Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/05/2026
Form Approved OMB
No. 0938-0391

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	03/10/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, facility investigation review, and policy review, the facility failed to timely report an allegation of misappropriation to all required entities. This affected one resident (Resident #73) out of three residents reviewed for misappropriation of narcotics. Facility census 65. Findings include:Review of the closed medical record for Resident #73 revealed an admission date of 01/12/16 and a discharge date of 01/14/26. Diagnoses included but were not limited to hemiplegia, malignant neoplasm of bladder and prostate. Review of the Medicare 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #75 had impaired cognition. Review of the Physician orders for January 2026 revealed an order for Fentanyl (opioid drug) Transdermal Patch 72 hour 50 microgram/hour (MCG/HR) apply patch transdermally one time a day every 2 days for chronic pain and remove per schedule.Review of the investigation report revealed on 01/14/26 with no time included, revealed former Director of Nursing (DON) #401 was notified by the night nurse, Licensed Practical Nurse (LPN) #222, of two missing Fentanyl patches, a powerful synthetic opioid which is about 50 to 100 times more potent than morphine, approved for treating severe, chronic, or acute pain. The alleged misappropriation was not reported to the Ohio Department of Health (ODH) through a Self-Reported Incident (SRI). The facility did not report the incident to the police or pharmacy. Interview on 03/05/26 at 12:19 P.M. with LPN #226 confirmed she received the medications from the pharmacy delivery of two Fentanyl patches in the pharmacy bag, pulled out the baggie and counted the two Fentanyl Patches and signed the pharmacy delivery slip. LPN #226 reported she then took the pharmacy bag with the medications to include the narcotics, two Fentanyl patches and handed them to LPN #228.Interview on 03/05/26 at 12:36 P.M. with LPN #228 revealed she did not receive the two Fentanyl patches from LPN #226. LPN #228 reported she didn't know she was supposed to have two Fentanyl patches. Interview on 03/05/26 at 12:57 P.M. and on 03/09/26 at 8:27 A.M. with Registered nurse (RN) #400 confirmed the two Fentanyl patches for Resident #73 were never found and it should have been reported to the ODH with a SRI initiated for misappropriation, police called, and all nursing staff working should have provided statements and drug tested. Interview on 03/09/26 at 7:51 A.M. with former DON #401 confirmed there were two missing Fentanyl patches, narcotic for pain for Resident #73. DON #401 confirmed the missing Fentanyl patches should have been reported to the ODH with a SRI should have been initiated immediately for misappropriation of narcotic medications and police notified. Former DON #401 reported she was told by corporate not to report the incident as a SRI or to police. During this interview former DON #401 revealed she received a text from Administrator regarding the Fentanyl patches just at the time of interview stating it's not misappropriation because it was the facilities property as the facility paid for the patch, therefore they can't misappropriate their own property. Interview on 03/09/26 at 10:06 A.M. with Regional RN #403 revealed she doesn't know why an SRI wasn't done on Resident #73 with the missing narcotics and would have to check with the Administrator.Interview on 03/09/26 at 5:25 P.M. with Pharmacist #406 confirmed he did not receive notification from the facility regarding any missing narcotics, to include Fentanyl patch 50 mcg for Resident #73 and he should have. He confirmed the Fentanyl (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
	366085	A. Building B. Wing	03/10/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patches are available in the Pixus at the facility, and they would just need to call to receive authorization to pull the medication.Interview on 03/10/26 7:14 A.M. with LPN #200 revealed she worked on 01/13/26 as a night nurse and in the morning LPN #226 brought back the pharmacy medication bags which she signed for and tried to give to her. LPN #200 reported she refused because day shift LPN #228 was with the medication cart and keys. LPN #200 reported LPN #226 handed the pharmacy bag off to LPN #228 and she counted the narcotic medications with RN #400. LPN #200 reported she received a call from former DON #401 with some questions regarding the missing Fentanyl patches for Resident #73 and was drug tested days later.Review of the facility policy, Abuse, Neglect, Exploitation & Misappropriation of Resident Property, revised November 01 2019, revealed it is the facilities policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment of resident, or misappropriation of Resident Property. Further states staff should immediately report all such allegations to the Administrator/designee and to the Ohio Department of Health (ODH) and in cases where a crime is suspected should report to local law enforcement. The policy included the investigation should be documented. Review of the facility policy, Controlled Substances, revised December 2012, revealed the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule 2 and other controlled substances. Controlled substances must be counted upon delivery and the nurse receiving the medication, along with the person delivering the medication must count the controlled substance together. Both individuals must sign the designated controlled substance record. Nurses must document and report any discrepancies to the DON. DON must consult with the pharmacy and administrator. This deficiency represents noncompliance investigated under Complaint Number 2726333.

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 03/10/2026
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 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** Based on record review, interview, facility investigation review, and policy review, the facility failed to ensure a thorough investigation was completed for missing narcotic medication. This affected one resident (Resident #73) out of three residents reviewed for misappropriation of narcotics. Facility census was 65. Findings include:Findings include:Review of the closed medical record for Resident #73 revealed an admission date of 01/12/16 and a discharge date of 01/14/26. Diagnoses included but were not limited to hemiplegia, malignant neoplasm of bladder and prostate. Review of the Medicare 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #75 had impaired cognition. Review of the Physician orders for January 2026 revealed an order for Fentanyl (opioid drug) Transdermal Patch 72 hour 50 microgram/hour (MCG/HR) apply patch transdermally one time a day every 2 days for chronic pain and remove per schedule.Review of the investigation report revealed on 01/14/26 with no time included, revealed former Director of Nursing (DON) #401 was notified by the night nurse, Licensed Practical Nurse (LPN) #222, of two missing Fentanyl patches, a powerful synthetic opioid which is about 50 to 100 times more potent than morphine, approved for treating severe, chronic, or acute pain. The investigation included only four statements from Registered Nurse (RN) #400, LPN #200, LPN #228, and LPN #226. There was no statement form LPN #222 who reported the missing Fentanyl Patches. There was no statement from LPN #209 who oriented with LPN #226. There was an email from the Administrator to former DON #401, dated 01/14/26 at 5:48 P.M. reporting this was LPN #226's statement with no signature on it. The investigation revealed only three staff were drug tested two days later on 01/16/26, to include LPN #200, LPN #226, and LPN #228. RN #400 who counted the narcotics with LPN #228 was not drug tested, LPN #209, who oriented with LPN #226 (who signed for the two missing Fentanyl patches) was not drug tested. There was a typed form signed by former DON #401, dated 01/16/26, revealed The investigation for the two Fentanyl patches has proven inconclusive. Patches believed to be disposed of when bags thrown away. The misappropriation was not reported to the Ohio Department of Health (ODH) through a Self-Reported Incident (SRI). The facility did not report the incident to the police or pharmacy. Interview on 03/05/26 at 12:19 P.M. with LPN #226 confirmed she received the medications from the pharmacy delivery of two Fentanyl patches in the pharmacy bag, pulled out the baggie and counted the two Fentanyl Patches and signed the pharmacy delivery slip. LPN #226 reported she then took the pharmacy bag with the medications to include the narcotics, two Fentanyl patches and handed them to LPN #228.Interview on 03/05/26 at 12:36 P.M. with LPN #228 revealed she did not receive the two Fentanyl patches from LPN #226. LPN #228 reported she didn't know she was supposed to have two Fentanyl patches. Interview on 03/05/26 at 12:57 P.M. and on 03/09/26 at 8:27 A.M. with Registered nurse (RN) #400 confirmed the two Fentanyl patches for Resident #73 were never found and it should have been reported to the ODH with a SRI initiated for misappropriation, police called, and all nursing staff working should have provided statements and drug tested. RN #400 confirmed a thorough investigation was not completed. RN #400 reported not all nurses who worked that evening gave statements and only three nurses were drug tested days later. RN #400 reported staff should have been drug tested immediately. RN #400 reported she wrote a full page statement and then last Wednesday, after this surveyor entered the facility, was asked to write a statement, which is in the investigation. RN #400 reported she checked with the Administrator who reported she didn't know where the original statement was. RN #400 confirmed there was no statement in the investigation for LPN #222, LPN #209, and LPN #226 statement was an email from the administrator not signed.Interview on 03/09/26 at 7:51 A.M. with former DON #401 confirmed there were two missing Fentanyl patches, narcotic for pain for Resident #73. DON #401 confirmed the missing Fentanyl patches should have been reported to the ODH with a SRI should have been initiated immediately for misappropriation of narcotic medications and police notified. Former DON #401 reported she was told (continued on next page)

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 03/10/2026
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by corporate not to report the incident as a SRI or to police. During this interview former DON #401 revealed she received a text from Administrator regarding the Fentanyl patches just at the time of interview stating it's not misappropriation because it was the facilities property as the facility paid for the patch, therefore they can't misappropriate their own property. Former DON #401 reported all nursing staff should have provided statements and all nurses drug tested. Former DON reported only LPN #200, LPN #226, and LPN #228 were drug tested.Interview on 03/09/26 at 10:06 A.M. with Regional RN #403 revealed she doesn't know why an SRI wasn't done on Resident #73 with the missing narcotics and would have to check with the Administrator.Interview on 03/09/26 at 5:25 P.M. with Pharmacist #406 confirmed he did not receive notification from the facility regarding any missing narcotics, to include Fentanyl patch 50 mcg for Resident #73 and he should have. He confirmed the Fentanyl patches are available in the Pixus at the facility, and they would just need to call to receive authorization to pull the medication.Interview on 03/10/26 7:14 A.M. with LPN #200 revealed she worked on 01/13/26 as a night nurse and in the morning LPN #226 brought back the pharmacy medication bags which she signed for and tried to give to her. LPN #200 reported she refused because day shift LPN #228 was with the medication cart and keys. LPN #200 reported LPN #226 handed the pharmacy bag off to LPN #228 and she counted the narcotic medications with RN #400. LPN #200 reported she received a call from former DON #401 with some questions regarding the missing Fentanyl patches for Resident #73 and was drug tested days later.Review of the facility policy, Abuse, Neglect, Exploitation & Misappropriation of Resident Property, revised November 01 2019, revealed it is the facilities policy to investigate all alleged violations involving abuse, neglect, exploitation, mistreatment of resident, or misappropriation of Resident Property. Further states staff should immediately report all such allegations to the Administrator/designee and to the Ohio Department of Health (ODH) and in cases where a crime is suspected should report to local law enforcement. The policy included the investigation should be documented. Review of the facility policy, Controlled Substances, revised December 2012, revealed the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule 2 and other controlled substances. Controlled substances must be counted upon delivery and the nurse receiving the medication, along with the person delivering the medication must count the controlled substance together. Both individuals must sign the designated controlled substance record. Nurses must document and report any discrepancies to the DON. DON must consult with the pharmacy and administrator. This deficiency represents noncompliance investigated under Complaint Number 2726333.

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 03/10/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, observation, and hospital record review, the facility failed to ensure surgical wound dressing orders were in place and provided as ordered, and failed to ensure post operative intervention was place to prevent blood clots. This affected three residents (#70, #71 and #72) our of three residents reviewed wound care, and two residents (#70 and #71) out of three residents reviewed for anticoagulant medication. The facility census was 65.Findings include: 1.Review of the closed medical record for Resident #70 revealed an admission date of 01/02/26 and a discharge date of 01/13/26. Diagnoses included but not limited to displaced fracture of base of neck of right femur, nicotine dependence, and obesity.Review of the Medicare 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 had intact cognition. Review of the Resident #70's physician orders for 01/02/26, 01/03/26, and 01/04/26 revealed there were no orders for a surgical wound dressing. Review of the orders for 01/05/26 for Resident #70 revealed an order for a dry dressing change to right hip, change daily, as needed (PRN) for soilage, one time a day for wound healing and every 12 hours PRN for surgical wound. There were no prior orders for dressing changes. The treatment was first implemented on 01/06/26.Interview on 02/26/26 at 1:39 P.M. with Resident #70 revealed her surgical wound was seeping and when the facility removed the band aid they never covered it back up until two days later. Resident #70 revealed when she took a shower and the dressing came off and the facility never covered it again. Resident #70 revealed the doctor and nurses never even looked at the wound.Interview on 03/09/26 at 1:52 P.M. with Registered Nurse (RN) #400 confirmed there were no orders for the surgical wound for Resident #70 until 01/06/26, four days later and the admitting nurse should have clarified with the physician and put in orders for a post surgical repair of hip fracture.Interview on 03/04/26 at 3:30 P.M. Regional RN #404 confirmed there were no orders for the surgical wound for Resident #70 until 01/06/26, four (4) days later and the admitting nurse should have clarified with the physician and put in orders for a post surgical repair of hip fracture to at least monitor site.Review of the facility policy, Wound Care, revised October 2010, revealed the purpose of this procedure is to provide guidelines for the care of wounds to promote healing and to verify a physician order.2. Review of the closed medical record for Resident #71 revealed an admission date of 01/05/26 and a discharge date of 01/16/26. Diagnoses included but were not limited to displaced intertrochanteric fracture of right femur.Review of the Medicare 5-day MDS assessment dated [DATE] revealed Resident #71 had intact cognition. Review of the physician orders for 01/05/36 revealed there were no orders for a surgical wound dressing changes or orders to monitor the surgical site.Review of the Medication Administration Records (MARS) and Treatment Administration Records (TARS) for Resident #71 for January 2026 revealed there were no surgical wound dressing orders or to monitor the wound site. Interview on 03/09/26 at 1:52 P.M. with RN #400 confirmed there were no orders for the surgical wound for Resident #71 and the admitting nurse should have clarified with the physician and put in orders for a post surgical repair of hip fracture.Interview on 03/04/26 at 3:30 P.M. Regional RN #404 confirmed there were no orders for the surgical wound for Resident #71 and there should have been orders. The admitting nurse should have clarified with the physician and put in orders for a post surgical repair of hip fracture to at least monitor site.Review of the facility policy, Wound Care, revised October 2010, revealed the purpose of this procedure is to provide guidelines for the care of wounds to promote healing and to verify a physician order.3. Review of the medical record for Resident #72 revealed an admission date of 03/03/26. Diagnosis included but were not limited to atrioventricular blood, complete, bradycardia, and presence of cardiac pacemaker.Review of the Medicare 5-day MDS assessment dated [DATE] revealed Resident #72 had intact cognition. Review of the Physician orders for 03/03/26 revealed on admission there were no orders for care of the surgical site of the pacemaker. Orders were entered on 03/04/36 at 7:00 P.M. by Regional RN #404 after surveyor intervention.Interview on 03/04/26 at 3:30 (continued on next page)

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 03/10/2026
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P.M. Regional RN #404 confirmed there were no orders for the surgical wound care for Resident #72 and there should have been orders. The admitting nurse should have clarified with the physician and put in orders for a post surgical wound to at least monitor the site.Interview on 03/09/26 at 1:52 P.M. with RN #400 confirmed there were no orders for the surgical wound dressing changes or care for Resident #72 until 03/04/26 at 7:00 P.M. RN #400 confirmed the admitting nurse should have clarified with the physician and put in orders for a post surgical wound.Review of the facility policy, Wound Care, revised October 2010, revealed the purpose of this procedure is to provide guidelines for the care of wounds to promote healing and to verify a physician order.4. Review of the closed medical record for Resident #70 revealed an admission date of 01/02/26 and a discharge date of 01/13/26. Diagnoses included but were not limited to displaced fracture of base of neck of right femur, nicotine dependence, and obesity.Review of the hospital papers dated 12/30/26 revealed Resident #70 was ordered Enoxaparin 40 milligrams (MG), (Lovenox a blood thinning anticoagulant medication), every 24 hours subcutaneously (SQ). Review of Resident #70's hospital Operative/Procedure Report, dated 12/30/26 revealed the postoperative plan after surgery was to include six weeks total of chemical deep vein thrombosis (DVT) prophylaxis of Lovenox, AC (anticoagulant). Review of Resident #70's physician orders revealed there were no orders for an anticoagulant, used to help prevent deep vein thrombosis after surgery.Review of Resident #70's medical record contained no evidence of preventive measures the facility was taking to prevent blood clots post surgery.Review of the Medicare 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #70 had intact cognition.Interview on 02/26/26 at 1:39 P.M. with Resident #70 revealed the facility never gave her blood thinners as she should have since day one of admission.Interview on 03/04/26 at 3:30 P.M. Regional Registered Nurse (RN) #404 confirmed there were no orders for anticoagulant medication for Resident #70. Regional RN #404 revealed the hospital should have been called by the admitting nurse for clarification on the AC. Regional RN #404 revealed after post operative hip surgery an AC is prescribed unless contraindicated.Interview on 03/09/25 at 1:52 P.M. with RN #400 confirmed Resident #70 should have been on an AC at the nursing home. RN #400 confirmed the admitting facility nurse should have contacted the Physician regarding clarification of the AC. RN #400 revealed after post operative hip surgery an AC is prescribed unless contraindicated.Review of facility policy, Anticoagulation -Clinical Protocol, revised September 2012, revealed the physician will identify individuals who are currently anticoagulated, to include those who have had a recent joint replacement surgery. Review of facility policy, Administering Medications, revised December 2012, revealed medications shall be administered in a safe and timely manner, and as prescribed.5. Review of the closed medical record for Resident #71 revealed an admission date of 01/05/26 and a discharge date of 01/16/26. Diagnoses included but were not limited to displaced intertrochanteric fracture of right femur,Review of the Medicare 5-day MDS assessment dated [DATE] revealed Resident #71 had intact cognition.Review of the hospital inpatient progress note dated 12/31/26 revealed Venous Thromboembolism prevention, are medical measures taken to prevent blood clots from forming in deep veins (DVT) or traveling to the lungs (PE). The progress note further stated VTE prophylaxis, means after hip surgery with an AC to prevent life-threatening venous thromboembolism (VTE) is appropriate, which includes DVT and PE. The preventive treatment is critical for up to 35 days post surgery. Review of the hospital referral records dated 01/05/26 revealed Resident #71 had a right hip fracture and right foot fracture and was ordered Enoxaparin 40 mg injection, Lovenox, every 24 hours SQ on 12/31/26.Review of Resident #71's physician orders revealed there were no orders for AC medications.Review of Resident #71's medical record contained no evidence of preventive measures the facility was taking to prevent blood clots post surgery.Interview on 03/05/26 at 3:30 P.M. with Regional RN #404 confirmed there were no orders for anticoagulant medication for Resident #71. Regional RN #404 revealed the hospital should have been called by the admitting nurse for clarification on the AC. Regional RN #404 revealed after post operative hip surgery a AC is prescribed unless contraindicated.Interview on 03/09/25 at 1:52 P.M. with RN #400 confirmed (continued on next page)

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 03/10/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #71 should have been on Lovenox, AC at the nursing home. RN #400 revealed the admitting nurse should have contacted the hospital regarding clarification of the AC.Review of facility policy, Anticoagulation -Clinical Protocol, revised September 2012, revealed the physician will identify individuals who are currently anticoagulated, to include those who have had a recent joint replacement surgery. Review of facility policy, Medication Utilization and Prescribing - Clinical Protocol, revised July 2016, revealed staff will ensure medications are given appropriately. This deficiency deficiency represents noncompliance investigated under Complaint Number 2723756.