STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365209	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Middletown LLC	6898 Hamilton Middletown Road Middletown, OH 45044

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** 36303 Based on medical record review, resident interview, staff interview, the facility failed to ensure the physician was notified when medications were not available due to a national shortage. This affected one (Resident #65) of three residents reviewed. The census was 138. Findings include: Review of Resident #65's medical record revealed an admitted [DATE]. Diagnoses included type II diabetes. Review of physician orders revealed an order dated 03/01/24 for Mounjaro subcutaneous pen-injector (diabetic medication) five milligrams (mg) per 0.5 milliliter (ml) inject one time day every Friday for four weeks. Review of medication administration records revealed Mounjaro was not administered due to not being available on 03/15/24, 03/22/24, and 03/29/24. Review of progress revealed no documentation of Resident #65's physician being notified of Mounjaro not being available on 03/15/24, 03/22/24, and 03/29/24. During an interview on 04/17/24 at 3:26 P.M. the Director of Nursing (DON) and Regional Nurse Consultant (RNC) #200 confirmed Resident #65 missed Mounjaro administrations on 03/15/24, 03/22/24, and 03/29/24 due to a national shortage. Both confirmed there was no documentation of Resident #65's physician being notified of the shortage of the medication. This deficiency represents non-compliance investigated under OH000152641 and is an example of continued noncompliance from the survey dated 02/14/24.

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

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

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	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** 36303 Based on medical record review, resident interview, staff interview, review of facility self-reported incidents (SRI), and review of facility policy, the facility failed to prevent physical abuse. This affected one (Resident #65) of three residents reviewed. The census was 138. Findings include: Review of Resident #65's medical record revealed an admitted [DATE]. Diagnoses listed included depressive mood disorder, anxiety disorder, hypertension, dependence of respiratory ventilator, type two diabetes mellitus, morbid obesity, and respiratory failure. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #65 was cognitively intact. Review of a care plan initiated 02/13/23 revealed Resident #65 exhibits behavior symptoms of abusive language and physical aggression directed towards Care Team Members, also makes false accusations of staff, has manipulative behaviors, refuses care, and refuses bed baths and showers. Resident #65 has diagnoses of of mood disorder and anxiety disorder. Interventions listed included administer medications as ordered, allow resident to vent (express) feelings/needs, approach resident in a calm and friendly manner, assess resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. treat as indicated, document behaviors per behavior management program, explain to resident what you are going to do before initiating task, if resident becomes combative or resistive, postpone care/activity and allow resident to regain their composure, re-approach as needed, maintain a safe environment for resident, pay attention to Resident #65's non-verbal cues, such as her facial expressions, body language, and tone of voice, to better understand their emotions and experiences, provide resident personal space, and remain calm and create a reassuring environment for Resident #65. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility self-reported incident (SRI) dated 04/03/24 revealed Resident #65 stated she feels unsafe due a verbal altercation with a staff member, Registered Nurse (RN) #100). Resident #65 was interviewed. Resident #65 stated she was at the nurse's station with headphones in RN #100 said you can ' t be up here at the nurse ' s station due to HIPAA (Health Insurance Portability and Accountability Act). Resident #65 stated that an aide assisted her by the door of her room per RN #100's request. Resident #65 reported that her and RN #100 were arguing back and forth. Resident #65 reported RN #100 was walking away and she called the RN #100 a expletive. Resident #65 reported that RN #100 attempted to assist her into her room after she yelled the expletive. Resident #65 stated she held onto to the door frame to prevent RN #100 from getting her into the room. Resident #65 reported that RN #100 stated I ' m going to get your fat expletive in here one way or another. Resident #65 then stated she grabbed her thermal cup, unscrewed the lid, and dumped water on Resident #65. Resident #65 reported that after she dumped water Resident #100 left the room. Interview with RN #100 revealed that Resident #65 was at nurses station and she was concerned with HIPAA. RN #100 had asked about moving Resident #65 to the lounge or by her room. RN #100 reported that Resident #65 began cursing and yelling at her calling her profanities. RN #100 reported she Resident #65 to her room, during this Resident #65 poured water on her and hit her with a cup. RN #100 denied calling the resident any profanities. STNA #130 was interviewed and reported that Resident #65 by the nurses station. The unit manager (RN #100) came to the nurses station and had asked if Resident #65 could go to the lounge area or by her room. Resident #65 started yelling and cussing. RN #100 stated this was disrupting resident peace and asked for Resident #65 to be moved into her room. Resident #65 proceeded to speak louder and RN #100 started to speak louder STNA #130 stated she could not make out what they were saying. STNA #130 stated that RN #100 assisted Resident #65 into her room and Resident #65 was applying resistance with the wall/doorframe with her hands and feet. Resident #65 foot was X-rayed due to reporting pain after potentially hitting it on her doorframe. A report was filed with local police on 04/08/24. RN #100 was suspended and resigned on 04/03/24. Review of progress notes dated 04/03/24 at 5:21 P.M. revealed the social worker engaged with Resident #65 following an incident that occurred. The social worker provided support to Resident #65 resident and allowed Resident #65 to vent (express feelings) openly without interruption. Resident #65 reported she was feeling better and has calmed down. The social worker reported to Resident #65 that's he would come check in with her again tomorrow. Review of progress notes dated 04/04/224 at 6:35 P.M. Resident #65 asked nurse to look at her right foot. Resident #65 stated that during an altercation with RN #100 that her foot was hit on the door frame. Resident #65 reported outer foot and toe pain. Redness and swelling was noted. Review of right foot X-ray results dated 04/05/24 revealed no acute findings. Review of progress notes dated 04/08/24 revealed the social worker contacted the local police department to file a police report about the incident between Resident #65 and an employee that occurred on 04/03/24. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/24 at 11:55 A.M. Resident #65 stated she was involved in an altercation with RN #100 on 04/03/24. Resident #65 was sitting in her wheelchair across from the nursing station by a mirror. RN #100 told her she couldn't sit there do to hearing other patient information. RN #100 had State tested Nursing Assistant (STNA) #130 move Resident #65 by her room. While being wheeled by STNA #130 Resident #65 told RN #100 I know what you did to that girl two weeks ago, referring to an altercation RN #100 had with another staff member. RN #100 said to Resident #65 you are going to your room now and took the wheelchair from STNA #130. RN #100 then tried to pull Resident #65 backwards through her doorway. Resident #65's legs were banging against the doorway an she was trying to hold on to prevent entering her room. RN #100 called her a fat expletive and that's when Resident #65 throw her water container at RN #100. During a phone interview on 04/17/24 at 2:37 P.M. STNA #130 stated on 04/03/24 Resident #65 was sitting across form the nursing station. RN #100 asked STNA #130 to move Resident #65 from the nursing station due to being able to hear other patient information. STNA #130 moved Resident #65 to her doorway. On the way Resident #65 told RN #100 I know what you did to that girl and called her a expletive. RN #100 then said she now wanted Resident #65 in her room and they both were yelling at each other. RN #100 tried to pull Resident #65 through her doorway. Resident #65 was holding on to the doorway with her hands and feet. STNA #130 tried to calm Resident #65 down. Scheduler #170 came up and said to STNA #130 asked her to get someone to report too. Scheduler #170 told STNA #130 to not get anyone right now. STNA #130 did not agree and went and reported the incident. During an interview on 04/17/24 at 3:36 P.M. the Director of Nursing (DON) and Regional Nurse Consultant (RNC) #200 confirmed Resident #65 reported concerns with an altercation with RN #100. Both the DON and RNC #200 confirmed STNA #130 reported that Resident #65 resisted being put in her room by RN #100 by holding on to her doorway. Resident #65 foot was X-rayed due to soreness reported after the altercation with RN #100. Both the DON and RNC #200 confirmed RN #100 did not Resident #65's care plan interventions by not letting postponing care and letting Resident #65 regain her composure after being verbally aggressive on 04/03/24. During a phone interview on 04/18/24 at 12:08 P.M. RN #100 denied abusing Resident #65. RN #100 that Resident #65 was sitting by the nursing station on 04/03/24 and told her she couldn't sit up there due to HIPAA concerns, there were other places to sit. RN #100 wheeled Resident #65 to her room. Resident #65's wheelchair is same size as doorway and had to roll her backwards into the room to get out of the doorway. RN #100 confirmed Resident #65 did not want to be in her room, but was being disruptive to other residents by yelling. Resident #65 threw a metal water cup an hit her. RN #100 denied seeing Resident #65 resist by holding on to the doorway with her hands and feet. Resident #65 had hit other staff recently. RN #100 resigned due to facility not doing enough to protect staff. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Abuse Prevention Program dated revised March 2021 revealed residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's symptoms. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. This deficiency represents non-compliance investigated under Complaint Number OH00152641.

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34291 Based on medical record review, death certificate review, policy review, dialysis center record review, physician interview, staff interview, and dialysis center staff interview, the facility failed to ensure Resident #06, with a diagnosis of end-stage renal disease (ESRD), received scheduled hemodialysis treatments as ordered by the physician. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, injuries, and/or death when Resident #06 went four days without hemodialysis treatments due to the facility's failure to communicate and coordinate continuity of care with the dialysis center, failure to transport the resident to hemodialysis treatments and failure to notify the physician of the resident not receiving ordered treatments. Resident #06 suffered cardiopulmonary arrest and expired in the facility on [DATE]. This affected one (Resident #06) of five residents (#06, #07, #08 #139 and #162) reviewed for hemodialysis services in an outpatient setting. The facility also failed to ensure communication was maintained with the dialysis center concerning pre- and post-dialysis treatments for three additional residents (#07, #08, #139) receiving hemodialysis that placed the residents at risk for the potential for more than minimal harm that was not Immediate Jeopardy. The facility census was 138. On [DATE] at 4:59 P.M., the Director of Nursing (DON) and Regional Nurse Consultant (RNC) #200 were notified Immediate Jeopardy began on [DATE] when Resident #06 did not attend scheduled dialysis on [DATE] and [DATE]. The facility staff were not aware of the appointments or that he did not receive his scheduled dialysis treatments. The facility staff were unaware of the dialysis schedule for [DATE] and were unaware transportation did not arrive on [DATE] to take Resident #06 to dialysis. The physician was never notified Resident #06 missed two dialysis appointments. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] through [DATE], the DON and RNC #200 completed a chart review of Residents #07 and #139. The facility reviewed the process and protocol for dialysis on [DATE]. See the following: Infection Preventionist Support Staff (IPSS) #215 designee re-educated all licensed nurses on [DATE] to communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form or other form, that will include, but not limit itself to: a. Physician/treatment orders, laboratory values, and vital signs. b. Advance Directives and code status; specific directives about treatment choices; and any changes or need for further discussion with the resident/representative, and practitioners. c. Nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provision of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	d. Dialysis treatment provided and resident's response, including declines in functional status, falls, and the identification of symptoms that may interfere with treatments. e. Dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site. f. Changes and/or declines in condition unrelated to dialysis. g. The occurrence or risk of falls and any concerns related to transportation to and from the dialysis facility. On [DATE], the DON completed a review of Residents #07 and #139 who were receiving dialysis services to ensure transportation was set with details, the appointment is listed on the shared calendar, and there were no barriers to receiving services. The facility noted Residents #07 and #139 were in compliance on [DATE]. On [DATE], the facility will immediately contact and communicate with the attending physician, resident/representative, and designated dialysis staff (i.e., nephrologist, registered nurse) any significant changes in the resident's status related to clinical complications or emergent situations that may impact the dialysis portion of the care plan. On [DATE], IPSS #215 and Clinical Leadership which included Registered Nurses (RN) #150 and #235, Licensed Practical Nurses (LPN) #220, #225, #230, and #235 educated licensed nurses on their responsibility to ensure that residents appointments are arranged, to review the calendar and communicate appointment needs to staff on duty, transport is set up, transport is monitored to ensure arrival at scheduled time, and secondary plan is in place and initiated immediately if transport is not on time. The education was expected to be completed by [DATE]. Any staff who are not educated will be educated prior to the start of their next scheduled shift. On [DATE], IPSD #215 and Clinical Leadership team RNs #150 and #235 and LPN #220, #225, #230, and #235 will educate licensed nurses on conducting risk benefit conversations for the following protocol: In the event of resident refusal, the nurse on duty will re-educate on the importance of obtaining the treatment, if the resident continues to make the same choice-the nurse will notify the unit manager and DON. The resident will be re-encouraged-the nurse will conduct a risk conversation with the resident which includes, continued kidney failure, organ failure, heart attack, inability for the body to filter toxins, and imminent death. The risk/benefit conversation will be documented in the medical record. On [DATE], IPSD #215 and Clinical Leadership team RN #150 and #235, LPN #220, #225, #230, and #235 will educate licensed nurses on notification: Any and all changes of condition including missing a dialysis treatment must be communicated to the provider, the response of the provider must all be documented. All new orders will be notified to the resident and/or responsible party. On [DATE], IPSD #215 and Clinical Leadership team RN #150 and #235, LPN #220, #225, #230, and #235 will educate licensed nurses on dialysis documentation: Pre and Post dialysis Evaluation to be completed with assessment of the resident dialysis access site listed on the form-completed prior to and after each dialysis session by the nurse. Nurses will utilize a dialysis communication binder to communicate these reports to the respective dialysis clinic. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The DON will review residents on dialysis weekly to ensure the resident received dialysis, transport secured, evaluations completed, and dialysis procedure compliant with policy, to be completed three times per week times four weeks, then monthly times two months. Quality Assurance and Performance Improvement (QAPI) was implemented to gather and process information from the audits. Audit findings will be completed and reported at the monthly Quality Assessment and Assurance (QAA) meeting for two months. On [DATE] through [DATE], Clinical Leadership RNs #150 and #235 and LPNs #220, #225, #230, and #235 completed hemodialysis competencies on all licensed nurses. Any licensed nurses who were not educated on the competency will receive competency prior to their next scheduled shift. On [DATE], the DON audited Residents #07, #08, #139 and #162 currently residing in the facility to ensure that residents received scheduled dialysis services, or if the resident did not receive dialysis services the physician/dialysis were notified; a risk benefit conversation was conducted regarding the risk of not receiving dialysis services, and there was communication between the facility, physician, and dialysis to ensure that dialysis provisions were provided. On [DATE] through [DATE], the DON and Clinical Leadership team RN #150 and #235 and LPN #220, #225, #230, and #235 obtained proof of dialysis visits from dialysis centers (Fresenius/DaVita) to validate compliance with dialysis provisions and services, with continued compliance validated. On [DATE], the DON and Clinical Leadership RN #150 and #235 and LPN #220, #225, #230, and #235 will re-educate the staff on dialysis protocol, communication process by [DATE]. Any staff not educated prior to [DATE] will be educated prior to their next scheduled shift. On [DATE], the DON and Clinical Leadership RN #150 and #235 and LPN #220, #225, #230, and #235 educated the medical records staff on obtaining dialysis documentation if the clinic does not send the visit notes. Ongoing Monitoring: Clinical Leadership RN #150 and #235 and LPN #220, #225, #230, and #235/designees will audit all current dialysis residents to ensure dialysis communication, and documentation, are completed for residents receiving dialysis weekly times four weeks, then monthly times two months. On [DATE], the QAPI committee reviewed the plan for education and ongoing monitoring for Dialysis Services in accordance with policy and regulations. During interviews on [DATE] at 4:30 P.M. with RN #160, [DATE] at 2:00 P.M. with LPN #250 and [DATE] at 12:49 P.M. with LPN #255, revealed they were educated on dialysis communication. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan including monitoring to ensure on-going compliance. Findings include: (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	1. Medical record review for Resident #06 revealed an admitted [DATE]. Medical diagnoses included end stage renal disease, heart failure, orthostatic hypotension, hemiplegia, seizure disorder, chronic embolism, and thrombosis of unspecified veins. Review of the care plan dated [DATE] revealed Resident #06 required hemodialysis on Tuesday, Thursday, and Saturday at 7:45 A.M. Interventions were to administer medications as ordered, assess bruit, and thrill every shift, diet as ordered, dressing changed per physician order, notify dialysis of any changes to resident's condition or abnormal findings related to access site, and vital signs as ordered and indicated and notify the physician of significant abnormalities. Review of the quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #06 was cognitively intact. Review of last visit with Nephrologist Nurse Practitioner (NNP) #300 dated [DATE] revealed Resident #06 was seen and examined. The resident had edema, shortness of breath which was stable, respirations were unlabored, and the resident stated he was overall doing well and denied any needs. There was a discussion about the need for hemodialysis as prescribed and a low potassium diet. His potassium was 5.6 milliequivalents per liter (mEq/L) which was high (Normal for an adult is 3XXX,d+[DATE].2 mEq/L). Review of progress notes dated [DATE] revealed Resident #06 went out to the hospital with complaints of pain in the dialysis port area of the chest. He had his port changed and came back to the facility on [DATE] with orders to see the surgeon in two days for a follow-up appointment. Resident #06's medical record contained no documentation from the appointment with the surgeon. Review of the dialysis calendar for Resident #06 revealed his dialysis appointments were missed on [DATE] and on [DATE]. There was no physician order for dialysis to be performed on [DATE]. Review of the progress notes dated [DATE] and [DATE] revealed no documentation regarding dialysis appointments or physician notification. Review of the progress notes dated [DATE] at 7:31 P.M. revealed vital signs were taken, and they were normal. At 10:45 P.M., Resident #06 was moved up in bed and repositioned. He requested ice and this was given. At 11:39 P.M., medication was taken to the room by LPN #255 and Resident #06 was found unresponsive. The code was called at 11:40 P.M. Cardiopulmonary resuscitation (CPR) was started and 911 was called. On [DATE] at 12:17 A.M., Resident #06 was pronounced dead. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility's investigation into Resident #06's missed dialysis appointments, dated [DATE], documented on [DATE] Resident #06 went to the surgeon's appointment at 11:30 A.M. His dialysis was canceled on [DATE] and rescheduled for [DATE]. Transport Scheduler (TS) #301 stated she reported this schedule change to Resident #06 and Unit Manager (UM) #302. On [DATE] there was an 8:00 A.M. pickup time for the dialysis and LPN #303 was not aware of the makeup appointment. An interview with the transport company revealed they were at the facility on [DATE] and no one was waiting up front. The transport company called three times to the facility and there wasn't an answer and the driver waited for 15 minutes and left. The receptionist wasn't aware of any calls on [DATE] and turned the phones on at 8:00 A. M. and sometimes 7:45 A.M. On [DATE] at 6:55 A.M., Resident #06 was noticed sitting in the lobby waiting for dialysis transport and at approximately 07:45 A.M. the night shift nurse took the call from dialysis and told them she thought he was already gone. At 8:30 A.M., the night shift left through the front lobby and noticed Resident #06 in the front of the facility and notified LPN #303 to call dialysis. At 10:30 A.M., LPN #303 discovered Resident #06 laying in his bed and stated transport didn't pick him up. Review of the written statement dated [DATE] from LPN #303 revealed she worked on [DATE] and didn't know Resident #06 had a makeup day for dialysis. She didn't receive any calls from dialysis on [DATE]. She stated she saw him in the lobby on [DATE] at 6:50 A.M. when she came to work. She was not sure when he was normally picked up for dialysis. She found him in his bed at 10:30 A.M. and she asked him if he had gone to dialysis, and he said no. Review of the written statement dated [DATE] from State tested Nursing Aide (STNA) #304 revealed she worked the night of [DATE]. She took a call from the dialysis center and told them he was already gone to dialysis. She documented when she was leaving her shift on the morning of [DATE] she saw Resident #06 sitting in the lobby and she told LPN #303 to call dialysis and let them know he was still in the facility. During an interview on [DATE] at 11:12 A.M., Social Worker (SW) #305 from the dialysis center confirmed Resident #06 missed his appointments on [DATE] and [DATE]. During an interview on [DATE] at 12:49 P.M., LPN #255 stated Resident #06 told her the evening of [DATE] he didn't feel well. She took his vital signs with no concerns. She said she went back to check on him and he wanted to be pulled up in the bed, so she pulled him up and gave him ice water. She stated the aide went in again and provided ice water and he was ok. She said he coded shortly after and was pronounced dead. She wasn't aware he missed two dialysis appointments that week. During an interview on [DATE] at 1:47 P.M., RN #235 stated she was the former unit manager. She stated she was the only supervisor on duty the night of [DATE] when Resident #06 coded. She stated she didn't know the resident had missed two dialysis appointments. During an interview on [DATE] at 4:25 P.M., TS #301 stated she took Resident #06 to the surgeon's appointment on [DATE]. The surgeon stated he wanted the resident to have dialysis on [DATE]. She told UM #302 what the doctor's order was as soon as she returned to the facility with the resident on [DATE]. She said the UM said, all right. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365209	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Middletown LLC	6898 Hamilton Middletown Road Middletown, OH 45044

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on [DATE] at 4:30 P.M., RDCS #200 and the DON confirmed there wasn't an order for dialysis for [DATE] put into the computer. UM #302 didn't tell LPN #303 about the rescheduled dialysis appointment for [DATE]. They confirmed transportation didn't pick up Resident #06 on [DATE] due to insurance problems even though the resident had been using the transportation company the insurance wanted him to use. They confirmed the physician wasn't notified concerning missing these two dialysis treatments. UM #302 was terminated, and LPN #303 resigned from the facility. During an interview on [DATE] at 9:37 A.M., NNP #300 stated Resident #06 didn't seem unstable when she saw him on [DATE]. She said the dangers of missing dialysis appointments were elevated potassium which could cause his heart to stop without any warning. She stated his potassium ran on the high side at times. The other danger was fluid overload which can cause pulmonary edema and elevated creatinine levels. All the levels of toxins in his body would rise. She stated the expectation of the facility would be to notify the dialysis center if he couldn't make it to the appointment so it could be rescheduled. During an interview on [DATE] at 9:48 A.M., RDCS #200 confirmed UM #302 knew about the appointment for [DATE] and didn't put the order into the computer. She confirmed UM #302 didn't know about the resident's chair time at the dialysis center and being a unit manager should have known about this. During an interview on [DATE] at 2:04 P.M., NP #307 stated she wasn't notified Resident #06 had missed dialysis appointments on [DATE] and [DATE]. She stated it would be the expectation staff would notify her of missed treatments. Attempts were made to contact LPN #303, UM #302 and STNA #304 via telephone. All phone numbers provided had been disconnected. 2. Medical record review for Resident #139 revealed an admitted [DATE]. Medical diagnoses included end stage renal disease. Review of the care plan dated [DATE] revealed he required hemodialysis, and it was scheduled for Monday, Wednesdays, and Fridays. Interventions included to assess bruit, diet as ordered, do not draw blood, or take blood pressure in arm with graft, enhanced barrier precautions, change dressing change per physician orders, labs as ordered and report to doctor and dialysis as needed and notify dialysis of changes in resident condition or abnormal findings related to access site. Review of the dialysis calendar revealed Resident #139 went to dialysis on [DATE]. Record review revealed no documentation regarding the dialysis treatment on [DATE]. The communication binder for dialysis contained no pre or post dialysis form for the treatment on [DATE]. 3. Medical record review for Resident #07 revealed an admitted [DATE]. Medical diagnoses included renal insufficiency. Review of the care plan dated [DATE] revealed she required hemodialysis, and it was scheduled for Monday, Wednesdays, and Fridays. Interventions included to assess bruit, diet as ordered, do not draw blood, or take blood pressure in arm with graft, change dressing change per physician orders, labs as ordered and report to doctor and dialysis as needed and notify dialysis of changes in resident condition or abnormal findings related to access site. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365209	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the dialysis calendar revealed Resident #07 had dialysis on [DATE], [DATE] and [DATE]. The communication binder for dialysis contained no pre or post dialysis form for the treatment dates listed above. 4. Medical record review for Resident #08 revealed an admitted [DATE]. His medical diagnoses included renal insufficiency. Review of the care plan dated [DATE] revealed Resident #08 required hemodialysis three times a week on Tuesday, Thursday, and Saturday. Interventions included to assess bruit, diet as ordered, do not draw blood, or take blood pressure in arm with graft, change dressing change per physician orders, Enhanced Barrier Precautions, labs as ordered and report to doctor and dialysis as needed and notify dialysis of changes in resident condition or abnormal findings related to access site. Review of the dialysis calendar revealed Resident #08 had dialysis on [DATE]. The communication binder for dialysis contained no pre or post dialysis form for the treatment on [DATE]. During an interview on [DATE] at 3:00 P.M., RDCS #200 verified there was missing documentation in the chart and in the dialysis binders for the residents but said all these residents did go to the dialysis center for their treatments. Review of the policy titled Dialysis Care, dated [DATE], revealed the facility will assure that each resident that requires dialysis services, receives such services that are consistent with professional standards. Including: Continued assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at an off-site dialysis center. Assessment of the resident before, during, and after dialysis treatments. Collaboration with the dialysis facility's plan of care. The facility will assist in transportation arrangements to and from the dialysis center. This deficiency represents non-compliance investigated under Complaint Number OH00152921.