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	01/06/2025

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** 39702 Based on medical record review, staff interviews and policy review, the facility failed to notify a resident representative of change in health care status. This affected one (#137) of three residents reviewed for change in condition. The facility census was 35. Findings include: Medical record review for Resident #137 revealed an admission on [DATE] and a discharge on [DATE] to hospital. Resident #137 expired on [DATE] under hospice care. Diagnoses including acute diastolic (congestive) heart failure, venous insufficiency (chronic) (peripheral), vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #137 revealed an impaired cognition. Resident #137 required supervision for eating and total staff dependence for bed mobility, transfers and toileting. Review of the plan of care for Resident #137 revealed the resident exhibits behaviors including refusing care, showers, turning and repositioning, medications and wound care. Interventions include encourage family involvement, approach in a friendly manner, maintain a safe environment, and positive feedback for good behavior. Review of the physicians orders for Resident #137 revealed an order dated [DATE] for STAT (urgent) complete blood count (CBC) with differentials, complete metabolic profile (CMP) and an ammonia level for one time only for change in condition, an order for stat chest x-rays one time only for increased confusion dated [DATE]. Review of the progress notes for Resident #137 dated [DATE] at 3:50 P.M. revealed the resident noted to have increased confusion stating he is seeing things that he knows are not there. Vital signs were obtained, and nurse practitioner was notified on changes regarding hallucinations, increased confusion and refusing to eat breakfast and lunch. Further record review revealed there was no documentation Resident #137's representative was notified of the residents change of condition or new orders. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note for Resident #137 dated [DATE] at 4:32 P.M. revealed nurse practitioner was made aware of changes in condition, confusion, hallucinations, and vital signs. New orders received for stat CBC with differentials, CMP, ammonia levels, an electromagnetic radiation (X-ray) of the chest and a urinalysis with culture and sensitivity. Further record review revealed there was no documentation Resident #137's representative was notified of the residents change of condition or new orders. Review of the progress notes for Resident #137 dated [DATE] at 8:00 A.M. revealed nursing staff was alerted that the resident did not look good. Pulse oximeter was 82 percent on room air. Resident #137 blood pressure was ,d+[DATE]. Head of bed was elevated and oxygen initiated. Oxygen saturation levels increase to 90 percent only to fall again. A rebreather mask was applied with oxygen saturation rate increasing to 96 percent. Nurse practitioner was notified with orders to call 911. Family was notified of change in condition at 8:08 A.M. and Resident #137 was transferred to the hospital at 8:20 A.M. Interview on [DATE] at 1:20 P.M. with the Assistant Director of Nursing (ADON) verified the family should have been notified when the change in condition occurred on [DATE] and was not. ADON verified the documentation was silent for family notification until transfer to the hospital on [DATE]. Review of the facility policy titled Change in Condition/Physician Notification, dated [DATE] revealed the nurse will notify the physician and the resident/representative when a significant change in the resident's physical, mental, or psychosocial status occurs. This deficiency represents non-compliance investigated under Complaint Number OH00160511.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, staff interview and policy review, the facility failed to ensure care conferences were completed as required. This affected one (#137) of three residents reviewed for care conferences. The facility census was 135. Findings included Medical record review for Resident #137 revealed an admission on 12/20/22 and a discharge on 11/03/24. Diagnoses including acute diastolic (congestive) heart failure, venous insufficiency (chronic) (peripheral), vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #137 revealed an impaired cognition. Resident #137 required supervision for eating and total staff dependence for bed mobility, transfers and toileting. Review of the plan of care for Resident #137 revealed the resident exhibits behaviors including refusing care, showers, turning and repositioning, medications and wound care. Interventions include encourage family involvement, approach in a friendly manner, maintain a safe environment, and positive feedback for good behavior. Review of Resident #137's progress notes dated 02/21/24 to 12/31/24 revealed only one care conference meeting between facility staff and resident which was held on 02/21/24. Interview on 12/31/24 with the Director of Nursing (DON) verified the medical record was silent for any care conference since 02/21/24 for Resident #137. The DON verified the residents should have had a care conference quarterly and aligning with the completion of the MDS assessment. Review of the facility policy titled Care Conference dated 12/12/23, stated care conferences will be scheduled to include the resident, resident representative and interdisciplinary team as soon as possible after admission, routinely and with a change in condition. Additionally the facility will provide the resident and resident representative advance notice of care conferences. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 39702 Based on medical record review, staff interview and policy review, the facility failed to follow physicians' orders for medication administration with blood pressure parameters which resulted in significant medication errors. This affected one (#37) of three residents reviewed for medication administration. The facility census was 135. Finding include: Medical record review for Resident #37 revealed an admission on 11/15/24 with diagnoses including but not limited to chronic respiratory failure, hypotension, hypertension and dependence of respirator with tracheostomy status. Review of the Minimum Data Set (MDS) assessment for Resident #37 revealed an intact cognition. Resident #37 required staff assistance for toileting, bed mobility and eating. Transfers not attempted for safety reasons. Review of the plan of care for Resident #37 revealed resident is at risk for impaired cardiac output related to diagnosis of hypertension and hypotension. Interventions include vital signs as ordered, observe for cardiac dysfunction, and administer medications as ordered. Review of the active physician orders for Resident #37 revealed an order for Midodrine oral tablet 5 milligrams giver one tablet by mouth three times a day for hypotension hold for systolic blood pressure over 120. Review of the medication administration record for Resident #37 for the month of December 2024 revealed a blood pressure recording of 121/55 on 12/01/24, a blood pressure of 125/66 on 12/10/24, a blood pressure of 149/79 on 12/14/24, a blood pressure of 125/80 on 12/15/24, a blood pressure of 127/69 on 12/20/24, a blood pressure reading on 12/20/24 of 128/66, a blood pressure of 149/83 on 12/24/24, a blood pressure of 132/78 on 12/28/24, a blood pressure of 124/77 on 12/29/24 with documentation of Resident #37's Midodrine being administered by nurse. Interview on 12/30/24 at 3:00 P.M. with Director of Nursing (DON) verified the documentation for Resident #37 revealed medication (Midodrine) was signed for as administered on days when documented blood pressure was out of the ordered parameters and should have been held. The DON confirmed Resident #37's Midodrine is order to increase the residents blood pressure. Review of the facility policy titled Medication Administration dated 01/02/24 revealed obtain and record vital signs, when applicable or per physicians order when applicable hold the medication for those vital signs outside of the physicians prescribed parameters. This deficiency represents non-compliance investigated under Complaint Numbers OH00160511 and OH00161077.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, observation, staff interview and policy review, the facility failed to implement their infection control policy during medication administration. This affected one (#114) of three residents observed for medication administration. The facility census was 135. Findings include Review of the medical record for Resident #114 revealed an admission on 08/07/24. Diagnoses include Coronavirus Disease 2019 (COVID-19), infection following surgical procedure, type two diabetes mellitus, depression and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #114 was cognitively intact. Resident #114 required staff assistance for completion of toileting, transfers, and bed mobility tasks. Review of the active physician orders for Resident #114 for the month of December 2024 revealed and order for cholecalciferol tablet 1000 units one tablet one time a day dated 11/13/24, ferrous sulfate tablet 325 milligrams (mg) one tablet daily dated 10/27/24, famotidine tablet 20 mg one tablet daily dated 10/05/24, multivitamin one tablet by mouth daily dated 10/10/24, multivitamin with minerals one tablet by mouth daily dated 11/14/24, transdermal scop 1.5 mg transdermal patch apply one patch transdermally one time a day every three days dated 10/05/24, duloxetine capsule 60 mg give one tablet daily dated 10/05/24, sitagliptin phosphate 100 mg one tablet daily dated 10/05/24, Jardiance 25 mg tablet give one tablet daily dated 10/05/24, and oxybutynin chloride extended release 10 mg give one tablet daily dated 11/15/24. Observation on 12/31/24 at 10:52 A.M. of Licensed Practical Nurse (LPN) #129 administering medications to Resident #114 revealed LPN #129 dropped one pill onto the floor, picked the pill up and handed it to Resident #114 for administration. Resident #114 accepted the medication and put it into her mouth and swallowed it. Interview on 12/31/24 at 10:57 A.M. with LPN #129 verified she dropped one pill (duloxetine) onto the residents' floor, picked it up and administered it to Resident #114. Interview on 12/31/23 at 11:27 A.M. with Director of Nursing (DON) verified the nurse should not have administered the medication that was dropped onto the floor. The DON verified the medication should have be destroyed and a replacement tablet offered to the resident. Review of the facility policy titled Medication Administration dated 01/02/24, revealed medication will be administered in accordance with professional standards of practice and in a manner to prevent contamination or infection. This deficiency is based on incidental findings discovered during the course of this complaint investigation.