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	06/18/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record, review of the facility's Self-Reported Incident (SRI), interview with staff and family, and review of the facility policy the facility failed to ensure Resident #53 was treated with dignity and respect during care by a facility staff member. This affected one resident (#53) of three residents reviewed for dignity and respect. The facility census was 53. Findings include: Review of the medical record revealed Resident #53 was admitted to the facility on [DATE]. Diagnoses included diabetes, Parkinson's disease, osteoarthritis, dementia, Alzheimer's disease, obstructive sleep apnea, major depressive disorder, attention-deficit hyperactivity disorder, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #53 had severely impaired cognition and had no behaviors. Review of the progress notes dated 05/27/24 at 8:09 P.M. revealed the Administrator left a message for the daughter of Resident #53 to call her regarding accusations made against a nursing assistant. The daughter returned the call, and the details were discussed. Review of the handwritten, signed statement from State tested Nurse Aide (STNA) #170 revealed on 05/26/24 (the event occurred on 05/27/24) she was assisting Resident #53. She asked Resident #53 to get up. She stated she did not see a camera or notice a recording taking place. She stated the resident was having a hard time following directions. The resident's daughter came in and yelled at her and asked her why she was being rude to her mother. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the follow up typed unsigned statement from the Administrator dated 06/02/24 at 4:33 P.M. revealed STNA #170 was called by the Administrator to provide clarification to her initial written statement. STNA #170 stated she came into provide morning care to Resident #53 and observed that she had wet herself. She stated she was trying to convince Resident #53 to stand up so she could change her, but Resident #53 was sitting down instead. STNA #170 stated Resident #53 was babbling about random things and began to cry. STNA #170 stated her intent was to get Resident #53 to the bathroom to change her clothes and then get dressed. She stated it was also time to pass out breakfast trays, so she exited the room. At lunch time STNA #170 stated Family Member (FM) #400 came into the building and stated she was going to go get her mother lunch and get an activity book for her mom because the only thing she had to do was watch television. STNA #170 stated she never said anything to her about a recording. STNA #170 stated FM #400 came back into the facility around suppertime and started yelling at her saying, You made her cry, do you want to see the video, and STNA #170 shook her head no and did not engage in confrontation with her. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the SRI tracking number 247986 dated 05/27/24 revealed FM #400 alleged STNA #170 was rude to her mother when attempting to redirect Resident #53 as she was attempting to change her wet clothing on morning of 05/27/24. FM #400 based this allegation on an audio recording played to the Administrator and the Interim Director of Nursing (DON). The audio was grainy, but one can hear STNA #170 repetitively asking the resident to sit and stand up while presumably trying to change her soiled clothing. FM #400 then confronted STNA #170 later in the day, screaming, cursing at her, and asking her if she wanted to view the video which STNA #170 declined. There were two witnesses to the confrontation, both of whom verified the yelling, cursing, and the response of STNA #170 who did not engage in the dialogue with the daughter. FM #400 stated she did not have a camera in the room but recorded the audio on her phone; however, she was overheard saying she did have a camera by the sister of another resident. FM #400 also informed the Administrator and Interim DON that she would bring back an enhanced version of the audio recording on Wednesday but did not do so on that day, Thursday, or Friday. The Administrator and Interim DON have only heard the audio recording one time. FM #400 told the Administrator and Interim DON in a meeting on Tuesday, 05/28/24 she was in the room and on the roommate's side to clean up trash that was left there by her mother, and the curtains were closed which is why STNA #170 did not notice her there. When asked by the Interim DON why she did not interrupt the alleged dialogue that she felt was abusive, FM # 400 stated she was in shock and left the room. FM #400 was unable to provide a description of the STNA and could not verify whose voice was in the audio. During this meeting, the Administrator asked FM #400 if she wanted to relocate her mother to another facility and she declined. STNA #170 stated there was no one in the room except Resident #53, and the curtains around her roommate's side of the bed were not closed. She stated Resident #53 was wet, and she was trying to convince her to change her clothing, but Resident #53 was not able to understand the directive, was uncooperative, was babbling and begun to cry. STNA #170 stated FM #400 returned at lunch time and stated she would get her mother lunch and an activity book but said nothing about a recording or video. At about 4:30 P.M., STNA #170 stated FM #400 returned to the facility looking for STNA #170 and once she found her, FM #400 began to yell and curse at STNA #170 asking her if she wanted to see the video to which STNA #170 declined. There were noted discrepancies as to how the recording was obtained, and it was unclear why FM #400 did not intervene when she heard the alleged verbal abuse. The existence of the audio does not relieve STNA #170 of her responsibilities to the resident as in to providing care in a dignified manner and to be respectful to the resident regardless of her ability to comprehend conversation. STNA#170 did not intend to inflict mental anguish upon the resident when she first engaged in care as she was attempting to convince someone who lacked capacity to get dressed. After repeated attempts were unsuccessful, STNA #170's frustration was heightened, and she made several comments that were considered inappropriate in both tone and content and indicative of poor customer service. STNA #170 would receive re-education on customer service, working with dementia residents, will not be assigned to the care of Resident #53, and will be monitored for 30 days by the DON or designee. She will also receive disciplinary action as needed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/13/24 at 11:52 A.M. an interview with FM #400 revealed she was visiting her mother on 05/27/24 and was on the other side of the privacy curtain because they had given her mother a box of gloves to play with and they were all over the floor. She stated STNA #170 came into the room and stated to her mother she was there to get her up, her mother said no she did not want to get up and STNA #170 stated, bullshit you are getting up. She stated she turned her phone on record because this had happened before, and the administrator did not believe her, so she wanted evidence this time. She stated STNA #170 told her mother that her family just dumped her here and other nasty things to her mother. She stated she left immediately afterward because she was so angry and did not want to confront anyone at that time. She stated her mother had dementia and did not understand what was going on, but she understood her family did not want her and she was crying. She stated the next day she went into the facility and met with the Administrator and the acting DON. On 06/17/24 at 10:10 A.M. an interview with STNA #170 stated she was no longer employed at the facility and her last day was 06/12/24. She stated she had gone into the room of Resident #53 to provide care and she had soiled herself. She stated she attempted to clean her up and change her clothes. She stated she continued to tell Resident #53 to stand up, and she would not stand up. Resident #53 started to cry, and with her crying and trying to get her cleaned up proved to be difficult. She stated Resident #53 was not being cooperative at all, and the way she spoke to her was not appropriate. She stated she was trying to get the resident cleaned up and pass out the breakfast trays. She verified she stated to Resident #53 her family just dumped her in the facility and pawned shit off on the staff. She verified she repeatedly yelled at her to stop scratching. She stated she did not know she was being recorded and confirmed she would not have said those things if she knew she was being recorded. She stated she was terminated due to this incident. Review of the facility policy titled, Quality of Life-Dignity, dated 08/09 revealed each resident would be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents would be treated with dignity and respect at all times. Staff would speak respectfully to residents at all times. This deficiency represents non-compliance investigated under Master Complaint Number OH00154452 and Complaint Number OH0015280.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on review of the medical record and interview with staff the facility failed to ensure an ultrasound was scheduled for Resident #53 in a timely manner. This affected one resident (#53) of three residents reviewed for care and services. The facility census was 53. Findings include: Review of the medical record revealed Resident #53 was admitted to the facility on [DATE]. Diagnoses included diabetes, Parkinson's disease, osteoarthritis, dementia, Alzheimer's disease, obstructive sleep apnea, major depressive disorder, attention-deficit hyperactivity disorder, and hypertension. Review of the Nurse Practitioner's progress note dated 02/26/24 revealed Resident #53 was having left breast pain. The plan was to schedule a mammogram. Review of the mammogram results dated 03/04/24 revealed Resident #53 had a 1.5 centimeter (cm) oval nodule in the right breast at 11 o'clock and a 2.0 cm oval nodule in the left breast at three o'clock. The results were incomplete, and the resident will need additional evaluation and an ultrasound was recommended. Review of the progress note from 03/04/24 to 05/29/24 revealed no documented evidence of the facility attempting to set up an ultrasound for Resident #53 or notifying her daughter of the need to set up an appointment. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #53 had severely impaired cognition and had no behaviors. Review of the physician's orders dated 06/13/24 revealed Resident #53 had an order for a ultrasound on 06/18/24 at 10:00 A.M. On 06/17/24 at 1:50 P.M. an interview with Interim Director of Nursing (DON) revealed about three weeks ago Family Member (FM)#400 asked about her mother's mammogram results and if they found anything. The Interim DON revealed she reviewed the results and got the ball rolling for the ultrasound. She stated she was not with the facility at that time, so she does not know why the ultrasound was not set up, but it was set up as soon as she found out about it. Review of the documentation from the appointment on 06/18/24 revealed Resident #53 had an abnormal ultrasound of both breasts and would need a breast biopsy on 06/25/24 at 8:00 A.M. This deficiency represents non-compliance investigated under Master Complaint Number OH00154452.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, review of the meal ticket, interview with staff, and review of facility policy the facility failed to ensure Resident #34 received to correct physician's ordered diet. This affected one resident (#34) of three residents reviewed for diet orders. The facility census was 53. Findings include: Review of the medical record revealed Resident #34 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, respiratory failure, diabetes, heart failure, muscle wasting, pulmonary hypertension, dysphagia, aphonia, gastrostomy, pulmonary embolism, and hypertension. Review of the June 2024 physician's orders revealed Resident #34 had an order for a regular diet with thin liquids dated 06/07/24. Review of the list of resident's diets revealed the facility had no residents receiving thickened liquids. Review of the diet ticket dated 06/17/24 revealed Resident #34 was to have nectar thick liquids. Observation of meal service on 06/17/24 at 11:15 A.M. revealed Resident #34 received nectar thick water and cranberry juice. On 06/17/24 at 11:15 A.M. an interview with Dietary Manager #133 stated they had one resident with thickened liquids, Resident #34. On 06/17/24 at 11:16 A.M. an interview with Regional Culinary Director #200 revealed she would find out why the list of diets indicated they had no residents with thickened liquid but had one resident on thickened liquids. On 06/17/24 at 11:55 A.M. an interview with Regional Culinary Director #200 revealed Resident #34 was not to have nectar thick liquids, his diet was changed on 06/06/24 and the order was never changed. She stated they did not have a dietary manager at the time, and it was never changed in the meal ticket system. Review of the facility policy titled, Tray Identification, dated 04/07, revealed appropriate identification would be used to identify various diets. To assist in setting up and serving the correct food tray and diets to residents, the Food Service Department would use appropriate identification to identify the various diets. The Food Service Manager or supervisor would check the tray for correct diets before the food carts were transported to their designated areas. This deficiency represents non-compliance investigated under Complaint Number OH00154280.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35765 Based on observations, review of pest control invoices, review of pest control logs, interview with staff, and review of the facility policy the facility failed to maintain a clean and sanitary kitchen. This had the potential to affect 51 residents who received meals from the kitchen. Two residents (#31 and #33) were identified by the facility as receiving nothing by mouth. The facility census was 53. Findings include: 1. Observation of the kitchen on 06/13/24 at 9:00 A.M. with [NAME] #122 revealed the stainless-steel table by the dishwasher, which had the chemical on it, was dirty with food debris and dirt, the stainless-steel table, by the steam table revealed the bottom shelf was dirty with food debris and dirt buildup, the stainless-steel table the coffee maker was on, had dirt on the top and the shelf underneath had coffee spilled, food debris and dirt on it. There was a three-drawer plastic container which was dirty with coffee and a pink substance spilled down the front of it. The flour and sugar plastic containers were dirty with a buildup of dirt on the outside of the container. The plate and bowl storage cart had pieces of paper and cereal spilled down in the compartment where the clean bowls and lids were kept. On 06/13/24 at 9:10 A.M. an interview with [NAME] #122 verified these findings. Review of the kitchen cleaning schedule provided by the facility revealed the storage shelves were to be wiped clean every day and the utility carts after each meal. Review of the facility policy titled, Sanitization, dated 10/08, revealed the food service area would be maintained in a clean and sanitary manner. All kitchens, kitchen areas and dining room would be kept clean, and free from litter and rubbish. All utensils, counter, shelves, and equipment would be kept clean, maintained in good repair and would be free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use or proper cleaning. 2. Review of the pest control invoice dated 06/03/24 revealed they came out to the facility for an extra service in the kitchen for cockroaches with no sighting. Review of the pest control invoice dated 06/13 24 revealed they came out for the routine service and retreated the kitchen for cockroaches with no live sightings. Rooms 203, 402 and 409 were also treated for cockroaches with no sightings. Observation of the kitchen on 06/13/24 at 9:00 A.M. with [NAME] #122 revealed several cockroach traps throughout the kitchen. On 06/17/24 at 10:50 A.M. an interview with Dietary Manager #133 confirmed she had seen cockroaches in the kitchen; on 05/24/24 there was a dead one in the steam table, on 06/03/24 there was a live one above the dishwasher, and on 06/10/24 a live one by the freezer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation in the kitchen on 06/17/14 at 11:00 A.M. revealed a cockroach ran across the floor and underneath the bread cart. Dietary Manager #133 verified it was a cockroach. She stated she would have pest control come out again. Review of the facility policy titled, Pest Control, dated 09/15/21, revealed the facility would be sprayed by pest controls. The policy was to establish a regimented time each month for spraying and to eliminate pests in the center. This deficiency represents non-compliance investigated under Complaint Number OH00154280.