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	05/01/2026

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 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** Based on record review, staff interview, review of self-reported incident (SRI), and facility policy review, the facility failed to ensure residents were free from verbal abuse. This affected one, (Resident #152) out of three (Residents #07, #45, #152) reviewed for abuse. The facility census was 128. Findings include:Medical record review for Resident #152 revealed she was admitted to the facility on [DATE] and discharged from the facilityto home on [DATE]. Her diagnoses included nontraumatic intracranial hemorrhage, dysphagia, lymphoid leukemia, anxiety disorder, Chronic Obstructive Pulmonary Disease (COPD), essential primary hypertension, and insomnia.Review of the Minimum Data Set (MDS) assessment for Resident #152, dated 02/26/25, revealed she was cognitively intact. Resident #152 was dependent on staff for medication administration. Resident #152 required set up assistance from staff with eating, oral hygiene, toilet use, bathing, lower body dressing, putting on shoes and oral hygiene.Review of the assessment titled, Safe Smoking Review, for Resident #152, dated 12/15/25, and signed 12/21/25 revealed Resident #152 was marked as a safe smoker. A second Safe Smoking Review, dated 01/30/26, revealed Resident #152 was determined to be a safe smoker and followed the smoking policy.Review of the smoking care plan for Resident #152, date initiated 02/07/25 through review date 03/06/26 revealed Resident #152 was a smoker. The goal was to adhere to the smoking policy daily. The interventions listed were as followed: complete smoking assessment quarterly and as needed, instruct resident about smoking risk, instruct resident about the facility smoking policy, notify the nurse immediately if you suspect the resident has violated the smoking policy, observed Resident's clothing and skin for any cigarette burns, smoking material is to be kept with the Resident.Review of the progress notes for Resident #152 dated 12/16/25 at 1:07 P.M., authored by the former Director of Nursing (DON) #506, revealed Resident #152 was smoking outside the designated smoking area and was now identified as a supervised smoker. On 12/24/25 at 2:30 P.M. a note authored by the Social Service Director (SSD) #204 revealed a psychosocial note was completed for Resident #152 to follow up on the incident that occurred on 12/23/25 when Resident #152 reported DON #506 yelled at embarrassed Resident #152 in the smoking area. Resident #152 appeared stable with no signs of distress.Review of the facility Self- Reported Incident (SRI) #269011, dated 12/23/25 at 7:23 P.M., revealed a discovery date of 12/23/25 of an allegation of emotional/verbal abuse from the former Director of Nursing (DON)#506 and Resident #152. On 12/23/25 at 12:15 P.M. Resident #152 alleged DON #506 was verbally aggressive toward her while in the hallway. Resident #152 revealed she was outside in the designated smoking area and she was approached by DON #506. DON #506 began to yell at Resident #152 stating Resident #152 was supposed to be supervised smoker. The DON followed Resident #152 to Resident #152's hallway and continued telling Resident #152 she was not permitted to smoke without supervision. The DON advised the nurse on duty (Licensed Practical Nurse (LPN) # 254) that Resident #152 is a supervised smoker and continued to smoke in the nonsmoking areas. Resident #152 was upset and embarrassed by the action of DON #506. DON #506 denied any intent for harm or disrespect. DON #506 revealed her goal was to keep Resident #152 safe. The facility completed an investigation of the alleged incident (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	between DON #506 and Resident #152. The facility substantiated the allegation of verbal/emotional abuse.Interview with LPN #254 on 04/30/26 at 10:46 A.M. revealed she was Resident #152's nurse on 12/23/25 in the afternoon. LPN #254 stated she was at the nurse's station and observed the former DON walking behind Resident #152 and yelling at Resident #152 in an aggressive loud voice. The DON yelled LPN #254's name down the hall and loudly told LPN #254 that Resident #152 was a supervised smoker and cannot be outside smoking unsupervised. Resident #152 was crying in the hallway and the DON #506 stormed off. LPN #254 stated she told Resident #152 she would get a concern form for her to fill out. As LPN #254 walked toward Resident #152, DON #506 returned and yelled down the hall to LPN #254 that Resident #152 was not permitted to have her cigarettes and lighter. LPN #254 heard DON #506 tell Resident #152 not to make DON #506 out to be the bad guy because she has to take her cigarettes. LPN #254 stated Resident #152 told her she did not know she was a supervised smoker. LPN #254 stated she (herself) was not aware that Resident #152 was a supervised smoker. LPN #254 revealed both herself and Resident #152 were very shaken up about the actions of DON #506. LPN #254 revealed she thought DON #506 was verbally and emotionally abusive toward Resident #152.Interview on 04/20/26 at 11:09 A.M. with Minimum Data Set (MDS) RN #206 revealed he was at the clinical meeting on 12/23/25 from 10:30 A.M. until close to noon. MDS #206 reported he observed Resident #152 smoking close to the door and not in the smoking area. MDS #206 reported he observed former DON #506 yell out the door to Resident #152 that she could not smoke by the door. Approximately twenty minutes later MDS #206 reported he observedformer DON #506 shouting at Resident #152 she was not to be smoking by the facility door. MDS #206 reported he felt former DON #506 was very inappropriate for yelling at Resident #152 in front of staff and other residents who were in the smoking area.Interview on 04/30/26 at 11:15 P.M. interview with the Social Service Director (SSD) #204 revealed on 12/23/25 at around 10:00 A.M. (from the clinical meeting) she observed Resident #152 in the smoking area. SSD #204 observed former DON #506 shout at Resident #152 and tell her that she is a supervised smoker. Former DON #506 threatened to take Resident #152's cigerettes. She observed former DON #506 leave the meeting to go Resident #152's nurse. SSD #204 revealed she followed up with Resident #152 on 12/24/25 for a psycho-social visit and Resident #152 reported she was embarrassed by former DON #506 action when she yelled at Resident #152 across the courtyard. SSD #152 reported the behavior of former DON #506 toward Resident #152 was inappropriate. Interview on 04/20/26 at 11:27 A.M. with the Assistant Director of Nursing (ADON) #207 revealed on 12/23/25 around 10:30 A.M. she was in the clinical meeting and observed Resident #152 smoking outside unsupervised and was supposed to be a supervised smoker. ADON #207 observed former DON #506 open the door and yelled at Resident #152 that she was a supervised smoker. ADON #207 revealed former DON #506 threatened to take Resident #152's smoking items. ADON #207 revealed former DON #506 sat down and then got back up and yelled again at Resident #152. ADON#207 revealed she felt former DON #506 belittled Resident #152. ADON #207 revealed former DON #506 was in appropriate when she yelled at Resident #152 in front of other residents and the tone former DON #506 used toward Resident #127. ADON #207 reported the meeting ended and she did not see what happened after the smoking incident.Interview on 04/30/26 at 12:07 P.M. interview with Unit Manager (UM) #261 revealed she was at the clinical meeting on 12/23/25 between 10:00 A.M. and 12:00 Noon. UM #261 observed Resident #152 outside smoking. UM #261 observed former DON #506 open the door and scolded Resident #152 like a child. UM #261 observed former DON #506 threaten to take Resident #152's smoking privileges. UM #261 stated former DON #506's tone toward Resident #152 was degrading and it was done in front of other Residents. UM #261 revealed about twenty minutes later she observed former DON #506 scold Resident #152 for a second time at the nurse's station. The former DON was yelling at Resident #152. UM #261 stated she observed Resident #152 cry. UM #261 observed Resident #152 tell the former DON she cannot treat Resident #152 like a child and Resident #152 stated she was embarrassed.Interview on 04/30/26 at 12:19 P.M. with former DON #506 confirmed she attended a meeting on 12/23/25. Former DON #506 denied any incident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occurred during the clinical meeting. The former DON stated she was seated in the conference room and observed Resident #152 who was a supervised smoker smoking outside unsupervised. Former DON #506 stated she waived Resident #152 toward her. Former DON #506 revealed Resident #152 had been told several times she was a supervised smoker. Former DON #506 told Resident #152 that she had to be a supervised smoker. Former DON #506 stated Resident #152 told her she had just lost her mother and began to cry. The former DON confirmed she told LPN #254 that Resident #152 had to provide LPN #254 with her cigarettes because Resident #152 is a supervised smoker. Former DON #506 denied yelling at Resident #152 in front of other Residents. Former DON #506 denied yelling or belittling Resident #152 in the hallway at the nurse's station.Interview with the Administrator on 04/30/26 at 10:40 A.M. confirmed the former DON and herself observed Resident #152 smoking out-front of the facility a few days prior to the incident on 12/23/25 and Resident #152 became a supervised smoker. The Administrator revealed the smoking assessments, care plans, and documentation would be nursing's responsibility not hers (the Administrator). The Administrator was not able to say why Resident #152 was never assessed as a supervised smoker or how Resident #152 was permitted to keep her cigarettes and lighter for the incident that occurred on 12/23/25.Subsequent interview with the Administrator on 05/01/26 at 11:59 P.M. confirmed former DON #506 was suspended pending the investigation from the incident on 12/23/25. The facility had determined the incident between former DON #506 and Resident #152 was staff to resident verbal abuse. The Administrator revealed the facility had planned to terminate former DON #506's employment immediately, however, former DON #506 quit and the notice was accepted. Review of the former DON #506 employee file revealed she was hired at the facility on 09/08/25. Review of former DON #506's termination paperwork revealed, former DON #506 was suspended pending investigation on 12/23/25, for a resident abuse allegation. The matter was treated as a Self Reported Incident (SRI). Upon investigation, the matter was substantiated. Subsequently a determination was made to end the employment relationship related to facility policy. Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation, dated 07/01/25 confirmed the residents at the facility have the right to be free from abuse, mistreatment, neglect, exploitation, and misappropriation. In the case of care team member to resident abuse, neglect, mistreatment, or misappropriation of resident property, the facility will follow the facility's procedure for disciplining or dismissing a care team member. The facility will report results of the investigation to the appropriate licensing agencies and registries (e.g. Board of Nursing, nurse aide registry).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to ensure safe resident smoking. This affected two Residents (#103, #152) out three Residents (#57, #103, #152) reviewed for smoking. The facility identified 22 Residents (#01, #07, #08, #11, #15, #25, #30, #38, #40, #43,#45,#48, #53, #55,#57, #67, #68, #72, #79, #91, #101, #112) who are smokers at the facility. The facility census was 128. Findings Include:1.Medical record review for Resident #103 revealed he was admitted to the facility on [DATE]. Resident #103 did reside on the memory care secured unit from 07/02/25 until he was moved off the memory care unit effective 10/12/25. His diagnoses include chronic obstructive pulmonary disease (COPD), emphysema, atherosclerotic heart disease, hyperlipidemia, insomnia, anxiety disorder, and vascular dementia. Resident #103 required a court appointed guardian to oversee his care. Review of the Minimum Data Set (MDS) assessment for Resident #103, dated 04/02/26, revealed he had moderately impaired cognition. Resident #103 was dependent on staff for medication administration. He was required set-up assistance from staff with eating. He required supervision from staff with oral hygiene, toilet use, upper body dressing, lower body dressing, putting on shoes, and personal hygiene. Resident #103 required moderate assistance from staff with bathing.Review of the most recent smoking evaluation for Resident #103 titled, Safe Smoking Review, dated 04/04/36, revealed Resident #103 was able to self-smoke safely. Review of the progress notes for Resident #103 revealed nothing documented about the findings from 04/30/26.Observation on 04/30/26 at 1:08 P.M. of Resident #103 in his bed with a beside table over the bed and it was covered with loose tobacco. A large cigar box was observed on the tabletop full of rolled cigarettes and cigarette papers scattered all around. A paper coffee cup was on the bedside table along with the lid to the paper cup. The lid to the paper coffee cup contained 10 cigarette butts.Interview on 05/01/26 at 1:08 P.M. with Resident #103 revealed he rolls his own cigarettes. Resident #103 revealed he does not smoke cigarettes in his room instead he brings them in from the smoking area.Interview on 04/30/26 at 4:02 P.M. with the Administrator as she walked toward Resident #103's room revealed she was surprised to hear that Resident #103 rolled his own cigarettes. The Administrator stated Resident #103 recently moved from the secured memory care unit onto his current non secured unit. The Administrator revealed Resident #103 was on the memory care unit related to his poor judgement and desire to elope.Interview on 04/30/26 with the Administrator and Resident #103 in his room revealed the Administrator questioned Resident #103 on where he got his cigarettes from. Resident #103 explained he rolls his own cigarettes. The Administrator questioned if Resident #103 got the items to roll his cigarettes from his nephew. Resident #103 denied getting them from his nephew. Resident #103 explained the reason he had the cigarette butts in the plastic coffee cup lid in his room was because he smokes the cigarettes and placed the butts in his pocket. Resident #103 explained he brings them to his room and will put them in his plastic trash can with a plastic liner. As the Administrator walked out of Resident #103 ?s room she revealed she had no words for what was observed in Resident #103's room.Interview with the Administrator on 05/01/26 at 11:57 A.M. confirmed Resident #103 required a guardian for his care. The Administrator confirmed the facility had failed to document the observation of smoked cigarette butts and smoking items she observed on 04/30/26 at 4:02 P.M. in Resident #103's room. The Administrator confirmed the facility did not reassess Resident #103 following the findings in Resident #103's room. The Administrator confirmed the care plan for Resident #103 stated the staff will keep Resident #103's cigarettes.Review of the smoking care plan for Resident #103, initiated 06/19/25, with a goal to comply with the facility smoking policy revised on 03/27/26 revealed the smoking interventions included, complete smoking assessments quarterly and as needed, instruct Resident #103 about smoking hazards, instruct Resident #103 about the smoking policy including smoking (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	designated areas, times, and safety concerns, notify the nurse immediately if suspected that Resident #103 had violated the facility smoking policy, and smoking material are to be kept with the nursing staff.2. Medical record review for Resident #152 revealed she was admitted the facility on 02/06/25 and discharged from the facility on 02/26/26. Her diagnoses included, nontraumatic intracranial hemorrhage, dysphagia, lymphoid leukemia, anxiety disorder, COPD, essential primary hypertension, and insomnia.Review of the MDS assessment for Resident #152, dated 02/26/25, revealed she was cognitively intact. Resident #152 was dependent on staff for medication administration. Resident #152 required set up assistance from staff with eating, oral hygiene, toilet use, bathing, lower body dressing, putting on shoes and oral hygiene.Review of the assessment titled, Safe Smoking Review, for Resident #152 dated 01/30/26, revealed Resident #152 was determined to be a safe smoker and followed the smoking policy.Review of the progress notes for Resident #152 dated 12/16/25 at 1:07 P.M., authored by the former Director of Nursing (DON) #506, revealed Resident #152 was smoking outside the designated smoking area and was now identified as a supervised smoker. On 12/24/25 at 2:30 P.M. a note authored by the Social Service Director (SSD) #204 revealed a psychosocial note was completed for Resident #152 to follow up on the incident that occurred on 12/23/25 when Resident #152 reported former DON #506 yelled at embarrassed Resident #152 in the smoking area. Resident #152 appeared stable with no signs of distress.Review of the smoking care plan for Resident #152 initiated on 02/07/25 through review date 03/0726 revealed Resident #152 was an independent smoker. The goal was listed to comply with the facility smoking policy. The interventions included the following: complete smoking assessments quarterly or as needed, instruct Resident about smoking hazards, instruct resident about the smoking policy, notify the nurse immediately if suspected violation of the smoking policy, smoking material to be kept with the resident. Interview with the Administrator on 04/30/26 at 10:40 A.M. confirmed the former DON and herself observed Resident #152 smoking out-front of the facility a few days prior to the incident on 12/23/25 and Resident #152 became a supervised smoker. The Administrator revealed the smoking assessments, care plans, and documentation would be nursing's responsibility not hers (the Administrator). The Administrator was not able to say why Resident #152 was never assessed as a supervised smoker or how Resident #152 was permitted to keep her cigarettes and lighter for the incident that occurred on 12/23/25.Review of the facility smoking policy titled, Smoking, dated 02/14/25, confirmed the purpose of the facility policy was to establish a safe environment for Residents to smoke in a designated area. Residents that meet the criteria to smoke independently will be allowed to do so within the guidelines. Smoking is only permitted in designated smoking areas. The smoking areas must provide suitable noncombustible ashtrays. The smoking area must be provided with metal containers equipped with self-closing covers for the disposal of cigarette butts and ashes. Violation of the smoking policy creates a potential risk to Resident's health and safety. Residents who are found to be non-compliant with this policy (i.e. smoking in enclosed areas or non-designated smoking areas) are considered a safety risk to all. An immediate meeting will occur with the Resident to discuss options up to and including discharge from the facility for safety reasons.Because of the risk to resident health and safety, if the facility observes or has evidence of the violation of the smoking policy, the facility will evaluate the need for appropriate level of supervision, evaluate the need to restrict smoking privileges or issue a discharge notice.