

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 02/04/2025
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 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44076</p> <p>Based on observation, medical record review, resident and staff interview, and policy review, the facility failed to ensure a resident with a colostomy was provided appropriate and adequate care. This affected one (#10) of three residents reviewed for ostomies. The census was 128.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #10 revealed a most recent admitted [DATE]. Diagnoses included malignant carcinoid of the stomach, severe protein calorie malnutrition, chronic obstructive pulmonary disease (COPD), and colostomy.</p> <p>Review of Resident #10's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed with intact cognition, required set up for eating, and was dependent for toileting hygiene and transfers.</p> <p>Review of a physician order for Resident #10 dated 01/05/23 revealed colostomy care orders to clean the colostomy with soap and water, pat dry, apply skin prep around the stoma site, and apply the pouch every shift. Further review of the physician order revealed for staff to change the pouch when it was one-third to one-half full and as needed.</p> <p>Review of a care plan dated 03/15/23 revealed Resident #10 had an alteration in gastro-intestinal status related to colostomy with an intervention to provide colostomy care as ordered and as needed.</p> <p>Review of a physician order dated 03/19/24 revealed Resident #10 was ordered Miralax (a laxative) 17 grams oral powder once daily by mouth for constipation.</p> <p>Review of a progress note dated 11/18/24 revealed Resident #10 was noted with a rash on the left side of his abdomen with a new order for a combination topical treatment of one part Mylanta and triad paste, mixed well, and applied to the rash every shift.</p> <p>Review of Resident #10's bowel elimination documentation between 01/06/25 and 02/04/25 revealed 18 days that were documented the resident had loose stool or diarrhea.</p> <p>Interview on 02/03/25 at 12:55 P.M. with Resident #10 revealed staff did not always replace his colostomy timely when it leaked and it caused a rash.</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
---	-------	-----------

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 02/04/2025
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 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and observation on 02/03/25 at 2:46 P.M. with Licensed Practical Nurse (LPN) #17 revealed she had a concern the night shift did not always empty Resident #10's colostomy pouch timely, and stated the pouch leaked once or twice a week. Observation of the resident's colostomy appliance revealed liquid stool was contained in the bag. Further observation revealed an approximately five millimeter (mm) circular raised area under the left side of the stoma covering an approximately one inch linear area. There was another patch of similar-looking raised circular areas on the resident's left side covering an approximate five inch long by three inch wide area. LPN #17 confirmed Resident #10's rash and stated the rash had shown improvement since her last observation.</p> <p>Interview on 02/03/25 at 3:25 P.M. with Certified Nurse Aide (CNA) #20 revealed she gave Resident #10 a bath earlier in the day, acknowledged the resident had a rash, and indicated it was not a new finding. CNA #20 stated Resident #10's colostomy bag leaked often and he would frequently need cleaned when she arrived at the facility.</p> <p>Interview and observation on 02/04/25 at 8:33 A.M. with the Director of Nursing (DON) revealed Resident #10 was lying in bed on his back and pulled back his bed covers to reveal his colostomy appliance. The colostomy bag was approximately one quarter full of liquid stool with no leaking observed. Continued observation revealed Resident #10 rolled to his right side to show a bath towel was placed under him and was saturated in a brown liquid. The DON acknowledged a towel should not be placed under a resident, and added she would expect to see a Chux pad (absorbent pad) used. The DON stated one side of Resident #10's colostomy stoma was almost flush with his abdomen which caused an issue with a proper fit for the appliance.</p> <p>Interview on 02/04/25 at 8:53 A.M. with Wound Nurse (WN) #22 revealed she was aware Resident #10 had a rash and stated it was caused by the gastric juices which would come into contact with his skin. WN #22 stated he has had the rash in the past, but it resolved and had just been informed it had reappeared the previous night.</p> <p>Observation of Resident #10 with WN #22 on 02/04/25 at 11:50 A.M. revealed the resident had just returned from an appointment and was seated in his wheelchair. WN #22 pulled back the resident's gown and asked him to shift to his right side in order to reveal the rash on his left side. As Resident #10 shifted in the seat, the colostomy came loose and liquid stool poured out. WN #22 used a towel to absorb the liquid and then removed the appliance in preparation of replacing it. As she did, she indicated the hole cut into the old wafer (piece of the pouching system which provides a skin barrier and sticks to the body) was cut too big. WN #22 also noted paste was used to secure the wafer and she explained the paste was not needed as the wafer adhesive was heat activated. WN #22 stated the nurse that worked the previous evening was Resident #10's usual nurse.</p> <p>Interview on 02/04/25 at 12:40 P.M. with LPN #26 revealed Resident #10's colostomy leaking was an ongoing issue and she had to change the appliance every day or two. LPN #26 acknowledged the resident had a rash for months which would come and go, and WN #22 had been aware of it.</p> <p>Interview on 02/04/25 at 3:12 P.M. with the DON verified there was no documentation of a rash on Resident #10's admission skin assessment and confirmed the first documentation of the rash in the resident's medical record was 11/18/24. The DON acknowledged, despite her own conversations with staff regarding the rash, and the confirmations that the rash came and went, there was no further documentation of it. The DON stated a different appliance may be beneficial for Resident #10 to prevent leaking.</p> <p>(continued on next page)</p>		

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 02/04/2025
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 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Ostomy Care, dated 01/02/24, revealed the surrounding skin of the ostomy will be monitored for excoriation, abrasion, and breakdown. Changes with the pouching system will be made as appropriate, and for ongoing pouching problems appropriate referrals such as ostomy nurses would be made.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161868.</p>		