable) was listed for wound care orders. Resident #80's primary care physician's name or phone number was not provided nor was the resident's pharmacy name and phone number. Resident #80's signature and the date of 04/05/25 was found on the paper assessment in the hard medical record.</p> <p>Review of the Discharge Notice sheet dated 04/05/25 in the hard medical record revealed Resident #80 was discharged home with HHA [the HHA name provided] and durable medical equipment (DME) [the DME company name provided] including a hospital bed and a wheelchair. The delivery date of the wheelchair was listed as 04/04/25 and delivery day of the hospital bed was 04/05/25.</p> <p>Interview on 04/22/25 at 2:00 P.M. with Resident #80's son revealed he was upset that Resident #80 was sent home without a hospital bed or wheelchair being delivered from the DME company. Resident #80's son stated that since the DME company's phone number was not on the resident discharge summary, he had to search for the phone number to call to follow up with the DME company. Resident #80 son's verified Resident #80 was not provided with a phone number on the discharge summary for the DME company or the HHA. Resident #80's son revealed Resident #80 had remained at home with family members staying with her at house and the resident was still receiving HHA physical and occupational therapy. Resident #80's son stated Resident #80 was not interested in returning to the facility.</p> <p>Interview on 04/22/25 at 2:35 P.M. with Social Services Designee (SSD) #1 revealed SSD #1 assisted with discharge planning however the two prior Medical Records Assistants set up DME and HHA and filled out the Discharge Notice sheet for the hard chart to let the nurses know the discharge plan. SSD #1 usually filled out the sections of the Ombudsman number and contact information, the resident's community primary care physician and contact information, and the resident's community pharmacy and contact information on the Post-Discharge Plan of Care assessment. For Resident #80's discharge though, SSD #1 was not working that day because it was a weekend so Licensed Practical Nurse (LPN) #2 (a floor nurse) filled out the Post-Discharge Plan of Care. SSD #1 was aware Resident #80 was discharging home on 04/04/25 because Resident #80 was given and signed a Notice of Medicare Non-Coverage (NOMNC) on 04/02/25 and the resident's last covered date was 04/04/25. SSD #1 verified the following information was not provided on Resident #80's Post-Discharge Plan of Care assessment: the Ombudsman name and contact information, the HHA name and contact information, the DME company's name and contact information, the wound care order, the community primary care physician name or contact information and the community pharmacy name and contact information.</p> <p>Interview on 04/22/25 at 3:40 P.M. with the Administrator, with the Administrator-in-Training (AIT) present, verified the following information was not provide on Resident #80's Post-Discharge Plan of Care: Ombudsman name and contact information, DME company name and contact information, HHA name and contact information, the wound care order, community primary care physician's name and contact information and the community pharmacy and contact information.</p> <p>Review of the facility's Resident-Initiated Transfer or Discharge policy dated 2001 revealed for resident-initiated discharges, the medical record contained: a discharge care plan. The comprehensive care plan contained the residents' goals for admission, desired outcomes, which would be aligned with the discharge if it was resident-initiated.</p> <p>(continued on next page)</p>		

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