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	01/22/2026

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and interview with staff, the facility failed to ensure the concerns of the family of Resident #58 were addressed timely. This affected one resident (Resident #58) of three reviewed for change in condition.Findings Include:Review of the medical record revealed Resident #58 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, chronic obstructive pulmonary disease, chronic bronchitis, acute respiratory failure, atherosclerotic heart disease, hypertension, congestive heart failure, ischemic cardiomyopathy and vision loss. Resident #58 was sent to the emergency room on [DATE] were he later passed away.Review of the face sheet for Resident #58 revealed Family Member #250 was the emergency contact.Review of the Health Care Power of Attorney (HCPOA) paperwork, dated and notarized on 08/11/25, revealed Family Member #250 was the HCPOA for Resident #58. This information was submitted to the facility on [DATE]. Review of the Do-Not-Resuscitate (DNR) form dated 08/27/25 revealed Resident #58 was a DNR comfort care arrest (CC-A). Review of the Brief Interview of Mental Status dated 08/27/25 revealed Resident #58 had moderately impaired cognition. Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #58 had intact cognition.Review of the Vital Signs documented on 09/15/25 at 10:27 A.M. revealed the vital signs for Resident #58 were blood pressure 126/85 millimeters of Mercury (mmHg) (normal ranges around 120/80 mmHg), pulse 88 beats per minute (bpm) (normal ranges from 60 to 100 bpm), respirations 18 breaths per minute (normal ranges from 12 to 20 breaths per minute), oxygen level 92 percent (%) on room air (normal ranges from around 95% to 100%) and temperature was 97.6 degrees Fahrenheit (F) (normal ranges from around 97 degrees F to 99 degrees F).Review of the Progress Note dated 09/15/25 at 4:18 P.M. revealed Resident #58 was resting in bed. The resident complained of being more tired than usual. The resident's family member called into the facility stating he must go to the hospital. The nurse explained to the resident's family that the facility was able to work-up the resident at the facility. Family Member #250 was in agreement. The physician was notified and ordered a comprehensive metabolic panel, complete blood count, chest x-ray. Review of the September 2025 physician's orders revealed Resident #58 had orders for a complete blood count (CBC), Comprehensive metabolic panel (CMP) and urinalysis, urine culture, and a chest X-ray for complaints of shortness of breath.Review of the chest x-ray results for Resident #58 dated 09/15/25 revealed suboptimal evaluation due to rotation, linear opacities were seen in the left lower zone which was possible fibro-atelectatic changes. Prominence of both pulmonary hila and attenuation of broncho-vascular markings were seen in the bilateral lungs, representing congestion. Elevations of the left dome of the diaphragm was seen. Recommend a follow up high resolution computer tomography (HRCT) lung scan which produced highly detailed images of the lungs. Review of the Progress note dated 09/16/25 at 10:38 A.M. revealed the chest x-ray results for Resident 358 revealed linear opacities were seen in the left lower zone which was possible fibro-atelectatic changes. Prominence of both pulmonary hila and attenuation of broncho-vascular markings were seen in the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bilateral lungs, representing congestion. Elevations of left dome of the diaphragm were seen. The resident's family member and doctor were aware. Review of the Change in Condition Summary dated 09/21/25 at 7:47 A.M. revealed the vital signs for Resident #58 were blood pressure 149/98 mmHg, pulse 89 bpm, respirations 24 breaths per minute, temperature 97.3 degrees F and oxygen level 98 % on room air. Review of the Progress Note dated 09/21/25 at 8:07 A.M. revealed Resident #58 was noted to have right sided facial droop, was aphasic and had a decreased mental status at 7:40 A.M. Nine-one-one (911) was activated immediately. The physician, Director of Nursing (DON) and emergency contact were contacted. The resident was sent to the hospital for stroke-like symptoms. Report was called to the hospital.On 01/20/26 at 10:20 A.M. an interview with Family Member (FM) #250 revealed she had asked several times for Resident #58 to be sent to the hospital because he was not acting right. She stated he was slurring his speech when she spoke to him on 09/15/25 and he normally called her several times a day and he had not called her in a couple days. She stated Resident #58 had told her he had wanted to go to the hospital. She stated when she spoke to Licensed Practical Nurse (LPN) #121 she was under the impression they were going to send Resident #58 to the hospital, however she received a call from LPN #121 stating he had spoken to the DON and they were going to just do a workup at the facility. She stated they were going to do a CBC, CMP and urinalysis, urine culture, and a chest x-ray. She stated she called the DON and questioned why they were not sending him out to the hospital like she had requested and was told she was not the MPOA and he was not exhibiting any signs of a change in condition that warranted him being sent out to the hospital. FM #250 stated she explained to the DON she completed the proper paperwork at the hospital to become his MPOA, however the DON stated they did not have that paperwork. She stated she had emailed the Social Worker several times concerning the MPOA paperwork. She stated she found the paperwork on 09/17/25 and sent it to both the Social Worker and DON. She stated they still did not send him to the hospital until 09/21/25 for stroke-like symptoms and he passed away at the hospital. She stated she lived in [NAME] Virginia and could not drive to the facility. On 01/20/26 at 11:34 A.M. an interview with LPN #121 revealed Resident #58 was alert but confused most of the time. He stated he remembered Resident #58 had been giving the staff a hard time about taking his medications, he had fallen and he was on fall precautions. LPN #121 stated he sent Resident #58 out [to the hospital] on 09/21/25 because he was showing signs of having a stroke. He stated he did not know when he worked with him prior to that day. He stated the resident's family member had requested Resident #58 to be sent out to the hospital prior to that, but he had explained to her they could do a full work up of him at the facility and he did not need to be sent out.On 01/21/26 at 10:20 A.M. an interview with the DON revealed the facility had completed a skilled assessment each day on Resident #58, they completed a chest x-ray which was sent to the physician to review. She stated a urine was sent and did not show any abnormal so they did not have to complete a culture. She stated Resident #58 refused to have his lab work done. She stated he had albuterol aerosols as needed ordered on admission but verified none were given for his shortness of breath. On 01/21/26 at 12:50 P.M. an interview with Physician #253 revealed he did not remember what had occurred with Resident #58 and he would have to review his notes. He stated he did look at the resident's chest x-ray today again and he did not see anything acute that needed addressed. He stated the DON also mentioned today the recommendation for the HRCT scan and that it was a recommendation, but he did not believe it would have been necessary at that moment. He stated he was not aware the resident's family had requested the patient be sent to the hospital because he was acting differently. He stated the information must not have been communicated to him because he would always send a patient out if the family stated the resident was not acting right, because they were the ones who (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	knew the resident the best.On 01/21/26 at 3:00 P.M. a second interview with the DON revealed she could not recall what she told the physician on 09/15/25. She stated she knew all of Resident #58's interventions were in place, and his vital signs were stable. She stated she did not feel Resident #58 needed sent out on 09/15/25 because his vital signs were stable and the facility did not have the proper paperwork to prove Family Member #250 was the MPOA, and she did not know the person she was speaking to on the telephone. She stated she assessed the resident and did not feel he needed to be sent out and she did not feel he was having slurred speech or having a stroke. She stated they put interventions in place to do lab work, the chest x-ray and urinalysis. She stated the resident declined lab work but did verify he was confused. She stated Resident #58 never mentioned to her he wanted to go to the hospital but she did not recall if she ever spoke to him about going to the hospital or how many times she actually spoke to him or saw him. She verified she never documented her assessment in his progress notes and did not recall if she spoke to the physician or if LPN #121 was the one to call him on 09/15/25. On 01/22/26 at 11:20 A.M. a second interview with LPN #121 revealed he believed the DON had called the physician on 09/15/25 for Resident #58. He stated he went back thorough his telephone and could not find a call or text that day to the physician and that was how he communicated with the physician, from his personal cell phone. He stated the day he spoke to the resident's family member he had planned to send him out to the hospital, but he could not remember why he did not send him out. He stated the plans must have changed. He stated he had no issues sending someone out to the hospital if the family requested they be sent out, especially if they were concerned about the resident's condition. He stated he did assess him after he got off the telephone with Family Member #250 and he appeared normal for him. He stated he was not having any slurred speech or shortness of breath on 09/15/25. He stated if he had been showing any of the signs of a stroke, he would have been out the door [indicating to the hospital]. He stated he did not notice a decline or change in condition from 09/15/25 to when he sent him out on 09/21/25. He stated the late entry skilled note from 09/16/25 for 09/15/25 was mainly due to the fact he did not have the time to get it completed the day prior. On 01/22/26 at 2:15 P.M. an interview with Social Service Designee #153 revealed she spoke to FM #250 about Resident #58 several times. She stated she got FM #250's name and the residents neighbor's name from the resident upon admission as his emergency contact, and their phone number from his hospital paperwork. She stated the residents family member was very upset that they were not sending Resident #58 out to the hospital. She stated she had contacted the hospital to get the MPOA paperwork, but they never sent it to her and the paperwork was never sent with his admission paperwork. She stated FM #250 even wanted him sent out after they received the MPOA however she could not remember the date, she stated she still wanted him sent out. She stated FM #250 told her the resident was complaining he could not breathe at night and nobody was giving him his aerosol treatments. She stated she told the DON, and they had gone to check on him, and he had an aerosol treatment on at that time, so she let the family member know that. She stated she told the family member the resident was not telling them the same thing he was telling her. She stated she updated the DON every time the family member had a concern about his condition because she knew the DON had been speaking to the family member about his care. She verified she had not documented any of her conversations with FM #250 in his medical record. She stated that her and FM #250 emailed a lot.This deficiency represents non-compliance investigated under Complaint Number 2631680.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and interview with staff the facility failed to notify the family of Resident #58 when he was ordered a psychotropic medication. This affected one resident (Resident #58) of three reviewed for medication administration. Findings Include:Review of the medical record revealed Resident #58 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, chronic obstructive pulmonary disease, chronic bronchitis, acute respiratory failure, atherosclerotic heart disease, hypertension, congestive heart failure, ischemic cardiomyopathy and vision loss. Resident #58 was sent to the emergency room on [DATE].Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #58 had intact cognition.Review of the Health Care Power of Attorney (HCPOA) paperwork, dated and notarized on 08/11/25, revealed Family Member #250 was the HCPOA for Resident #58. This information was submitted to the facility on [DATE]. Review of the Progress note dated 09/19/25 at 8:09 A.M. revealed the physician gave an order for Resident #58 to start on Remeron (antidepressant) 7.5 milligrams at bedtime for decreased appetite. There was no documentation the resident's representative was notified. On 01/21/26 at 5:03 P.M. an interview with Family Member #250 revealed she was never told Resident #58 was started on Remeron. She stated if the facility started him on Remeron it was to sedate him versus appetite, because Resident #58 never had any issues with his appetite and he enjoyed eating. She stated if he was having a decrease in his appetite, which she was never told, then it was likely due to him having pneumonia or change in condition.On 01/22/26 at 12:10 P.M. an interview with the Director of Nursing revealed she spoke to Licensed Practical Nurse (LPN) #136 who wrote the order for the Remeron for Resident #58, and LPN #136 stated Resident #58 had good days and bad days eating. She stated LPN #136 told her the resident ate better when the friend brought him in homemade food and he was not eating as well and she did not want him to lose any weight, so she called the physician to get an order for Remeron. She verified there was no documentation of a rationale as to why Resident #58 was started on the Remeron or that the representative was notified.On 01/22/26 at 12:30 P.M. an interview with LPN #136 revealed she had noticed Resident #58 had not been eating as much over the couple days leading up to her getting the order. She stated he was consuming less than 50 percent of his meals so she notified the physician because she did not want him to lose any weight. She stated she could have spoken to the dietitian however the dietitian had not been at the facility on that day, so she just called the physician, and he ordered the Remeron. She stated he did not have an order for health shakes, but she had attempted to give him protein shakes off her medication cart, but he did not like them, and he was not ordered any other supplement. She stated she spoke to the two emergency contacts on his chart numerous times about his care and she was sure she told them about the Remeron however she verified she failed to chart it. She stated she did not see any decline in his condition other than his not eating as much as before prior to him being sent out for a stroke. This deficiency represents non-compliance investigated under Complaint Number 2631680.

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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** Based on review of the medical record and interview with staff the facility failed to notify the family of Resident #58 when he was ordered a psychotropic medication. This affected one resident (Resident #58) of three reviewed for medication administration. Findings Include:Review of the medical record revealed Resident #58 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, chronic obstructive pulmonary disease, chronic bronchitis, acute respiratory failure, atherosclerotic heart disease, hypertension, congestive heart failure, ischemic cardiomyopathy and vision loss. Resident #58 was sent to the emergency room on [DATE].Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #58 had intact cognition.Review of the Health Care Power of Attorney (HCPOA) paperwork, dated and notarized on 08/11/25, revealed Family Member #250 was the HCPOA for Resident #58. This information was submitted to the facility on [DATE]. Review of the Progress note dated 09/19/25 at 8:09 A.M. revealed the physician gave an order for Resident #58 to start on Remeron (antidepressant) 7.5 milligrams at bedtime for decreased appetite. There was no documentation the resident's representative was notified. On 01/21/26 at 5:03 P.M. an interview with Family Member #250 revealed she was never told Resident #58 was started on Remeron. She stated if the facility started him on Remeron it was to sedate him versus appetite, because Resident #58 never had any issues with his appetite and he enjoyed eating. She stated if he was having a decrease in his appetite, which she was never told, then it was likely due to him having pneumonia or change in condition.On 01/22/26 at 12:10 P.M. an interview with the Director of Nursing revealed she spoke to Licensed Practical Nurse (LPN) #136 who wrote the order for the Remeron for Resident #58, and LPN #136 stated Resident #58 had good days and bad days eating. She stated LPN #136 told her the resident ate better when the friend brought him in homemade food and he was not eating as well and she did not want him to lose any weight, so she called the physician to get an order for Remeron. She verified there was no documentation of a rationale as to why Resident #58 was started on the Remeron or that the representative was notified.On 01/22/26 at 12:30 P.M. an interview with LPN #136 revealed she had noticed Resident #58 had not been eating as much over the couple days leading up to her getting the order. She stated he was consuming less than 50 percent of his meals so she notified the physician because she did not want him to lose any weight. She stated she could have spoken to the dietitian however the dietitian had not been at the facility on that day, so she just called the physician, and he ordered the Remeron. She stated he did not have an order for health shakes, but she had attempted to give him protein shakes off her medication cart, but he did not like them, and he was not ordered any other supplement. She stated she spoke to the two emergency contacts on his chart numerous times about his care and she was sure she told them about the Remeron however she verified she failed to chart it. She stated she did not see any decline in his condition other than his not eating as much as before prior to him being sent out for a stroke. This deficiency represents non-compliance investigated under Complaint Number 2631680.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of the fall investigation, interview with the staff, and review of facility policy, the facility failed to ensure Resident #58 had fall inventions in place. This affected one resident (Resident #58) of three reviewed for falls.Findings Include: Review of the medical record revealed Resident #58 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, chronic obstructive pulmonary disease, chronic bronchitis, acute respiratory failure, atherosclerotic heart disease, hypertension, congestive heart failure, ischemic cardiomyopathy and vision loss. Resident #58 was sent to the emergency room on [DATE]. Review of the Morse Falls assessment dated [DATE] revealed Resident #58 was a high risk for falls. Review of the care plan dated 08/27/25 revealed Resident #58 was at risk for falls related to deconditioning and gait/balance problems. Interventions included anticipate and meet the resident's needs, be sure the residents call light was within reach and encourage the resident to use it, ensure the resident was wearing appropriate footwear when ambulating or mobilizing in the wheelchair, frequently used items to be close to the resident, gripper socks to be wore when not wearing proper fitting shoes (initiated 09/07/25), therapy to evaluate and treat, and a toileting plan before and after each meal and at bedtime. Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #58 had intact cognition and had no falls. Review of the Progress notes dated 09/05/25 at 8:30 P.M. revealed Resident #58 stood up from his bed and was reaching for his nightstand when he stepped forward with his left foot and lost his balance. This was witnessed and he had not hit his head. Resident #58 reported he was trying to see what clothing were on his nightstand, he was wearing only socks. Resident #58 was educated on proper footwear and using his call light to ask for assistance. He demonstrated proper use of the call light. Review of the Fall Scene Investigation Report dated 09/05/25 at 8:15 P.M. revealed Resident #58 was not wearing shoes only socks. The new intervention was to encourage him to use proper footwear and to ask for assistance prior to getting up. Review of the Progress note dated 09/07/25 at 3:12 P.M. revealed the Intradisciplinary team met to review a fall. Resident #58 was observed reaching and stepping forward to look at an item and landed on his bottom. He was assisted up with two staff assistance and placed in the chair. He had no visual or verbal signs of pain at the time and no apparent injury. He was not wearing gripper socks only regular socks. Gripper socks were to be worn when not wearing proper fitting shoes and his frequently used items to be closer to the resident. He was unable to be educated due to his Brief Interview for Mental Status only being a nine out of 15. The family and doctor were made aware. Review of the physician's orders revealed Resident #58 had an order for gripper socks to be worn when not wearing proper fitting shoes, check each shift to assure proper placement dated 09/07/25. Review of the Progress note dated 09/14/25 at 1:43 A.M. revealed the nurse was called into the room of Resident #58 by his roommate. The resident was lying on the floor outside of the bathroom. Resident #58 stated he was walking back to bed from the bathroom and lost his balance and fell. He stated he did not hit his head. The resident was checked for injuries with a noted bruise to his left thigh. He was assisted off the floor with two staff assistance and walked back to bed. Vital signs were taken and neurological checks were started. The resident was placed in non-skid socks. The resident was to have non-skid socks on at all times when out of bed. The physician, on-call nurse and niece were notified. Resident to use non-skid socks while out of bed. Review of the undated Fall Scene Investigation Report revealed Resident #58 was found on the floor right outside if the bathroom. He was coming back from the bathroom in his socks, and he had been given a laxative. The conclusion was to place the resident on a toileting plan before and after (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meals. He had socks on at the time of the fall. Further review of the physician's orders revealed Resident #58 had an order for non-skid socks while out of bed dated 09/14/25 however it was discontinued the same day on 09/14/25. On 01/22/26 at 12:10 P.M. an interview with the Director of Nursing verified Resident #58 did not have gripper socks on as ordered when he fell however she stated he changed them himself. She verified there was no documentation he removed his clothes or would change his gripper socks into regular socks. Review of the facility policy titled, Assessing Falls and Their Causes, dated 10/2010 revealed the purpose of the procedure was to provide guidelines for assessing a resident after a fall and to assist the staff in identifying causes of the fall.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, interview with staff, and review of facility policy, the facility failed to maintain and medication error rate of less than five percent (%). Nine medications were given in error out of 25 opportunities for error, to equal an error rate of 36%. This affected one resident (Resident #18) out of four observed for medication administration.Findings Include: Review of the medical record revealed Resident #18 was admitted to the facility on [DATE]. Diagnoses included lupus, acute respiratory failure, moderate protein-calorie malnutrition, gastrostomy status, and dysphagia.Review of the January 2026 physician's orders revealed Resident #18 had orders due at 9:00 A.M. for acidophilus 500 million units daily, Bactrim DS 800/160 milligrams (mg) daily, prednisone 10 mg daily, Protonix 40 mg Delayed Release (DR) daily, zinc sulfate 220 mg daily, Mucinex 600 mg twice daily, senna plus 8.6/50 mg twice daily, baclofen 10 mg three times daily, and oxycodone 10 mg three times daily. Further review of the physician orders revealed orders for his medication to be given via percutaneous endoscopic gastrostomy (PEG) tube (a tube that is inserted through the abdomen into the stomach, used to provide long term nutritional support) however, the resident did not have an order for his medication to be cocktailed (mixed together) and given all at once.Observation on 01/21/26 at 8:30 A.M. revealed Licensed Practical Nurse (LPN) #127 prepared one capsule of acidophilus 500 million units, one tablet of Bactrim DS 800/160 mg, one tablet of prednisone 10 mg, one tablet of Protonix 40 mg, one tablet of zinc sulfate 220 mg, one tablet of Mucinex 600 mg, one senna plus 8.6/50 mg, one tablet of baclofen 10 mg and one tablet oxycodone 10 mg for Resident #18. LPN #127 crushed all the medication and placed the powdered medications into one medication cup mixed together and prepared to administer the medications to the resident. She verified at this time Resident #18 was to receive all his medication via a PEG tube however he did not have an order to cocktail his medication and administer them all at the same time. Review of the facility policy titled, Administering Medication through an Enteral Tube, dated 03/2015 revealed the purpose of the procedure was to provide guidelines for a safe administration of medication through an enteral tube. General guidelines were to not mix medication together prior to administration through an enteral tube unless there was a physician's order stating otherwise with a rationale. It noted to administer each medication separately unless there was a physician's order stating otherwise.

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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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and interview with staff, the facility failed to ensure radiologic study recommendations were scheduled and addressed in a timely manner for Resident #58. This affected one resident (Resident #58) of three reviewed for a change in condition.Findings Include:Review of the medical record revealed Resident #58 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, chronic obstructive pulmonary disease, chronic bronchitis, acute respiratory failure, atherosclerotic heart disease, hypertension, congestive heart failure, ischemic cardiomyopathy and vision loss. Resident #58 was sent to the emergency room on [DATE].Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #58 had intact cognition.Review of the Progress Note dated 09/15/25 at 4:18 P.M. revealed Resident #58 was resting in bed. The resident complained of being more tired than usual. The resident ' s family called into the facility stating he must go to the hospital. The nurse explained to the family member that the facility was able to work-up the resident at the facility. The family was in agreement. The physician was notified and ordered a comprehensive metabolic panel, complete blood count, and a chest x-ray. Review of the September 2025 physician ' s orders revealed Resident #58 had orders for complete blood count (CBC), Comprehensive metabolic panel (CMP) and urinalysis, urine culture, and a chest x-ray for complaints of shortness of breath.Review of the chest x-ray results for Resident #58 dated 09/15/25 revealed suboptimal evaluation due to rotation, linear opacities were seen in the left lower zone which was possible fibro-atelectatic changes. Prominence of both pulmonary hila and attenuation of broncho-vascular markings were seen in the bilateral lungs representing congestion. Elevations of left dome of the diaphragm was seen. The scan recommended a follow up for a high-resolution computer tomography (HRCT) lung scan which produced highly detailed images of the lungs.Review of the Progress note dated 09/16/25 at 10:38 A.M. revealed the chest x-ray results for Resident #58 revealed linear opacities were seen in the left lower zone which was possible fibro-atelectatic changes. Prominence of both pulmonary hila and attenuation of broncho-vascular markings were seen in the bilateral lungs representing congestion. Elevations of left dome of the diaphragm were seen. The resident's family (Family Member #250) and doctor were aware. On 01/21/26 at 10:20 A.M. an interview with the Director of Nursing (DON) revealed the facility had completed a skilled assessment each day on Resident #58, and they completed a chest x-ray which was sent to the physician to review. She stated she did not recall if she spoke to the physician about the recommendation for the chest x-ray and verified there was no evidence of a follow up or that the HRCT lung scan was ordered or set up. On 01/21/26 at 12:50 P.M. an interview with Physician #253 revealed he did not remember what had occurred with Resident #58 and he would have to review his notes. He stated he did look at the resident ' s chest x-ray today again and he did not see anything acute that needed addressed. He stated the DON did also mention on this day about the recommendation for the HRCT scan and he confirmed that it was a recommendation, however he did not believe it would have been necessary at that moment. On 01/21/26 at 5:03 P.M. an interview with Family Member #250 revealed she was not aware of the recommendation for a CT-scan of his lungs.This deficiency represents non-compliance investigated under Complaint Number 2631680.

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	01/22/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview with staff, and review of facility policy, the facility failed to maintain a sanitary kitchen and failed to properly date food items when opened. This affected all the residents in the facility except three residents (Resident #2, #18 and #57) who did not eat their meals from the kitchen. Findings Include:Observations of the kitchen during the initial tour with [NAME] #114 on 01/20/26 at 8:25 A.M. revealed the following concerns:a. In the food preparation room there was food debris and pieces of cardboard boxes on the floor, an uncooked/raw biscuit that was stepped on and smashed on the floor, the steel table had a large amount of food debris on the lower shelf, there was pieces of food debris and dried brown and white liquids splashed onto the wall behind the food preparation table and sink, and there were two trays of bowls filled with dried cereal on a cart with no date as to when they were poured or prepared.b. In the refrigerator there was a large round plastic container with an unknown red liquid in it with no date as to when it was made or what it was, there was a square container of cherry tomatoes with no date as to when they were placed in the container, and a large five pound bag of salad mix was open to air and had no date as to when it was opened.c. In the freezer there was a large plastic container of an unknown type of soup with no date as to when in was made or placed in the freezer, there were two three-tiered black plastic carts with food debris and a dark brown liquid spilled on them, the wall behind the steamer was dirty with dried liquid splashed on it and running down the wall, and the floor behind the steamer was dirty with a large buildup of black dirt. On 01/21/26 at 8:40 A.M. an interview with [NAME] #114 verified all the above concerns. Review of the undated facility policy titled, Food Storage, revealed sufficient storage facilities were provided to keep food safe, wholesome and appetizing. Food was stored, prepared and transported at an appropriate temperature and by methods designed to prevent contamination. Leftover food was stored in covered containers or wrapped carefully and securely. Items stored for a period of 24, or more, hours should be clearly labeled and dated before being refrigerated. Leftover food was to be used within two to six days,Review of the undated facility policy titled, Cleaning and Sanitizing Dietary Areas and Equipment revealed all kitchen areas and equipment should be maintained in a sanitary manner and be free of buildup of food, grease and other soil. The facility would provide sanitary food service that met the State and federal regulations. This deficiency represents non-compliance investigated under Complaint Number 2579510.