

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/29/2024
NAME OF PROVIDER OR SUPPLIER  Majestic Care of Middletown LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570</b></p> <p>Based on medical record review, staff interview, and policy review, the facility failed to notify the physician or nurse practitioner of significant weight changes and wound treatment refusals. This affected one (#26) of three residents reviewed for nutrition and one (#108) of three residents reviewed for wounds. The facility census was 142.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #26 revealed an admitted [DATE] with diagnoses of unspecified dementia with other behavioral disturbance and psychotic disorder with delusions due to known physiological condition.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had severe cognitive impairment and required supervision assistance with eating.</p> <p>Review of the care plan dated 03/29/24 revealed Resident #26 had a potential for nutritional risk with interventions to obtain weights as ordered/indicated and notify the physician of significant weight changes.</p> <p>Review of Resident #26's weight record revealed the resident weighed 223.0 pounds (lbs.) on 10/04/23 and weighed 182.0 lbs. on 05/01/24 which represented an 18.39 percent (%) weight loss over approximately six months.</p> <p>Review of Resident #26's progress notes revealed no charting present of notification to the physician of the significant weight loss.</p> <p>Interview on 05/29/24 at 3:01 P.M. with Regional Nurse Consultant #320 confirmed the physician was not notified of the weight loss for Resident #26 as care planned.</p> <p>2. Review of the medical record for Resident #108 revealed an admitted [DATE] with diagnoses of chronic obstructive pulmonary disease, vascular dementia, and anxiety .</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 365209
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MDS assessment dated [DATE] revealed Resident #108 had severe cognitive impairment, required partial assistance for oral hygiene and personal hygiene, required substantial assistance for toileting and dressing, and was dependent on staff for bathing, bed mobility, and transfers. Further review of the MDS assessment revealed Resident #108 was assessed with one stage four pressure ulcer (full-thickness skin and tissue loss).</p> <p>Review of physician orders for Resident #108 revealed an order dated 04/26/24 for treatment to the right buttocks wound to be cleansed with normal saline, pat dry, apply calcium alginate ag rope (be sure to loosely pack into undermining and tunnels), cover with dry dressing, and change daily and as needed. The order further identified to notify the nurse practitioner (NP) personally with every refusal of treatments.</p> <p>Review of Resident #108's progress notes revealed progress notes on 05/22/24 at 4:58 A.M. and on 05/26/24 at 10:15 P.M. that wound treatments were refused due to pain. Further review of the progress notes revealed no documentation of the physician or nurse practitioner being notified of the refusal of treatments.</p> <p>Interview on 05/29/24 at 2:21 P.M. with Licensed Practical Nurse (LPN) #306 confirmed Resident #108 refused her treatments to her right buttocks on 05/22/24 and 05/26/24 when the calcium alginate treatment was applied. LPN #306 also confirmed the physician or nurse practitioner was not notified when the Resident #108 refused, and verified there was a physician order dated 04/26/24 for the NP to be personally notified of every wound treatment refusal.</p> <p>Interview on 05/29/24 at 2:24 P.M. with Unit Manager LPN #335 confirmed the NP was not notified of Resident #108's wound treatment refusals as ordered.</p> <p>Review of the change in condition policy dated 10/19 revealed the charge nurse was responsible for notification of physician and responsible party prior to end of the shift. If the physician has not returned the call by the end of the shift, the oncoming nurse will be notified for follow up.</p> <p>This deficiency represents continued non-compliance from the survey dated 02/14/24 and 04/29/24.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48570</p> <p>Based on observation, medical record review, staff interview, and policy review, the facility failed to perform timely and adequate incontinence care and failed to ensure physician orders were followed for use of incontinence products. This affected four (#14, #43, #108 and #116) out of five residents reviewed for incontinence. The facility census was 142.</p> <p>Findings include:</p> <p>1. Review of Resident #14's medical record revealed an admitted [DATE] with a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #14 was cognitively intact and required substantial assistance with toileting.</p> <p>Review of the care plan dated 01/02/24 revealed Resident #14 required assistance from staff for incontinence care with an intervention to check routinely for incontinence and provide incontinence care as needed.</p> <p>2. Review of Resident #43's medical record revealed an admitted [DATE] with a diagnosis of unspecified chronic obstructive pulmonary disease.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #43 was cognitively intact and was dependent on staff for toileting.</p> <p>Review of the care plan dated 01/03/24 revealed Resident #43 had episodes of bowel and bladder incontinence with an intervention to check routinely for incontinence and provide incontinence care as needed.</p> <p>3. Review of Resident #116's medical record revealed an admitted [DATE] with diagnoses of acute and chronic respiratory failure and anoxic brain damage.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #116 had a memory problem and was dependent on staff for all care.</p> <p>Review of the care plan dated 03/15/23 revealed Resident #116 had episodes of incontinence of bladder and bowel with an intervention to check routinely for incontinence and provide incontinence care as needed.</p> <p>4. Review of Resident #108's medical record revealed an admitted [DATE] with diagnoses of unspecified chronic obstructive pulmonary disease, vascular dementia, and anxiety.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #108 was assessed with severe cognitive impairment and required substantial assistance for toileting.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the care plan dated 09/22/23 revealed Resident #108 had episodes of incontinence of bladder and bowel with an intervention to check routinely for incontinence and provide incontinence care as needed.</p> <p>Review of Resident #108's physician orders revealed an order dated 01/04/24 for the resident to not have any briefs on while in bed every shift but may use disposable absorbent pads (Chux).</p> <p>Observation on 05/28/24 at 8:22 A.M. revealed Resident #14, Resident #43, Resident #108, and Resident #116's incontinence briefs were noted with heavy moisture present.</p> <p>Interview on 05/28/24 at 9:22 A.M. with State tested Nurse Aide (STNA) #342 revealed incontinence care should be done every two hours, but was not always able to get it done that soon.</p> <p>Observation on 05/28/24 at 9:34 A.M. revealed Resident #14, Resident #43, Resident #108, and Resident #116's incontinence briefs revealed each resident remained wet with heavy moisture present and the briefs were bulging.</p> <p>Interview on 05/28/24 at 9:34 A.M. with STNA #342 confirmed she had not changed or completed peri-care on Resident #108 at all that shift and confirmed she began her shift at 7:00 A.M. STNA #342 also confirmed Resident #108 had an incontinence brief on.</p> <p>Interview on 05/28/24 at 9:35 A.M. with Licensed Practical Nurse (LPN) #340 stated residents need incontinence care every two hours at a minimum. LPN #340 stated STNA #342 was told twice that shift to change Resident #108 due to the resident being wet and confirmed it had not been completed. Interview with LPN #340 confirmed Resident #108's incontinence brief was wet, bulging, and full of urine. LPN #340 also confirmed Resident #108 was wearing a brief and had a physician order not to wear a brief in bed.</p> <p>Interview on 05/28/24 at 9:44 A.M. with LPN #355 confirmed Resident #14, Resident #43, and Resident #116 remain wet and peri-care was not completed since the start of the shift at 7:00 A.M.</p> <p>Interview on 05/28/24 at 9:45 A.M. with STNA #321 confirmed incontinence care had not been done that shift for Resident #14, Resident #43, and Resident #116.</p> <p>Interview on 05/23/24 at 10:39 A.M. with STNA #321 confirmed she completes incontinence rounds every four hours.</p> <p>Interview on 05/29/24 at 2:21 P.M. with LPN #306 confirmed Resident #108 did wear an incontinence brief while in bed and confirmed the resident had a physician order for no incontinence briefs while in bed. LPN #306 confirmed staff did not follow the resident's physician order by putting the brief on Resident #108 while in bed.</p> <p>Interview on 05/29/24 at 2:24 P.M. with Unit Manager LPN #335 confirmed staff put a hypoallergenic brief while in bed on Resident #108 due to the resident having heavy urinary incontinence and confirmed there was a physician order dated 01/04/24 for no briefs while in bed and staff may use a disposable chux.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the perineal care policy dated 02/18 revealed the purpose of the procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00154225 and Complaint Number OH00153635, and represents continued non-compliance from the survey dated 02/14/24.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570</b></p> <p>Based on observation, resident and staff interview, medical record review, and policy review, the facility failed to provide residents with a palatable meal with appetizing temperatures. This affected two (#69 and #113) of three residents reviewed for meals. The facility census was 142.</p> <p>Findings include:</p> <p>1. Review of the medical record for Resident #69 revealed an admitted [DATE] with diagnoses of acquired clubfoot to the right foot, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the right dominant side, and mild protein-calorie malnutrition.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69 was cognitively intact and required supervision assistance with eating.</p> <p>Interview on 05/23/24 at 11:28 A.M. with Resident #69 revealed the food was not favorable and it was usually cold when it should be hot.</p> <p>2. Review of the medical record for Resident #113 revealed an admitted [DATE] with diagnoses of heart failure, and unspecified and chronic obstructive pulmonary disease.</p> <p>Review of the MDS assessment dated [DATE] revealed Resident #113 was cognitively intact and had no functional impairment to bilateral upper and lower extremities.</p> <p>Observation on 05/28/24 at 1:24 P.M. revealed a sample food test tray was placed on the cart, and at 1:42 P.M. the test tray was removed from cart and food temperatures were obtained by Account Manager Healthcare Services (AMHS) #401. Further observation revealed the temperature of the barbequed meat was 121.0 degree Fahrenheit (F), baked beans were 110 degrees F, spinach was 60.2 degrees F, fruit was 60.3 degree F, and milk was 43.3 degrees F. A sampling of the food revealed the food items were cold to taste, the milk was luke warm, and food items were not palatable.</p> <p>Interview on 05/28/24 at 1:25 P.M. with AMHS #401 confirmed the food and milk temperatures from the test tray where not at an appropriate level to serve.</p> <p>Interview on 05/28/24 at 2:46 P.M. with Resident #69 confirmed she did not eat much of her lunch today because it was cold. Resident #69 reported she did not ask for anything else and that staff did not ask her if she wanted something else.</p> <p>Interview on 05/28/24 at 2:49 P.M. with Resident #113 confirmed the food was cold at lunch today and he did not eat much. Resident #113 stated he received his food tray last during meals and it was always cold.</p> <p>Review of the undated food and nutrition services policy revealed each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.</p> <p>(continued on next page)</p>		

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F 0804  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	This deficiency represents non-compliance investigated under Master Complaint Number OH00154225.