STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366085	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legends Care Rehabilitation and Nursing Center	2311 Nave Road SE Massillon, OH 44646

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record, interview with the staff, interview with the resident and review of the facility policy the facility failed to ensure an allegation of mistreatment was reported to the Ohio Department of Health (ODH). This affected one resident (Resident #49) of six reviewed for abuse. The facility census was 57. Findings included: Review of the medical record revealed Resident #49 was admitted to the facility on [DATE]. Diagnoses included disorder of the muscles, muscle wasting and atrophy, cirrhosis of the live due to alcohol, severe protein-calorie malnutrition, epilepsy, transient ischemic attack, vitamin D deficiency, anemia, cholelithiasis, liver disease, history of falls, and altered mental status. Review of the quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #49 had intact cognition. She received partial to moderate assistance for rolling side to side in bed. She was also frequently incontinent of bowel and bladder function. Review of the progress notes from 03/22/34 to 03/31/24 revealed no documentation of any incident happening with Resident #49 and a nursing assistant. On 03/28/24 at 9:15 A. M., an interview with Resident #49 revealed last weekend State tested Nursing Assistant (STNA) #120 was working. She stated she turned her call light on and it took about an hour and 45 minutes for her to answer it. She stated she had taken some lactulose syrup (laxative) for her bowels and she really had to go. She stated STNA #120 came into her room and asked her what she wanted. She stated she had messed herself. She stated STNA #120 told her she just cleaned her once up. She stated she told her she knows but she went again. She stated she could roll herself over but STNA #120 pushed her over really hard into the bedrail and she hit her face in the bedrail (there were no visible injuries). She stated when she was done cleaning her up, she told her she was cold and STNA #120 threw the urine-soaked cold sheet up on her and it hit her in the face. She stated she had urine on her face. She stated then STNA #120 left the room. She stated she told the day shift aide and they went and got the Director of Nursing (DON) and she told her everything that had happened and she stated she would take care of it. She told the DON she did not want the STNA back in her room ever again. (continued on next page)

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/28/24 at 12:13 P.M. an interview with the Administrator revealed on Friday 03/22/24 the cousin of Resident #49 came to her and stated STNA #120 threw a wet sheet at Resident #49 and hit her in the face. She stated she also told her she turned her a little too hard. She stated the DON went down to speak to her. She stated she never opened a Self-Reported Incident or started an investigation because she did not think it was necessary. She stated STNA #120 had been suspended pending the investigation. On 03/28/24 at 12:40 P.M. an interview with the DON revealed she spoke to Resident #49 on Friday 03/22/4 and she just told her she thought Resident #49 thought STNA #120 was a little rough with her when she turned her and she did not clean her up thoroughly. She stated she told her she threw the covers up on her. She stated the resident told her she did not need anyone to turn her but she did not believe that to be true She stated the resident never told her she was hit in the face with a wet sheet or blanket. She stated she did not start an investigation. Observation and interview on 03/28/24 at 2:00 P.M. revealed Patrolman # 700 was at the facility to get a statement from Resident #49 concerning the incident with STNA #120. On 04/02/24 at 9:53 A.M. an interview with STNA #120 revealed she was doing rounds at 4:30 P.M. and was at the linen cart in the hallway when Resident #49 seen her and yelled out into the hallway she needed changed. She stated she told her she had just changed her and she was going to change the rest of the residents and she would change her when she got to her room. She stated she went in a little while later and changed her and there was no issues. She stated she came back to work and heard that Resident #49 was telling everyone she pushed her face into the bedrail and smacked her in the face with a dirty wash rag and that was a lie. She stated that was all Resident#49 does was lie about stuff to get people in trouble. She stated the DON spoke to her about the incident on Thursday 03/21/24 and did not have her write up a statement. She just told her she was not to go in her room anymore. Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation of Resident Property, dated 11/01/19 revealed the facility would not tolerate abuse, neglect, exploitation, or misappropriation of resident property. It was the facility policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment of a resident or misappropriation of resident property, including injuries of unknown source. The facility staff should immediately report all such allegation to the Administrator or designee and to the Ohio Department of Health would be notified within 24 hours from the time the allegation was made known to a staff member. This deficiency represents noncompliance as an incidental finding during the investigation of Master Complaint Number OH00152437 and Complaint Numbers OH00152345, OH00151684 and OH00151665.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record, interview with the staff, interview with the resident and review of the facility policy the facility failed to thoroughly investigate an allegation of mistreatment. This affected one resident (Resident #49) of six reviewed for abuse. The facility census was 57. Findings included: Review of the medical record revealed Resident #49 was admitted to the facility on [DATE]. Diagnoses included disorder of the muscles, muscle wasting and atrophy, cirrhosis of the live due to alcohol, severe protein-calorie malnutrition, epilepsy, transient ischemic attack, vitamin D deficiency, anemia, cholelithiasis, liver disease, history of falls, and altered mental status. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #49 had intact cognition. She received partial to moderate assistance for rolling side to side in bed. She was also frequently incontinent of bowel and bladder function. Review of the progress notes from 03/22/34 to 03/31/24 revealed no documentation of any incident happening with Resident #49 and a nursing assistant. On 03/28/24 at 9:15A.M., an interview with Resident #49 revealed last weekend State tested Nursing Assistant (STNA) #120 was working. She stated she turned her call light on and it took about an hour and 45 minutes for her to answer it. She stated she had taken some lactulose syrup (laxative) for her bowels and she really had to go. She stated STNA #120 came into her room and asked her what she wanted. She stated she had messed herself. She stated STNA #120 told her she just cleaned her once up. She stated she told her she knows but she went again. She stated she could roll herself over but STNA #120 pushed her over really hard into the bedrail and she hit her face in the bedrail (there were no visible injuries). She stated when she was done cleaning her up, she told her she was cold and STNA #120 threw the urine-soaked cold sheet up on her and it hit her in the face. She stated she had urine on her face. She stated then STNA #120 left the room. She stated she told the day shift aide and they went and got the Director of Nursing (DON) and she told her everything that had happened and she stated she would take care of it. She told the DON she did not want the STNA back in her room ever again. On 03/28/24 at 12:13 P.M. an interview with the Administrator revealed on Friday 03/22/24 the cousin of Resident #49 came to her and stated STNA #120 threw a wet sheet at Resident #49 and hit her in the face. She stated she also told her she turned her a little too hard. She stated the DON went down to speak to her. She stated she never opened a Self-Reported Incident or started an investigation because she did not think it was necessary. She stated STNA #120 has been suspended pending the investigation. On 03/28/24 at 12;40 P.M. an interview with DON verified she spoke to Resident #49 on Friday 03/22/24 about the allegation against STNA #120 from Resident #49's cousin that was told to the Administrator. The DON verified she did not open an investigation because the DON did not think it was necessary. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 03/28/24 at 2:00 P.M. revealed Patrolman # 700 was at the facility to get a statement from Resident #49 concerning the incident with STNA #120. On 04/02/24 at 9:53 A.M. an interview with STNA #120 verified she spoke to the DON on 03/21/24 about the incident and the DON did not have her write up a statement, and instead told her not to go into Resident #49's room anymore. Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation of Resident Property, dated 11/01/19 revealed the facility would not tolerate abuse, neglect, exploitation, or misappropriation of resident property. It was the facility policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment of a resident or misappropriation of resident property, including injuries of unknown source. The facility staff should immediately report all such allegation to the Administrator or designee and to the Ohi Department of Health would be notified within 24 hours from the time the allegation was made known to a staff member. This deficiency represents noncompliance as an incidental finding during the investigation of Master Complaint Number OH00152437 and Complaint Numbers OH00152345, OH00151684 and OH00151665.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record, review of the hospital records and interview with staff the facility failed to ensure Resident #60 was not unnecessarily transferred to a hospital. This affected one resident (Resident #60) of three reviewed for hospitalization . The facility census was 57. Finding included: Review of the medical record revealed Resident #60 was admitted to the facility on [DATE]. Diagnoses of encephalopathy, diabetes, acute kidney disease, protein-calorie malnutrition, Respiratory failure, chronic obstructive pulmonary disease, disruption of external operation wound, anemia, schizophrenia, ileostomy, hyperlipidemia, and hypertension. Resident #60 was sent to the hospital emergency room (ER) on 03/22/24 but not admitted to the hospital. He was later discharged to another facility on 03/25/24. Review of the Medicare Five-Day assessment dated [DATE] revealed Resident #60 had intact cognition. He had an ostomy and was frequently incontinent of bladder and bowel. He had a surgical wound. Review of the March 2024 progress notes revealed documentation the physician was notified prior to Resident #60 being sent out to the hospital on 03/22/24 for elevated white blood cells (WBC). Further review of the medical record revealed no findings of any test/laboratory results to confirm he had an elevated WBC count. In addition, there was no documentation of him having a change in status to warrant being sent to a hospital nor was there any documentation of Resident #60 or resident representative requesting he be sent out to the hospital. Review of the eINTERACT form dated 03/22/24 revealed Resident #60 was sent out to the hospital for elevated WBC and possible sepsis. Review of the emergency room (ER) report dated 03/22/24 revealed Resident #60 was admitted to the hospital earlier this year for a gunshot wound to the abdomen. He now had a colostomy and an open abdominal wound with a wound vac. He was admitted to the skilled nursing facility five days ago. He stated they had been having issues today with his wound vac not sealing properly and his blood work was abnormal. The facility communicated Resident #60's WBC count was high. The ER nurse was asked to call the facility and they were unable to find the blood work or documentation of why he was sent to the ER. He denied an abdominal pain, fever, or vomiting. He was complaining of leakage at the lower aspect of the wound vac. The wound vac did appear to be accumulating a little bit of serosanguineous fluid to the inferior aspect of the dressing. His laboratory results from the ER showed mild leukocytosis (elevated WBC count which could indicate infection or inflammation in the body) of 11 up from last weeks of 10.6 The final impression was wound vac leaking and mild leukocytosis. The resident had no clinical signs of infection, the mild leukocytosis was trivial and he had no other signs of infection at this time. The wound vac was leaking due to a poor seal but the fluid appeared serosanguineous and not purulent. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 03/23/24 at 6:23 A.M. revealed Resident #60 was admitted back to the facility at 12:45 A.M. His wound vac and colostomy bag were intact. Resident reported his wound vac was changed at the hospital. He had no new orders from the ER visit. On 03/28/24 at 4:10 P.M. an interview with the Director of Nursing revealed on 03/22/24 after she went home Licensed Practical Nurse (LPN) #171 called her and stated there was something wrong with Resident #60's wound and wound vac was not working properly. She stated she told LPN #108 to assess his wound thoroughly because he could possibly have an elevated WBC count. The DON stated there were no test/laboratory results to indicate an elevated WBC count so the only reason she could think of for LPN #171 indicating on the hospital transfer form he had an elevated WBC count was because the DON said he could possibly have elevated WBC count. She stated he was only out to the hospital for a couple hours before he was sent back to the facility with no new orders. She verified at this time there was not proper testing, documentation, or accurate physician notification to send Resident #60 to the hospital and Resident #60's needs could have been met in the facility. This deficiency represents non-compliance investigated under Complaint number OH00152345.

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Legends Care Rehabilitation and Nursing Center	2311 Nave Road SE Massillon, OH 44646

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record, review of the ostomy company invoice and interview with staff the facility failed to ensure ostomy and drainage tube care was provided to Resident #60. This affected one resident (Resident #60)of three reviewed for ostomy care. The facility census was 57. Findings included: Review of the medical record revealed Resident #60 was admitted to the facility on [DATE]. Diagnoses of encephalopathy, diabetes, acute kidney disease, protein-calorie malnutrition, respiratory failure, chronic obstructive pulmonary disease, disruption of external operation wound, anemia, schizophrenia, ileostomy, hyperlipidemia, and hypertension. He was discharged to another facility on 03/25/24. Review of the physician's orders from 03/19/24 to 03/24/24 revealed no orders for ostomy or drainage tube care. Review of the Medicare Five-Day Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #60 had intact cognition. He had an ostomy and was frequently incontinent of bladder and bowel. Review of the ostomy supply company invoice dated 03/25/24 revealed ostomy pouches were ordered on 03/25/24 and would be delivered on 03/26/24. There was not a resident name attached to the invoice. Review of the March 2024 Treatment Administration Record and Medication Administration Record revealed no documentation ileostomy care was done for Resident #60 from 03/19/24 to 03/25/24. On 03/27/24 at 3:26 P.M. an interview with the Director of Nursing revealed there was no documentation ostomy care or drainage tube care was done for Resident #60 the whole time he was at the facility. She stated he had a drainage tube right beside his ostomy site and it drained into what looked like an ostomy bag. This deficiency represents non-compliance investigated under Complaint number OH00152437 and OH00152345.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record, review of the emergency medication kit list, review of the hospice notes and interview with staff the facility failed to ensure an effective pain management program was implemented for Resident #58. This affected one resident (Resident #58) of three reviewed for pain management. The facility census was 57. Findings included: Review of the medical record revealed Resident #58 was admitted to the facility on [DATE]. Diagnoses included cerebrovascular disease ischemic cardiomyopathy, atherosclerotic heart disease, paroxysmal atrial fibrillation, congestive heart failure, biventricular heart disease, anemia, cerebral infarction, cognitive communication deficit, and dementia. He expired on [DATE]. Review of the Admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #58 had moderately impaired cognition and received no pain medications. Review of the physician's orders dated [DATE] revealed Resident #58 had orders for hospice services and hydromorphone (a narcotic pain medication) 2.0 milligrams (mg) every two hours for pain and air hunger. Review of the progress note dated [DATE] at 6:54 P.M. revealed hospice was in to see Resident #58 and he opened with hospice services. The niece was aware of the new orders. Review of the pharmacy order clarification form dated [DATE] at 1:06 P.M. revealed the hydromorphone for Resident #58 was on backorder and they did not have an estimated time of delivery. Review of the progress note dated [DATE] at 3:58 P.M. revealed hospice was notified the pharmacy was out of hydromorphone with no estimated delivery date. They had no new orders at this time. Review of the pain level on [DATE] at 11:41 P.M. revealed Resident #58 was having a three out of ten pain level. Review of the pain level on [DATE] at 9:07 A.M. and 6:50 P.M. revealed Resident #58 was having a zero out of ten pain level. Review of the pain level on [DATE] at 11:21 P.M. revealed Resident #58 was having a seven out of ten pain level. Review of the physician's orders revealed Resident #58 received an order for Hydrocodone-Acetaminophen (pain medication) ,d+[DATE] mg every six hours for pain and every six hours as needed for pain dated [DATE]. Review of the pain level on [DATE] at 9:29 A.M. and 11:57 A.M. revealed Resident #58 was having a zero out of ten pain level. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress note dated [DATE] at 7:30 P.M. revealed the hospice nurse and aide were present at bedside along with the family and were working on getting pain medication. The facility nurse spoke with the hospice physician and family who stated morphine may be administered for pain even though the resident had an allergy listed to this medication due to they did not know the severity of the reaction. Hospice was requesting this nurse pull morphine immediately and give the medication. The facility nurse explained that they could not just pull morphine that it had to go through pharmacy, they would require a physician script for the medication and an authorization number from the pharmacy before they could pull the medication. Now awaiting physician and pharmacy. Review of the hospice note dated [DATE] at 8:10 P.M. revealed the hospice nurse reached out to the pharmacy about the hydromorphone delivery and the hospice receptionist let the hospice nurse know that she did not get a response from the pharmacy receptionist about the order being received or dispatched. The hospice receptionist informed the hospice nurse she would call her when she received more information. The hospice nurse called the hospice physician and asked about the possibility of starting morphine due to the family's request. The physician was wanting more information on his morphine allergy. After talking with the family, it was determined the reaction was unknown. Still waiting on a response from the physician. The family was upset at bedside. The hospice nurse informed the family they were doing everything they could to pacify the situation. The physician called and gave the order for morphine sulfate 0.5 ml/10 mg every two hours as needed for pain. The family were aware of his potential morphine allergy and they indicated they just want him to be comfortable. Review of the physician's orders revealed Resident #58 received an order for 0.5 milliliters (ml) Morphine Sulfate (pain medication) oral solution 20 mg /ml every two hours as needed for pain and air hunger dated [DATE]. Review of the progress note dated [DATE] at 9:00 A.M. revealed the pharmacy received the written prescription from the physician to pull the morphine from stock and give it every two hours. Review of the pain level on [DATE] at 9:33 A.M. revealed Resident #58 was having a zero out of ten pain level. Review of the hospice notes dated [DATE] at 1:31 A.M. revealed the emergency visit was due to family concerns. The family was at bedside distressed with the resident's state earlier in the evening. The resident was slightly restless. He was medicated at 11:00 P.M. with morphine. The niece was clear she wanted him medicated around the clock to the full potential of the orders and she wanted it addressed immediately. The niece expressed her disappointment with the breakdown in communication and asked why his medication was not ordered from a local pharmacy when she could have just picked it up. The hydromorphone finally arrived on [DATE] at 12:15 A.M. which was several hours after anticipated time. She asked why his mediation was not immediately available at the beginning of his hospice care on [DATE]. The hospice nurse offered possible causes for some of the concerns but did not have the answers to some. Review of the hospice notes revealed Resident #58 expired on [DATE] at 6:31 A.M. Review of the February 2024 Medication Administration Records revealed Resident #58 was never administered hydromorphone 2.0 mg ordered on [DATE]. He was administered Hydrocodone-Acetaminophen ,d+[DATE] mg every six hours routinely. He was administered morphine sulfate on [DATE] at 1:01 A.M. for an eight of ten-pain level and at 3:00 A.M. for a 10 out of 10 pain level. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of the emergency medication kit with the Director of Nursing (DON) on [DATE] at 9:05 A.M. revealed there were six tablets of hydromorphone 2.0 mg available. On [DATE] at 10:15 A.M. an interview with the DON confirmed the facility did have hydromorphone 2.0 mg tables in their emergency stock kit, however, she was not sure if it was in the kit at the time Resident #58 received the order. She could not provide proof the hydromorphone was pulled for another resident. On [DATE] at 11:00 A.M. an interview with Pharmacy Technician #500 revealed hydromorphone was on back order and had been for a while, she thought since [DATE]. She stated she did not know if it was pulled or not at the time Resident #58 received an order. However, if it had been pulled for someone else it wound not had been replaced due to it being on backorder. So, if it was not in the kit it was used for someone but it could have been months ago because it had been on backorder since at least ,d+[DATE]. She stated if it was in the kit now, they would not have been able to refill it due to the shortage. She stated the DON had called the pharmacy last week and was asking the same questions about whether or not it had been in the kit at the time Resident #58 received the order and they told her the same thing. This deficiency represents non-compliance investigated under Complaint number OH00151684.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record and interview with staff the facility did not ensure the application of a negative pressure wound therapy machine was accurately documented in the medical record for Resident #60. This affected one resident (#60) of three residents reviewed for wound care documentation. The facility census was 57. Findings included: Review of the medical record revealed Resident #60 was admitted to the facility on [DATE]. Diagnoses of encephalopathy, diabetes, acute kidney disease, protein-calorie malnutrition, respiratory failure, chronic obstructive pulmonary disease, disruption of external operation wound, anemia, schizophrenia, ileostomy, hyperlipidemia, and hypertension. He was discharged to another facility on 03/25/24. Review of the hospital discharge orders dated 03/19/24 revealed Resident #60 had an abdominal wound managed with negative pressure wound therapy (wound vac) to be change on Monday, Wednesday, and Friday with specialized foam. Review of the admission assessment dated [DATE] revealed Resident #60 had an abdomen wound which measured 15 centimeters (cm) in length by 6.0 cm in width by 0.75 cm in depth and an abdomen wound which measured 1 cm in length by 1.0 cm in width by 0.1 cm in depth. He had a left abdominal drain and a right upper quadrant ostomy. Review of the physician's orders dated 03/19/24 revealed Resident #60 had an order to apply a wound vac to his abdominal wound every Monday, Wednesday, and Friday. If the wound vac was removed or nonfunctional apply a wet to dry dressing. Review of the Wound Nurse Practitioner (NP) Care Note dated 03/20/24 revealed Resident #60 was being seen for a surgical wound to the abdomen, The wound was being treated with local dressing changes to the site and there had been no fever or sign of infection per nursing report. The abdominal midline incision was with significant dehiscence (separation of the wound edges/improper healing). A wound vac was ordered upon discharge however it had not arrived yet. Saline wet to dry to be utilized until the wound vac arrives. Wound measured 14 centimeters in length by 3.9 cm in width by 1.1 cm in depth with a large amount of serosanguinous drainage and no odor. Review of the Medicare Five-Day Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #60 had intact cognition and a surgical wound. Review of the Treatment Administration Record (TAR) dated March 2024 for Resident #60 revealed no documentation of the wound vac being applied until 03/22/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366085	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legends Care Rehabilitation and Nursing Center	2311 Nave Road SE Massillon, OH 44646

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/24 between 1:38 P.M. and 1:50 P.M. an interview with Licensed Practical Nurse (LPN) #108 revealed she had only been doing the wounds for about two weeks. She stated it usually only took a day or two to get a wound vac in for a resident. LPN #108 stated the wound vac for Resident #60 was not put on until the next day after admission because the Wound NP was going to be in that day on 03/20/24 to assess the wound. LPN #108 verified she put the wound vac on Resident #60 on 03/20/24, but she did not document it on the TAR. LPN #108 also verified the application of the wound vac was not documented on the TAR until 03/22/24. On 03/27/24 at 2:40 P.M. an interview with the Director of Nursing (DON) revealed she does not know why the Wound NP documented the wound vac was not available because they had it in the building and it was put on either late Wednesday (03/20/24) or early Thursday (03/21/24) morning but they did not wait until Friday 03/22/24 to put it on. The DON verified there was no documentation it was put on Resident #60 until 03/22/24. This deficiency represents non-compliance as an incidental finding investigated under Complaint number OH00152437 and OH00152345.