STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365396	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Fairfield LLC	5200 Camelot Drive Fairfield, OH 45014

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35035 Based on staff interview and review of resident fund account documents, the facility failed to ensure timely conveyance of resident funds following discharge. This affected one (#3) of three residents reviewed for funds post discharge. The facility census was 144. Findings include: Review of Resident #3's medical record revealed an admitted [DATE]. Resident #3 passed away, in the facility, on [DATE]. Diagnoses included multiple sclerosis, pulmonary disease and chronic pain syndrome. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition and was a two-person assist for Activities of Daily (ADL). Review of resident fund documents revealed on [DATE], Resident #03 had an account balance of $150.97. On the same date, the Social Security Administration (SSA) made a deposit of $1160.00 into the resident's account, for a total account balance of $1310.97. Further review revealed on [DATE] the account was closed and the total of $1310.97 was debited from the account, with the payee noted to be Resident #3 himself. Also, on [DATE], the SSA withdrew its payment of $1160.00 back from the resident's account, leaving a negative balance of $1159.77 (minus $0.23 in interest from [DATE]). Interview on [DATE] at 11:50 A.M. with the Administrator revealed after Resident #3's death on [DATE], the SSA deposited the [DATE] payment into the resident's account. The SSA rescinded the payment and debited $1160.00 from Resident #3's account, leaving a negative balance. The Administrator verified there was no evidence on [DATE] of a check being paid to the estate of Resident #3 for the $1310.97, as was indicated on the account statement. The Administrator confirmed once the SSA rescinded the [DATE] payment of $1160.00, Resident #3's account balance should have been $150.97 and payment should have been sent to resident's estate within 30 days of his passing. The Administrator verified there was no evidence Resident #3's remaining account balance was sent to the resident's estate. This deficiency represents non-compliance investigated under Complaint Number OH00153805.

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: 365396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Majestic Care of Fairfield LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 Camelot Drive Fairfield, OH 45014	

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35035 Based on medical record review, review of a facility Self-Reported Incident (SRI), review of a local police report, staff interview, review of the county on-line court docket and review of facility policy, the facility failed ensure residents were free from misappropriation. This affected one resident (#1) of five residents reviewed for misappropriation. The facility census was 144. Findings include: Review of Resident #1's medical record revealed an admitted [DATE]. The resident discharged on [DATE]. Diagnoses included hemiplegia, chronic respiratory failure, muscle weakness and dystonia. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition and was a one-person assist for Activities of Daily (ADL). Review of the facility SRI #240101, initiated 10/12/23 and completed on 10/17/24, revealed on 10/12/23, the facility was notified by Resident #1 and her family that the resident was missing a check from her checkbook. Per the SRI, all staff and like residents were interviewed regarding the incident and the local law enforcement was conducting an investigation into the incident. The SRI did not indicated a name for the Specified Perpetrator (SP). On 10/17/23, the facility determined there was no conclusive evidence of misappropriation and the allegation was unsubstantiated. Review of the facility's investigation revealed all staff who cared for Resident #1 during the time of the incident were interviewed and all denied any knowledge of the incident. The resident's roommate was interviewed and denied any knowledge of the misappropriation. Per the investigation all staff were re-educated on the misappropriation policy. Review of the police investigation narrative report, dated 10/19/23, revealed between 10/06/23 at 6:00 P.M. and 10/12/23 at 8:00 A.M., Resident #1 stated an unknown person took one of her checks from her checkbook, filled the check out for $325.00 and cashed it. Resident #1 discovered this after she received a copy of the canceled check from her bank. On 10/17/23 at 10:00 A.M., Police Detective (PD) #520 responded to the bank and spoke with an unknown clerk. PD #520 was informed SP #500 deposited the check into her own account. PD #520 attempted to contact SP #500, via telephone and at her home, but was unsuccessful. PD #520 contacted the facility and spoke with a manager to see if the facility knew SP #500. Per the report, the unknown manager told him SP #500 worked at the facility cleaning rooms. SP #500 was not working at the time PD #520 called. PD #520 asked to be notified the next time SP #500 worked and was told by the manager this would have to be looked up. PD #520 told the manager SP #500 was only a suspect and no charges had been filed at that time. Further review of the report revealed on 10/19/23 at 5:00 P.M., PD #520 received a voicemail from an unknown supervisor at the facility to advise him SP #500 had been suspended from work until the investigation was completed. Review of the facility's addendum to SRI #240101, dated 05/31/24, revealed the local police determined a facility contracted worker, SP #500, cashed Resident #1's check and charges were filed against the former employee. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Majestic Care of Fairfield LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5200 Camelot Drive Fairfield, OH 45014	

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/03/24 at 3:00 P.M. with the Director of Nursing (DON) revealed SP #500 was identified to the DON after charges had been filed, on or around 04/26/24. The DON stated SP #500 had been a contracted housekeeper at the facility and had not worked since the stolen check was cashed on 10/06/23. The DON stated the resident and her family reported the suspected misappropriation to the facility on [DATE] and stated Resident #1 did not report who the staff member was who stole the check. The DON stated all staff who worked in the facility during the time of the missing check were interviewed but confirmed SP #500 was not interviewed because the facility did not know her identify during their investigation. The DON stated to prevent any further misappropriation, all residents were provided lockboxes and all staff were educated on the misappropriation policy. Interview on 06/24/24 at 9:30 A.M. with the Administrator revealed he was unaware of PD #520 speaking with anyone at the facility and identifying SP #500 as a suspect in the misappropriation involving Resident #1 during the course of the facility's investigation from 10/12/23 through 10/17/23. As a result, the facility unsubstantiated the allegation of misappropriation. The Administrator could not recall the actual date he was notified of SP #500 being a suspect, but stated it was after the facility had closed their investigation on 10/17/23. The Administrator stated when he did speak with the police, it was reported SP #500 was wanted for questioning and had not been formally charged. The Administrator confirmed SP #500 stole a check from Resident #1 and cashed it in the amount of $325.00. The Administrator stated the bank reimbursed Resident #1 the funds that were withdrawn from her bank account. While the facility re-educated staff on the facility's abuse police and offered lockboxes to residents for their belongings, the Administrator confirmed the facility implemented no further action to ensure residents were free from misappropriation, such as conducting audits and involving the facility's Quality Assurance and Performance Improvement (QAPI) committee to ensure on-going compliance. Interview on 06/24/24 at 11:30 A.M. with Assistant Director of Nursing (ADON) #250 revealed she was interviewed during the SRI investigation and confirmed staff were re-educated on the facility's misappropriation policy. ADON #250 stated the identity of SP #500 was not known during the facility's investigation into the incident. ADON #250 stated once the police reported to the facility the identity of SP #500, which was sometime after 10/17/23, SP #500 was considered suspended and her employing agency was notified she was not to return to the facility. ADON #250 could not recall the actual date SP #500 was suspended, but stated it was after the facility was made aware of her identity. Review of the [NAME] County, Ohio on-line court docket confirmed, on 06/06/24, SP #500 pleaded guilty to petty theft, amended from a felony charge of theft from an elderly person or disabled adult. Review of the facility policy titled Abuse Prevention, revised March 2021, revealed residents had the right to be free from abuse, including misappropriation of resident's property. Further review revealed misappropriation was defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. This deficiency represents non-compliance investigated under Master Complaint Number OH00154308.

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Majestic Care of Fairfield LLC	5200 Camelot Drive Fairfield, OH 45014

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35035 Based on medical record review, review of a facility Self-Reported Incident (SRI), review of the facility investigation, review of a local police report, staff interview, review of the county on-line court docket and review of facility policy, the facility failed to ensure an accurate and thorough investigation of misappropriation was completed. Furthermore, the facility failed to implement corrective actions to monitor and/or prevent further instances of resident misappropriation. This affected one resident (#1) of five residents reviewed for misappropriation. The facility census was 144. Findings include: Review of Resident #1's medical record revealed an admitted [DATE]. The resident discharged on [DATE]. Diagnoses included hemiplegia, chronic respiratory failure, muscle weakness and dystonia. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition and was a one-person assist for Activities of Daily (ADL). Review of the facility SRI #240101, initiated 10/12/23 and completed on 10/17/24, revealed on 10/12/23, the facility was notified by Resident #1 and her family that the resident was missing a check from her checkbook. Per the SRI, all staff and like residents were interviewed regarding the incident and the local law enforcement was conducting an investigation into the incident. The SRI did not indicated a name for the Specified Perpetrator (SP). On 10/17/23, the facility determined there was no conclusive evidence of misappropriation and the allegation was unsubstantiated. Review of the facility's investigation revealed all staff who cared for Resident #1 during the time of the incident were interviewed and all denied any knowledge of the incident. The resident's roommate was interviewed and denied any knowledge of the misappropriation. Per the investigation, all staff were re-educated on the misappropriation policy. Review of the police investigation narrative report, dated 10/19/23, revealed between 10/06/23 at 6:00 P.M. and 10/12/23 at 8:00 A.M., Resident #1 stated an unknown person took one of her checks from her checkbook, filled the check out for $325.00 and cashed it. Resident #1 discovered this after she received a copy of the canceled check from her bank. On 10/17/23 at 10:00 A.M., Police Detective (PD) #520 responded to the bank and spoke with an unknown clerk. PD #520 was informed SP #500 deposited the check into her own account. PD #520 attempted to contact SP #500, via telephone and at her home, but was unsuccessful. PD #520 contacted the facility and spoke with a manager to see if the facility knew SP #500. Per the report, the unknown manager told him SP #500 worked at the facility cleaning rooms. SP #500 was not working at the time PD #520 called. PD #520 asked to be notified the next time SP #500 worked and was told by the manager this would have to be looked up. PD #520 told the manager SP #500 was only a suspect and no charges had been filed at that time. Further review of the report revealed on 10/19/23 at 5:00 P.M., PD #520 received a voicemail from an unknown supervisor at the facility to advise him SP #500 had been suspended from work until the investigation was completed. Review of the facility's addendum to SRI #240101, dated 05/31/24, revealed the local police determined a facility contracted worker, SP #500, cashed Resident #1's check and charges were filed against the former employee. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/03/24 at 3:00 P.M. with the Director of Nursing (DON) revealed SP #500 was identified to the DON after charges had been filed, on or around 04/26/24. The DON stated SP #500 had been a contracted housekeeper at the facility and had not worked since the stolen check was cashed on 10/06/23. The DON stated the resident and her family reported the suspected misappropriation to the facility on [DATE] and stated Resident #1 did not report who the staff member was who stole the check. The DON stated all staff who worked in the facility during the time of the missing check were interviewed but confirmed SP #500 was not interviewed because the facility did not know her identify during their investigation. The DON stated to prevent any further misappropriation, all residents were provided lockboxes and all staff were educated on the misappropriation policy. Interview on 06/24/24 at 9:30 A.M. with the Administrator revealed he was unaware of PD #520 speaking with anyone at the facility and identifying SP #500 as a suspect in the misappropriation involving Resident #1 during the course of the facility's investigation from 10/12/23 through 10/17/23. As a result, the facility unsubstantiated the allegation of misappropriation. The Administrator could not recall the actual date he was notified of SP #500 being a suspect, but stated it was after the facility had closed their investigation on 10/17/23. The Administrator stated when he did speak with the police, it was reported SP #500 was wanted for questioning and had not been formally charged. The facility investigation was not updated to reflect SP #500 had been identified as a suspect in the misappropriation of Resident #1's funds. The Administrator confirmed no further action related to the investigation was taken once additional information was received, such as reopening the SRI once SP #500's identify was known, notifying the Ohio Department of Health (ODH) of SP #500's identity or substantiating the allegation of misappropriation. Additionally, the Administrator confirmed the facility did not conduct any audits or involve the facility's Quality Assurance and Performance Improvement (QAPI) committee to ensure on-going compliance. Interview on 06/24/24 at 11:30 A.M. with Assistant Director of Nursing (ADON) #250 revealed she was interviewed during the SRI investigation and confirmed staff were re-educated on the facility's misappropriation policy. ADON #250 stated the identity of SP #500 was not known during the facility's investigation into the incident. ADON #250 stated once the police reported to the facility the identity of SP #500, which was sometime after 10/17/23, SP #500 was considered suspended and her employing agency was notified she was not to return to the facility. ADON #250 could not recall the actual date SP #500 was suspended, but stated it was after the facility was made aware of her identity. Review of the [NAME] County, Ohio on-line court docket confirmed on 06/06/24 SP #500 pleaded guilty to petty theft, amended from a felony charge of theft from an elderly person or disabled adult. Review of the facility policy titled Abuse Prevention, revised March 2021, revealed misappropriation was defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. Further review revealed the facility had procedures in place to ensure a timely and thorough investigation of allegations of abuse, the reporting and filing of accurate documents relative to incidents of abuse, an on-going review and analysis of incidents of abuse, and implementation of changes to prevent future occurrences of abuse. This deficiency represents non-compliance investigated under Master Complaint Number OH00154308.