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	03/20/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on staff interview, record review, and facility policy review, the facility failed to notified the resident's family/responsible party and the physician timely upon the death of two residents (#60 and #61). This affected two residents (#60 and #61) of three residents reviewed for death. The facility census was 53. Findings include: 1. Review of the closed medical record for Resident #60 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), esophageal obstruction, and cerebrovascular disease. Review of Resident #60's physician's orders dated 06/15/21 revealed the resident was a Full Code (advance directives). The physician orders dated 04/30/24 revealed an order for Hospice Provider #333 to provide services for Resident #60 for a diagnosis of COPD with lower obstruction. Review of the progress notes for Resident #60 dated 03/01/25 at 8:30 A.M. and completed by Registered Nurse (RN) #301 revealed Resident #60 was absent of vital signs at 8:30 A.M. This was verified by RN #301 and nurse on duty (Licensed Practical Nurse (LPN) #313) for Resident #60. The progress notes dated 03/01/25 at 8:30 A.M. completed by LPN #313 revealed Hospice Provider #333 was notified Resident #60 was not responding. Hospice Provider #333 stated they would send a nurse to the facility. The progress note dated 03/01/25 at 9:30 A.M. completed by LPN #313 revealed Resident #60 was absent of vital signs at 8:30 A.M. and this was verified by two nurses (LPN #313 and RN #301). Hospice Provider #333 and Physician #331 were notified. The note included hospice would call the family and funeral home. Interview on 03/13/25 at 10:07 A.M. with Clinical Manager #335 at Hospice Provider #333 stated the facility nurses at the facility to call the physician for the time of death. (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: 366085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/17/25 at 2:28 P.M. with Regional Director of Clinical Services (RDCS) #328 confirmed there was no documentation in Resident #60's medical record of Resident #60's primary physician being notified or the family being notified when Resident #60 was found to have absence of vital signs. RDCS #328 confirmed the physician and family should have been notified immediately. 2. Review of the closed medical record for Resident #61 revealed an admitted [DATE]. Diagnoses included vascular dementia and cerebrovascular disease . Review of the physician orders for Resident #61 dated 10/03/24 revealed an order to admit to Hospice #336 for cerebrovascular disease. An additional physician order dated 04/02/24 for Resident #61 included do not resuscitate comfort care (DNRCC). Review of the progress note for Resident #61 dated 11/02/24 at 5:20 A.M. completed by Licensed Practical Nurse (LPN) #229 revealed Resident #61 without vital signs and this was verified by second nurse. Hospice notified. Review of the progress note dated 11/02/25 at 6:18 A.M. completed by LPN #229 revealed Hospice Registered Nurse (RN) in and called time of death at 6:15 A.M. Hospice is notifying family. Interview on 03/18/25 at 11:55 A.M. with Medical Director #331 confirmed a resident's time of death was at the time of absence of vital signs. Interview and record review on 03/20/25 at 1:25 P.M. with Regional Director of Clinical Services (RDCS) #328 confirmed Resident #61 had no documentation or evidence of the physician or family being notified regarding his death by the facility and in a timely manner. Review of the facility policy titled Death of a Resident, Documentation revised July 2017 revealed the Nurse Supervisor/Charge Nurse will inform the resident's family of the resident's death. Review of the facility policy titled Change in Resident's Condition or Status revised May 2017 revealed the facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the residents medical/mental change and or status. This was an incidental finding during the complaint investigation.

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, medical record review, review of hospital records, review of facility Self-Reported Incidents (SRI), review of facility abuse investigations, review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property, review of the facility policy titled Resident Rights, and interviews, the facility failed to ensure Resident #23 and Resident #38 were free from incidents of resident to resident physical and verbal abuse. This resulted in Immediate Jeopardy and actual harm beginning on 02/04/25 at approximately 8:30 P.M. when Resident #38 was abused by Resident #15, a resident who was identified to not like other residents in his space or touching his things. On 02/04/25 Resident #15 verbally threatened and then physically assaulted Resident #38 by dragging Resident #38 out of his bed, throwing Resident #38 from his room, resulting in Resident #38 falling to the floor in the hallway causing a closed compression fracture of L5 vertebra (lower back). As a result of the incident, Resident #38 was no longer able to independently ambulate. The Immediate Jeopardy and actual harm continued on 02/10/25 at 9:51 P.M. when Resident #23 was physically assaulted by Resident #15 when Resident #15 stabbed the resident with a fork in the hand causing the resident to bleed and sustain puncture wounds. This affected two residents (#23 and #38) reviewed for physical abuse and had the potential to affect an additional four residents (#7, #9, #19, and #40) the facility identified who were cognitively impaired and independently mobile who could be subject to abuse by Resident #15 or any other physically abusive resident. The facility census was 53. On 03/13/25 at 4:06 P.M., the Administrator, Director of Nursing (DON), Unit Manager #322, Regional Director of Clinical Services (RDCS) #328 and the Regional Director of Operations #330 were notified Immediate Jeopardy began on 02/04/25 at approximately 8:30 P.M., when the facility failed to develop and implement the necessary care, supervision and interventions to prevent incidents of resident to resident abuse initiated by Resident #15. Resident #15 was identified to have a history of wandering and a history of becoming aggressive when other residents enter his space. The facility failed to develop a comprehensive and individualized plan of care to address these behaviors and to ensure the safety of other residents. On 02/04/25 at 8:30 P.M., Resident #38 wandered into Resident #15's room and laid on Resident #15's bed. Resident #15 entered the room and was verbally and physically aggressive with Resident #38 to move out of his space. Resident #15 threw Resident #38 out of his room and Resident #38 flew onto the hallway floor resulting in a fall sustaining a closed compression fracture of L5 vertebra (lower back). Resident #38 is now confined to a wheelchair for mobility. On 02/10/25 at 9:51 A.M., Resident #15 and Resident #23 were noted to be sitting next to each other in the dining room. Resident #23 reached over to Resident #15's space to obtain a spoon and Resident #15 physically assaulted Resident #23 with a fork in the hand causing Resident #23's to bleed and sustain puncture wounds. The Immediate Jeopardy was removed on 03/13/25 when the facility implemented the following corrective actions: On 02/04/25 at 8:30 P.M., Registered Nurse (RN) #301 observed Resident #38 laying on the floor outside of (Resident #15's room) laying on her back. Resident #38 was holding her head saying she was in a lot of pain. Emergency (911) was called, and Resident #38 was transported to Hospital #339 at 8:45 P.M. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 02/10/25 at 8:07 A.M., it was reported Resident #15 stabbed Resident #23 with a fork. Resident #23 and Resident #15 were immediately separated. On 02/10/25 at 8:09 A.M., Resident #23 was taken to the nurse for first aid. The nurse cleaned the puncture wound with normal saline and applied clean dry dressing for his hand. Resident #23 received a small break in the skin during the incident with Resident #15. On 02/10/25 at 2:15 P.M., Resident #15 was seen by Psychiatric-Mental Health Nurse Practitioner (PMHNP) #338 with new orders received to increase Zoloft to 50 milligrams (mg) daily for anxiety and agitation. Start hydralazine 25 mg by mouth twice daily for anxiety/agitation for 14 days. On 02/11/25 an action plan was developed due to the facility failing to appropriately manage residents' behavior/change in condition. The DON initiated education to licensed nursing staff on behavioral management and appropriate management of interventions. The DON reviewed all nursing progress notes for the past seven days to ensure that all behaviors/change of condition were documented in the facility's electronic medical record with appropriate interventions. On 02/11/25 the facility implemented a plan for the DON to conduct an audit five days a week for four weeks reviewing nursing progress noted to monitor for any change in condition or any behaviors that did not have an intervention in place and ensure that the physician was notified. By 02/14/25 at 4:30 P.M., the facility implemented a plan for skin assessments to be completed on all nonverbal residents by the Wound Nurse. On 03/13/25 at 5:30 P. M., Resident #15 was placed on 1:1 supervision to ensure the resident's safety and to protect other residents with diagnosis with dementia to prevent them from entering Resident #15's personal space by the Administrator. Resident #15 would continue to be followed by psychiatric services. On 03/13/25 at 5:35 P. M., the Unit Manager placed a stop sign on Resident #15's door to deter other residents from entering the room. On 03/13/25 at 5:45 P. M., a whole house audit was completed identifying six residents, Resident #7, #9, #19, #23, #38, and #40 with a dementia diagnosis and were also self-ambulatory to identify the potential risk of these residents entering Resident #15's personal space. These findings led the facility to implement 1:1 supervision for Resident #15. In addition, a whole house audit was completed of all residents' records to determine if any residents had aggressive or violent behaviors. The audit revealed that one resident, Resident #40 had a diagnosis of aggressive behavior prior to admitting to the facility due to the resident not taking prescribed medications. However, as of this date Resident #40 had not displayed any aggressive behaviors while residing in the facility and had been taking his prescribed medications for aggressive behaviors. On 03/13/25 at 6:10 P.M., RDCS #328 educated the staff present in the facility on interventions implemented for Resident #15 which included: 1:1 supervision until Resident #15 was discharged , placing a stop sign on Resident #15's room door and that Resident #15 would eat at a separate table in the dining room for meals. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 03/13/25 at 6:26 P.M., RDCS #328 informed Resident #15's family/responsible party the resident had been placed on 1:1 supervision, a stop sign was placed on Resident #15's door and he would be eating at separate table for meals. On 03/13/25 at 6:49 P. M., an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held to discuss interventions for Resident #15 to ensure resident's safety and to protect other residents (including those with a diagnosis of dementia) to prevent them from entering Resident #15's personal space. The meeting was held with Medical Director #331 via telephone, Administrator, Director of Nursing (DON), Unit Manager #322, Wound Nurse#332, Business Office Manager (BOM) #310, Social Worker/Admissions #203, Dietary Manager #212, MDS Nurse #303, Central Supply/Scheduler #224, Activities Director #231, Human Resources Director #226, RDCS #328, and Regional Director of Operations #330. On 03/13/25 at 7:12 P.M., all facility staff were educated by DON/Designee on the facility policy and procedure for abuse (including resident-to-resident abuse) and immediate action to take. The facility would monitor/audit/document aggressive and violent behavior to ensure appropriate interventions are implemented timely. All staff were also educated that Resident #15 was to be on 1:1 supervision until Resident #15 was discharged , a stop sign was placed on Resident #15's room door and Resident #15 would eat at a separate table at meals. Resident #15's interventions were implemented to prevent the six identified residents with dementia and who were ambulatory, from entering Resident #15's personal space to prevent physical abuse. Staff education of three RNs, 10 licensed practical nurses (LPNs), 28 certified nursing assistants (CNAs), five housekeepers, one laundry personnel, six dietary staff, one activities personnel, and 11 department heads was completed. Beginning 03/13/25, the facility implemented a plan for the Administrator/Designee to audit resident behaviors by reviewing clinical documentation and implementation of interventions to ensure the safety of others, five times weekly for four weeks. Beginning 03/13/25, the facility implemented a plan for the Administrator/Designee to interview three staff members three times a week for four weeks to identify any observations of physically abusive behaviors. If behaviors were identified, the facility would put appropriate resident centered interventions in place. Beginning 03/13/25 the facility implemented a plan for the Administrator/Designee to audit that Resident #15's interventions of 1:1 supervision, eating at separate table for meals, and stop sign were in place at Resident #15's room door five times a week for four weeks. Beginning 03/13/25 the facility implemented a plan that all findings would be submitted to the QAPI Committee for review and recommendations for six months. Although the Immediate Jeopardy was removed on 03/13/25, the deficiency remained at a Severity Level II (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and were monitoring to ensure on-going compliance. Findings include: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Record review revealed Resident #38 was readmitted to the facility on [DATE] with diagnoses including Parkinson's disease without dyskinesia, dementia, Alzheimer's disease, and attention deficit disorder. Review of the care plan dated 09/28/23 revealed Resident #38 was an elopement risk/wanderer disoriented to place, history of attempt to leave the facility unattended, and had impaired safety. Interventions included distracting the resident from wandering by offering pleasant diversions, activities, food, conversation, television, reading material. Identify pattern of wandering, divert as needed and intervene as appropriate. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 was severely cognitively impaired. Resident #38 had no impairment of the upper or lower extremities, Resident #38 did not use a wheelchair and required supervision or touch assistants with ambulation. Resident #38 had no verbal or physical symptoms directed towards others. Review of the progress notes for Resident #38 dated 02/04/25 at 8:58 P.M. completed by RN #301 revealed Resident #38 was observed at 8:30 P.M. lying on the floor outside of Resident #15's room laying on her back. The note included the resident's fall was observed by a CNA (#329) who stated Resident #38 hit her head on the ground. Resident #38 was holding her head saying she was in a lot of pain. Emergency 911 was called, and Resident #38 was transported to Hospital #339 at 8:45 P.M. Review of the Hospital After Visit Summary for Resident #38 dated 02/04/25 (untimed) revealed Resident #38 was seen by Physician #337 at Hospital #339. The reason for the visit was due to a fall and diagnosis of closed compression fracture of L5 vertebra. There were no new orders. Review of a facility self-reported incident (SRI) dated 02/04/25 at 8:58 P.M. revealed the facility reported an allegation of physical abuse involving Resident #15 and Resident #38 to the State agency. The SRI noted here were no witnesses. Resident #15 with a low cognitive function allegedly pushed Resident #38 who also had low cognitive function. A CNA (#329) reported she was walking down the hallway when she saw a female resident (Resident #38) fall backwards losing contact with the floor out of a male resident's room (Resident #15). The facility concluded evidence was inconclusive and abuse was not suspected. The progress note dated 02/05/25 at 11:11 A.M. completed by RN #301 revealed Resident #38 returned from Hospital #339 at 10:15 A.M. Resident #38 complained of pain to her back, as needed (PRN) tramadol (opioid pain medication to treat moderate to severe pain) was administered with effective results. The progress note dated 02/05/25 at 1:27 P.M. completed by RN #301 revealed Resident #38's emergency room (ER) diagnosis was closed compression fracture of L5 vertebra with no intervention needed. The progress note dated 02/06/25 at 1:24 P.M. completed by DON revealed Resident #38's fall was reviewed in safety meeting. The note revealed Resident's fall was observed by CNA #329. Resident #38 fell backwards and hit her head on the floor. Resident #38 complained of head/neck hurting. The physician orders dated 02/12/25 revealed Resident #38's Tramadol was increased from 50 milligrams (mg) PRN to 100 mg three times a day for pain. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/12/25 at 1:52 P.M. with LPN #208 revealed Resident #15 had been aggressive with Resident #38 and Resident #38 fractured her back as a result of the incident. The LPN revealed Resident #38 was confused, wandered in his (Resident #15's) room, got in his bed, he pulled her by the hair and pulled her out of the room. The LPN revealed Resident #15 was not violent unless someone goes in his space, his roommate (#6) stays on his own side. Everyone knows not to go in Resident #15's space, or he would get violent. The LPN stated Resident #38 was a wanderer, she used to walk everywhere all day long but now since Resident #15 assaulted Resident #38, she can't walk because she was in a wheelchair. Interview on 03/12/25 at 3:46 P.M. with RN #301 revealed she was the charge nurse on 02/04/25 when Resident #38 fell and fractured her back in front of Resident #15's doorway. RN #301 stated Resident #15's roommate (Resident #6) was there and witnessed everything when the incident occurred. RN #301 stated Resident #6 was very alert and oriented. Observation on 03/12/25 at 3:55 P.M. revealed Resident #15 resided in the same room as Resident #6. Based on the layout of the room, Resident #15's bed was against the wall and Resident #6 would have a clear view of Resident #15's bed and the doorway. Interview with Resident #6 at the time of the observation revealed he remembered what happened regarding Resident #38's fall that day (02/04/25) very well. Resident #6 stated Resident #38 came into their room and sat in Resident #15's bed. Resident #15 came in and said get out of my bed. Resident #38 did not respond, and Resident #15 said get up or I am going to hurt you. Resident #15 grabbed Resident #38 by the shoulders moved her to the doorway and pushed her in the hall. Resident #6 stated he saw the whole thing. Resident #38 screamed. Resident #6 stated he felt so bad for Resident #38. Resident #6 stated he was not afraid of Resident #15 because he knew Resident #15 only gets aggressive when provoked, meaning if you get near his things or get in his space, otherwise he doesn't say anything or do anything. Resident #6 stated he stays to himself in his area of the room. Resident #6 stated the facility staff did not interview him or ask for a statement regarding Resident #15's assault with Resident #38. Interview on 03/12/25 at 5:41 P.M. with the DON revealed the DON recalled the incident on 02/04/25 between Resident #15 and Resident #38. The DON stated the incident happened on an off shift, and all they knew was Resident #38 was found outside Resident #15's door. Resident #38 had fallen backwards, she was injured and fractured her back. They immediately sent Resident #38 to the hospital, but no one saw the fall. The DON stated no one said anything that it might be Resident #15 who pushed Resident #38, and the staff just said he (Resident #15) was in his room. The DON confirmed she read Resident #38's nurses notes (as noted above) and reiterated there were no witnesses to the incident. The DON confirmed she did not interview Resident #6 who was present at the time of Resident #38's fall. The DON confirmed Resident #6 was alert and oriented to the person, place and time and stated she did not interview him because she was not sure if he saw it. The DON stated she could not answer why she didn't interview Resident #6. Observation on 03/12/25 at 4:37 P.M. revealed Resident #38 was sitting up in the wheelchair in the lounge area. Resident #38 was pleasantly confused and rambled incoherent sentences unrelated to the questions asked by the surveyor. Resident #38 was unable to participate in the conversation or follow simple direction when asked. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/12/25 at 5:06 P.M. with Occupational Therapy Assistant (OTA) #342 confirmed prior to Resident #38's fall, Resident #38 ambulated frequently throughout the facility. Resident #38 received physical therapy services from 02/06/25 through 03/07/25. She was discharged because she met her maximum potential. OTA #342 confirmed Resident #38 was no longer able to ambulate independently and required moderate assistance to transfer safely since the incident with Resident #15 on 02/04/25. Interview on 03/17/25 at 9:10 A.M. with CNA #329 revealed on 02/04/25 she witnessed the incident with Resident #15 and #38. CNA #329 stated she actually saw the incident. CNA #329 stated she wrote up a statement describing what she saw when Resident #38 flew out of Resident #15's room. Two days after the incident occurred, the Administrator and Unit Manager called her on the telephone. The Administrator said the verbiage on the witness statement was too strong, it made it sounded like it was a lot. The Administrator told CNA #329 that she did not physically see Resident #15 push Resident #38. CNA #329 replied to the Administrator that she did see Resident #38 and Resident #38 fly through the air, she flew right through the doorway and flew to the ground. Resident #15 was standing right there in the doorway. CNA #329 stated she asked Resident #15 what happened, and Resident #15 said Resident #38 was in his bed, so he got her out of his room. The Administrator and Unit Manager typed up a different statement for CNA #329; however, CNA #329 stated she refused to sign the witness statement they wrote. Interview on 03/18/25 at 12:28 P.M. with Physical Therapist (PT) #343 revealed Resident #38 was up ad lib with a steady gait prior to the fall on 02/04/25. Resident #38 was discharged from therapy requiring the use of a wheelchair for mobility due to the resident exhibiting no progression with ambulation. PT #343 confirmed Resident #38 did not have aggressive behaviors during therapy. 2. Record review revealed Resident #23 was admitted to the facility on [DATE] with diagnoses including dementia, altered mental status, lack of coordination, and muscle wasting and atrophy. Review of the quarterly MDS assessment dated [DATE] revealed Resident #23 was severely cognitively impaired. Resident #23 had no impairment of the upper or lower extremities, used a wheelchair for mobility, required supervision or touch assist with mobility and with eating. A progress notes for Resident #23 dated 02/10/25 at 7:00 A.M. completed by LPN #327 revealed Residents #15 and #23 were sitting in the dining room at the same table. Resident #15 stated he thought Resident #23 was trying to steal his spoon so Resident #15 stabbed Resident #23 with a fork in his left hand. The residents were immediately separated, and Resident #23 was taken to the nurse for first aid on his left hand. Review of the Wound Tool for Resident #23 dated 02/10/25 at 10:05 A.M. completed by Unit Manager #207 revealed left back of hand skin tear first observation measured two centimeters (cm) in length by 0.4 cm wide by less than 0.1 cm in depth. Cleanse with normal saline and apply clean, dry dressing. Change bandage daily and PRN. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a facility SRI dated 02/10/25 revealed the facility reported an allegation of physical abuse involving Resident #15 and Resident #23. The residents were both in the dining room sitting at the table when Resident #15 took a fork and struck Resident #23's hand due to thinking Resident #23 was going to take Resident #15's spoon. Both residents were separated to ensure they did not come into each others space. Resident #15 was placed on 1:1 supervision. Resident #23 received first aid treatment. Stat laboratory work was ordered for Resident #15. Resident #15 also received a physician order for medication changes and would now receive plastic cutlery. The facility concluded the evidence was inconclusive due to Resident #15 having low cognitive function and had no willful intent to harm Resident #23. Interview on 03/12/25 at 1:52 P.M. with LPN #208 revealed Resident #23 and #15 were in the dining room a few weeks ago and they sat at the same table. Resident #23 was reaching into Resident #15's space and Resident #15 stabbed Resident #23's hand with the fork, and it created a wound. Interview on 03/12/25 at 2:05 P.M. with CNA #395 revealed she took care of Resident #15 every day when she worked. During the interview, the CNA revealed Resident #15 had become aggressive with both Resident #23 and Resident #38. CNA #395 stated Resident #15 becomes aggressive if any resident gets in his space. CNA #395 stated she witnessed the dining room incident (involving Resident #23). She stated she was passing breakfast, and she heard Resident #23 say ouch. CNA #395 looked over and saw Resident #15 with the fork in his hand with a stabbing motion. Resident #23 sustained three puncture marks, and his hand was bleeding. Resident #15 said he didn't do it, Resident #23 said yes you did, you got my hand right here. Resident #15 said he shouldn't have grabbed his spoon. Resident #15 then acted normal again like nothing happened. CNA #395 stated residents do not have designated seats in the dining room, and they sit wherever they want. On 03/12/25 at 5:15 P.M. an interview with the DON while observing the dining room confirmed residents, including Resident #15 did not have assigned seating in the dining room and residents were permitted to sit where they wanted. Observation revealed Resident #15 ambulated independently with no assistance. Resident #15 used plastic silverware. The fork had pointed prongs and sharp ends. Interview on 03/12/25 at 5:41 P.M. with the DON revealed the DON recalled the incident on 02/10/25 between Resident #15 and #23. Resident #15 stabbed Resident #23 in the hand with a fork. The DON stated, Yea it happened, they were separated, and psych services were called. Unit Manager #322 then entered the room and joined the interview. Unit Manager #322 and the DON confirmed there were additional residents residing at the facility who had a diagnosis of dementia and were independently mobile who would be at risk for incidents of resident to resident abuse (including Resident #7, #9, #19 and #40). The DON stated she did not know what was done to protect the other residents who might enter Resident #15's space. The DON asked Unit Manager #322 what was being done, Unit Manager #322 stated Resident #15 was placed on 1:1 observation for a while. Neither DON nor Unit Manager #322 were sure about how long Resident #15 had been on 1:1 supervision as a result of these incidents; however, the resident was not on 1:1 at this time. Unit Manager #322 revealed they had also obtained a urinalysis for Resident #15 which was negative. Both the DON and Unit Manager #322 confirmed residents who had a diagnosis of dementia and were independently mobile had individualized interventions in place to prevent incidents of resident to resident abuse or to prevent them from inadvertently getting into Resident #15's personal space and potentially being harmed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Legends Care Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #15's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, anxiety disorder, and mood disorder due to known physiological condition with depressive features. Review of the modification of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 was severely cognitively impaired. Resident #15 had little interest or pleasure in doing things. Resident #15 had behavioral symptoms that occurred one to three days such as hitting or scratching self, pacing, rummaging, public sexual acts, throwing or smearing food or bodily wastes, or verbal vocal symptoms such as screaming, disruptive sounds. The presence of wandering also occurred one to three days. Resident #15 had no impairment to the upper or lower extremities. Record review revealed a plan of care related to behaviors was not initiated until 02/05/25 which revealed Resident #15 had a behavior problem of physical aggression of pushing other residents out of room. The plan also noted Resident #15 had a behavior of physical aggression of stabbing another resident. Interventions included encouraging the resident to express feelings appropriately and stop and talk with him passing by. Resident #15's care plan and medical record did not identify Resident #15 did not like anyone in his personal space and there were no interventions on how to prevent residents from entering his personal space to prevent incidents of resident to resident abuse. Review of the facility policy titled Resident Rights revised December 2016 revealed Federal and State Laws guarantee certain basic rights to all residents of this facility. These rights include the right to be treated with respect, kindness and dignity and the right to be free from abuse, neglect, misappropriation of property and exploitation. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property revised 11/01/19 revealed for prevention and identification, the facility's procedure will include the assessment, care planning and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other residents rooms, residents with self-injurious behaviors, residents with communication disorders, and those who require heavy nursing care and or are dependent on staff. This deficiency represents non-compliance investigated under Complaint Number OH00162589.

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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** 42011 Based on resident and staff interview, observation, medical record review, review of the Self-Reported Incident (SRI) and investigation, and review of the facility policy, the facility failed to thoroughly investigate an allegation of resident-to-resident physical abuse. This affected two (Residents #15 and #38) of three residents reviewed for abuse. The facility census was 53. Findings include: Record review for Resident #15 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, anxiety disorder, and mood disorder due to known physiological condition with depressive features. Review of the modification of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 was severely cognitively impaired. Resident #15 had little interest or pleasure in doing things. The presence of wandering also occurred one to three days. Review of the progress note dated 02/04/25 at 8:58 P.M. completed by the Director of Nursing (DON) revealed Resident #15 was seen pushing another resident in the hallway. Another resident (Resident #38) fell to the ground. Resident #15 was immediately escorted from the area and went back into his room, where he laid down in bed, and visual checks were performed every 15 minutes. Record review for Resident #38 revealed a re-admitted [DATE]. Diagnoses included Parkinson's disease without dyskinesia, dementia, Alzheimer's disease, and attention deficit disorder. Review of the quarterly MDS assessment dated [DATE] revealed Resident #38 was severely cognitively impaired. Review of the progress notes for Resident #38 dated 02/04/25 at 8:58 P.M. completed by Registered Nurse (RN) #301 revealed Resident #38 was observed at 8:30 P.M. lying on the floor outside of Resident #15's room laying on her back. Resident's fall was observed by a certified nursing assistant (CNA) (#329) who stated Resident #38 hit her head on the ground. Resident #38 was holding her head saying she was in a lot of pain. Emergency 911 was called, and Resident #38 was transported to Hospital #339 at 8:45 P.M. Review of the Hospital After Visit Summary for Resident #38 dated 02/04/25 revealed the reason for the visit was due to a fall and diagnosis of closed compression fracture of L5 vertebra. The progress note dated 02/05/25 at 1:27 P.M. completed by RN #301 revealed the emergency room (ER) diagnosis was closed compression fracture of L5 vertebra with no intervention needed. The progress note dated 02/06/25 at 1:24 P. M. completed by DON revealed Resident #38's fall was reviewed in safety meeting. Resident's fall was observed by CNA #329. Resident #38 fell backwards and hit her head on the floor. Resident #38 complained of head/neck hurting. Review of the SRI dated 02/04/25 at 8:58 P.M. revealed the facility reported an allegation of physical abuse involving Resident #15 and Resident #38. There were no witnesses. Resident #15 with a low cognitive function allegedly pushed Resident #38 who also had low cognitive function. A CNA (#329) reported she was walking down the hallway when she saw a female resident (Resident #38) fall backwards losing contact with the floor out of a male resident's room (Resident #15). The facility concluded the evidence is inconclusive and abuse was not suspected. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's investigation did not include any resident interviews, including Resident #15's roommate (Resident #6) who was cognitively intact and witnessed the resident-to-resident abuse on 02/04/25. The facility's investigation did not have a witness statement signed by CNA #329, who also witnessed the incident. Interview on 03/12/25 at 3:46 P.M. with RN #301 stated she was the charge nurse on 02/04/25 when Resident #38 fell and fractured her back in front of Resident #15's doorway. RN #301 stated Resident #15's roommate (Resident #6) was there and witnessed everything when the incident occurred. RN #301 stated Resident #6 was very alert and oriented. Observation and interview on 03/12/25 at 3:55 P.M. revealed Resident #15 resided in the same room as Resident #6. Resident #15's bed was against the wall and Resident #6 would have a clear view of Resident #15's bed and the doorway. Interview with Resident #6 stated he remembered what happened regarding Resident #38's fall that day very well. Resident #6 stated Resident #38 came into their room and sat in Resident #15's bed. Resident #15 came in and said get out of my bed. Resident #38 did not respond, and Resident #15 said get up or I am going to hurt you. Resident #15 grabbed Resident #38 by the shoulders moved her to the doorway and pushed her in the hall. Resident #6 stated he saw the whole thing. Resident #38 screamed. Resident #6 stated he felt so bad for Resident #38. Resident #6 stated he was not afraid of Resident #15 because he knows Resident #15 only gets aggressive when provoked, meaning if you get near his things or get in his space, otherwise he doesn't say anything or do anything. Resident #6 stated he stays to himself in his area of the room. Resident #6 stated the facility staff did not interview him or ask for a statement regarding Resident #15's assault with Resident #38. Interview on 03/12/25 at 5:41 P.M. with the DON revealed the DON recalled the incident on 02/04/25 with Residents #15 and #38. The DON stated the incident happened on an off shift, and all they knew was Resident #38 was found outside Resident #15's door. Resident #38 had fallen backwards, she was injured and fractured her back. They immediately sent Resident #38 to the hospital, no one seen the fall. No one said anything that it might be Resident #15 who pushed Resident #38, and the staff just said he was in his room. The DON confirmed she read Resident #38's nurses notes and reiterated there were no witnesses. The DON confirmed she did not interview Resident #6 who was present at the time of Resident #38's fall. The DON confirmed Resident #6 was alert and oriented to the person, place and time and stated she did not interview him because she was not sure if he saw it. The DON stated she could not answer why she didn't interview Resident #6. Interview on 03/17/25 at 9:10 A.M. with CNA #329 stated on 02/04/25 she witnessed the incident with Resident #15 and #38. CNA #329 stated she actually seen the incident. CNA #329 stated she wrote up a statement describing what she saw when Resident #38 flew out of Resident #15's room. Two days after the incident occurred, the Administrator and Unit Manager called her on the telephone. The Administrator said the verbiage on the witness statement was too strong, it made it sounded like it was a lot. The Administrator told CNA #329 that she did not physically see Resident #15 push Resident #38. CNA #329 replied to the Administrator that she did see Resident #38 and Resident #38 fly through the air, she flew right through the doorway and flew to the ground. Resident #15 was standing right there in the doorway. CNA #329 stated she asked Resident #15 what happened, and Resident #15 said Resident #38 was in his bed, so he got her out of his room. The Administrator and Unit Manager typed up a different statement for CNA #329 and CNA #329 refused to sign the witness statement that they wrote. (continued on next page)

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/17/25 at 10:03 A.M. with the Administrator confirmed her and Unit Manager #322 called CNA #329 on the phone to discuss the witness statement she wrote due to the statement was not 100% accurate. The Administrator stated she wanted to clarify the written statement because it did not reflect exactly what happened. The typed statement was the conversation on the telephone and CNA #329 agreed it was accurate on the phone. The Administrator confirmed CNA #329's original handwritten statement was not in the investigation file. The Administrator stated she would check to see if it was in her office. The Administrator never returned with the original statement. Review of the facilities policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property revised 11/01/19 included once the Administrator and ODH are notified, an investigation of the allegation violation will be conducted. Interview the resident, the accused and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident, came in close contact with the resident the day of the incident (including other residents) and employees who worked closely with the accused employee and or alleged victim the day of the incident. Obtain a statement from the resident, if possible, the accused, and each witness. This deficiency represents non-compliance investigated under Complaint Number OH00162589.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on closed record review, facility policy review and interview, the facility failed to initiate Cardiopulmonary Resuscitation (CPR) or call 911 for Emergency Medical Services (EMS) for Resident #60, who was found unresponsive, without a pulse/heartbeat and was identified to have advance directives reflecting the resident was a Full Code status. This resulted in Immediate Jeopardy and serious life-threatening harm/death on [DATE] when staff failed to initiate CPR or call 911 for medical services assistance when the resident was found unresponsive. Resident #60 subsequently passed away. This affected one resident (#60) of three residents reviewed for death in the facility. The facility census was 53 residents. On [DATE] at 4:11 P.M., the Administrator, Director of Nursing (DON), Regional Director of Clinical Services (RDCS) #328, Regional Director of Operations (RDO) #330, and Unit Manager #322 were notified Immediate Jeopardy began on [DATE] at approximately 8:30 A.M. when Licensed Practical Nurse (LPN) #313 found Resident #60, who had an advanced directive for a Full Code status, in her bed unresponsive and absent of vital signs. On [DATE] at 8:30 A.M., LPN #313 left the room and asked Registered Nurse (RN) #301 to confirm Resident #60 had expired. RN #301 found Resident #60 without a pulse and blood pressure. LPN #313 and RN #301 confirmed the absence of Resident #60's vital signs but failed to initiate CPR or call 911. LPN #313 indicated she did not think to check Resident #60's medical record to determine code status, initiate CPR or call 911 because Resident #60 received hospice services. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 8:30 A.M., Resident #60 was found absent from vital signs. On [DATE] at 2:30 P.M., RDCS #328 identified that CPR was not initiated when Resident #60, who was a Full Code, was found absent from vital signs on [DATE] at 8:30 A.M. On [DATE] at 5:03 P.M., education on CPR/code status was completed by the DON for all licensed nurses to include residents receiving hospice services have the right to determine their own code status, which may include Full Code status. On [DATE] at 5:10 P. M., a whole house audit of 54 residents was completed by RDCS #328 verifying code status, care plans and signed DNR forms. On [DATE] at 5:30 P.M., the crash cart (cart with emergency supplies/equipment) was audited by the DON to ensure all supplies were in stock and available. On [DATE] at 5:45 P.M., RDCS #328 verified all licensed nursing staff (three RNs and 10 LPNs) had valid CPR certifications. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:47 P.M., all nursing staff present when Resident #60 expired were interviewed by the Administrator, DON, and RDCS #328 regarding details of the event and nursing staff statements were obtained. The investigation revealed LPN #313 and RN #301 failed to check the code status of Resident #60 and did not perform CPR. On [DATE] at 6:00 P. M., an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was completed to discuss CPR and Code Status for all residents. The outcome of the meeting was the development of education pertaining to code status and location of code status. Also, the development of education of the residents who are under Hospice care have the right to choose to be Full Code status. The meeting also addressed developing audits to address the root cause of failing to not follow advanced directives. The meeting was held with Medical Director #331 via telephone, Administrator, DON, Unit Manager #322, Wound Nurse #322, Business Office Manager (BOM) #310, Social Worker/Admissions #203, Dietary Manager (DM) #312, and Central Supply/Scheduler #224. On [DATE] at 9:00 A.M., all department managers were educated by RDCS #328 and RDO #330 on the differences in code status and resident code status location. All future employees would be educated during orientation. On [DATE] at 7:05 P.M., all staff were educated on CPR, code status and the location of code status. Staff trained included three RNs, 10 LPNs, 28 certified nursing assistants (CNA), five housekeepers, one laundry personnel, six dietary staff, one activities personnel, and 11 department heads. On [DATE] at 7:30 P.M., Resident #60's physician (#331) was notified Resident #60 did not receive CPR per her (advance directives) code status. An attempt to reach Resident #60's listed family members revealed the telephone numbers were no longer in service. On [DATE] at 7:30 P. M., an Ad Hoc QAPI meeting was held to discuss the differences in code status and resident code status location, as well as to review the State agency findings and develop an abatement to address the specifics of the Immediate Jeopardy template. The meeting was held with Medical Director #331 via telephone, Administrator, DON, Unit Manager #322, Wound Nurse #322, BOM #310, Social Worker/Admissions #203, DM #312, Minimum Data Set (MDS) Nurse #303, Central Supply/Scheduler #224, Activity Director #231, Human Resources Director #226, RDCS #328, and RDO #330. On [DATE] at 11:29 A.M., LPN #313 was terminated from services related to not following policy and procedure regarding advanced directives. RN #301 received one-on-one education provided by RDCS #328 regarding failing to confirm Resident #60's code status. Beginning [DATE], the facility implemented a plan for the DON/Designee to conduct code drills on alternating shifts weekly for four weeks. Administrator/Designee would audit all deaths that occur in the facility to ensure the resident's advanced directives were facilitated per preference five times a week for four weeks. All findings would be submitted to the QAPI Committee for review and recommendations for six months. Although the Immediate Jeopardy was removed on [DATE], the facility remains out of compliance at Severity Level 2 (the potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective actions and monitoring for effectiveness and on-going compliance. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings include: Review of the closed medical record for Resident #60 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), esophageal obstruction, and cerebrovascular disease. Review of a plan of care plan created [DATE] revealed Resident #60's advanced directives were for the resident to be a Full Code (full life-saving measures to be taken in the event of cardiac/respiratory arrest). Interventions included assess advanced directives upon admission, quarterly, annually and with significant change to ensure the resident's wishes maintained. Respect resident regarding code status decisions. Review of Resident #60's physician's orders dated [DATE] revealed the resident was a Full Code (advance directives). The physician orders dated [DATE] revealed an order for Hospice Provider #333 to provide services for Resident #60 for a diagnosis of COPD with lower obstruction. Review of the modification of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 was moderately cognitively impaired. The assessment indicated the resident did have a condition or chronic disease that would result in a life expectancy of less than six months. Review of the progress notes for Resident #60 revealed no progress notes were documented for February 2025. Review of the first progress note documented for [DATE] revealed it was dated [DATE] at 8:30 A.M. and completed by RN #301. The progress note stated Resident #60 was absent of vital signs at 8:30 A.M. This was verified by RN #301 and nurse on duty (LPN #313) for Resident #60. The progress notes dated [DATE] at 8:30 A.M. completed by LPN #313 revealed Hospice Provider #333 was notified Resident #60 was not responding. Hospice Provider #333 stated they would send a nurse to the facility. The progress note dated [DATE] at 9:30 A.M. completed by LPN #313 revealed Resident #60 was absent of vital signs at 8:30 A.M. and this was verified by two nurses (LPN #313 and RN #301). Hospice Provider #333 and Physician #331 were notified. The note included hospice would call the family and funeral home. The progress note dated [DATE] at 10:23 A.M. completed by LPN #313 revealed Hospice Provider #333 present in the facility. The progress note dated [DATE] at 10:25 A.M. completed by LPN #313 revealed time of death was now 10:25 A.M. Interviews during the survey revealed facility staff including LPN #313 could not explain why LPN #313 changed the time of death to 10:25 A.M. The progress note dated [DATE] at 11:06 A.M. completed by LPN #313 revealed the nurse from Hospice Provider #333 called the funeral home to come get Resident #60's body. Interview on [DATE] at 1:52 P.M. with LPN #208 revealed Resident #60 received Hospice services so she would have been a Do Not Resuscitate (DNR) so no CPR would have been done when Resident #60 was found to be absent of vital signs. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 3:46 P.M. with RN #301 revealed on [DATE], she was working on the other side of the facility. LPN #313 was Resident #60's nurse that day. Resident #60 received Hospice services. RN #301 stated LPN #313 approached her and stated Resident #60 passed and requested her to verify absence of vital signs. RN #301 stated she verified Resident #60 had no pulse or blood pressure and stated she was not Resident #60's nurse, and she did not know Resident #60 was a Full Code. RN #301 stated she should have checked for her code status. RN #301 confirmed no CPR was done and EMS were not notified to come to the facility. RN #301 stated she never asked the code status because Resident #60 was on hospice services. RN #301 confirmed Resident #60 had an order for a Full Code status and confirmed CPR should have been initiated immediately when Resident #60 was found to have no pulse. Interview of [DATE] at 4:06 P.M. with the DON and RDCS #328 confirmed on [DATE], Resident #60 was Full Code status. On [DATE], Resident #60 was found with no vital signs and confirmed CPR was not initiated. RDCS #328 stated because Resident #60 received Hospice services, the nurses assumed she was a DNR status. RDCS #328 confirmed CPR should have been initiated, and CPR was not initiated for Resident #60. Interview on [DATE] at 10:07 A.M. with Clinical Manager #335 at Hospice Provider #333 confirmed any resident could receive hospice services and still choose to be a Full Code status. Clinical Manager #335 confirmed Resident #60 received hospice services through their company and was a Full Code at time of death. Interview on [DATE] at 2:28 P.M. with RDCS #328 confirmed there was no documentation in Resident #60's medical record to reveal what led to Resident #60's absence of vital signs and no documentation of Resident #60's primary physician being notified when Resident #60 was found to have absence of vital signs. RDCS #328 confirmed the physician should have been notified immediately and stated only a physician could pronounce a resident's time of death. Review of the facility policy titled Emergency Procedure - Cardiopulmonary Resuscitation revised [DATE] revealed if an individual was found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest was likely, begin CPR: Instruct a staff member to activate the emergency response system (code) and call 911. Verify or instruct a staff member to verify the DNR or code status of the individual. Initiate the basic life support (BLS) sequence of events. The BLS sequence of events is referred to as C-A-B (Chest compressions, airway, breathing). Review of the facility policy titled Resident Rights revised [DATE] revealed Federal and State Laws guarantee certain basic rights to all residents of the facility. These rights include the residents' right to choose an attending physician and participate in decision making regarding his or her care. This deficiency represents non-compliance investigated under Complaint Number OH00163552.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER: Legends Care Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on interview, record review, and facility policy review, the facility failed to ensure staff were competent and compliant with implementing cardiopulmonary resuscitation per the physician orders and failed to ensure the resident's time of death was called by the physician for accuracy. This affected two residents (#60 and #61) of three residents reviewed for Advanced Directives. The facility census was 53. Findings include: 1. Review of the closed medical record for Resident #60 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), esophageal obstruction, and cerebrovascular disease. Review of Resident #60's physician's orders dated [DATE] revealed the resident was a Full Code (advance directives). The physician orders dated [DATE] revealed an order for Hospice Provider #333 to provide services for Resident #60 for a diagnosis of COPD with lower obstruction. Review of the modification of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 was moderately cognitively impaired. The assessment indicated the resident did have a condition or chronic disease that would result in a life expectancy of less than six months. Review of the progress note dated [DATE] at 8:30 A.M. and completed by Registered Nurse (RN) #301. The progress note stated Resident #60 was absent of vital signs at 8:30 A.M. This was verified by RN #301 and nurse on duty (Licensed Practical Nurse (LPN) #313) for Resident #60. The progress notes dated [DATE] at 8:30 A.M. completed by LPN #313 revealed Hospice Provider #333 was notified Resident #60 was not responding. Hospice Provider #333 stated they would send a nurse to the facility. The progress note dated [DATE] at 9:30 A.M. completed by LPN #313 revealed Resident #60 was absent of vital signs at 8:30 A.M. and this was verified by two nurses (LPN #313 and RN #301). The progress note dated [DATE] at 10:23 A.M. completed by LPN #313 revealed Hospice Provider #333 present in the facility. The progress note dated [DATE] at 10:25 A.M. completed by LPN #313 revealed time of death was now 10:25 A.M. Interviews during the survey revealed facility staff including LPN #313 could not explain why LPN #313 changed the time of death to 10:25 A.M. Interview on [DATE] at 1:52 P.M. with LPN #208 stated Resident #60 received Hospice services so she would have been a Do Not Resuscitate (DNR) so no CPR would have been done when Resident #60 was found to be absent of vital signs. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 3:46 P.M. with RN #301 revealed on [DATE], she was working on the other side of the facility. LPN #313 was Resident #60's nurse that day. Resident #60 received Hospice services. RN #301 stated LPN #313 approached her and stated Resident #60 passed and requested her to verify absence of vital signs. RN #301 stated she verified Resident #60 had no pulse or blood pressure and stated she was not Resident #60's nurse, and she did not know Resident #60 was a Full Code. RN #301 stated she should have checked for her code status. RN #301 confirmed no CPR was done. RN #301 stated she never asked the code status because Resident #60 was on hospice services. RN #301 confirmed Resident #60 had an order for a Full Code status and confirmed CPR should have been initiated immediately when Resident #60 was found to have no pulse. Interview of [DATE] at 4:06 P.M. with the Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) #328 confirmed on [DATE], Resident #60 was Full Code status. On [DATE], Resident #60 was found with no vital signs and confirmed CPR was not initiated. RDCS #328 stated because Resident #60 received Hospice services, the nurses assumed she was a DNR status. RDCS #328 confirmed CPR should have been initiated, and CPR was not initiated for Resident #60. Interview on [DATE] at 10:07 A.M. with Clinical Manager #335 at Hospice Provider #333 confirmed any resident could receive hospice services and still choose to be a Full Code status. Clinical Manager #335 confirmed Resident #60 received hospice services through their company and was a Full Code at time of death and revealed their nurses do not call the time of death in a medical facility, that was up to the nurses at the facility to call the physician for the time of death. Hospice only verifies the resident is absent of vital signs and calls the time of death if the resident is residing in their private home where no other medical staff were available to assess the resident. Interview on [DATE] at 2:28 P.M. with RDCS #328 confirmed there was no evidence of Resident #60's primary physician being notified when Resident #60 was found to have absence of vital signs. RDCS #328 confirmed the physician should have been notified immediately and stated only a physician could pronounce a resident's time of death. Interview on [DATE] at 11:55 A.M. with Medical Director #331 confirmed a resident's time of death is at the time of absence of vital signs. 2. Review of the closed medical record for Resident #61 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included vascular dementia and cerebrovascular disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 was severely cognitively impaired and the resident did have a condition or chronic disease that would result in a life expectancy of less than six months. Review of the physician orders for Resident #61 dated [DATE] revealed an order to admit to Hospice #336 for cerebrovascular disease. An additional physician order dated [DATE] revealed Resident #61's code status was do not resuscitate comfort care (DNRCC). Review of the progress note for Resident #61 dated [DATE] at 5:20 A.M. completed by Licensed Practical Nurse (LPN) #229 revealed Resident #61 without vital signs and this was verified by second nurse. Hospice notified. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The progress note dated [DATE] at 6:18 A.M. completed by LPN #229 revealed Hospice RN in and called time of death at 6:15 A.M. Hospice is notifying family. Interview on [DATE] at 2:28 P.M. with RDCS #328 confirmed there was no evidence of Resident #61's primary physician being notified when Resident #61 was found to have absence of vital signs. RDCS #328 confirmed the physician should have been notified immediately and stated only a physician could pronounce a resident's time of death. Interview on [DATE] at 11:55 A.M. with Medical Director #331 confirmed a resident's time of death is at the time of absence of vital signs. Review of the facility policy titled Emergency Procedure - Cardiopulmonary Resuscitation revised [DATE] revealed if an individual was found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest was likely, begin CPR: Instruct a staff member to activate the emergency response system (code) and call 911. Verify or instruct a staff member to verify the DNR or code status of the individual. Initiate the basic life support (BLS) sequence of events. Review of the facility policy titled, Death of a Resident, Documentation revised [DATE] revealed a resident may be declared dead by a Licensed Physician or Registered Nurse with Physician Authorization in accordance with State Law. Information pertaining to resident's death (i.e. date, time of death, the name and title of the individual pronouncing the resident dead, etc.) must be recorded in the nurses notes. The Nurse Supervisor/Charge Nurse will inform the resident's family of the resident's death. The name of the mortician and person removing the deceased resident must be entered in the residents medical record. The person removing the deceased resident from the facility must sign the release for the body, and the release must be filed in the resident's medical record. This deficiency represents non-compliance investigated under Complaint Number OH00163552.