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	06/10/2026

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 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 medical record review, resident interview, staff interview, and facility policy review the facility failed to ensure residents followed safe smoking practices which included smoking in their rooms. This affected two Residents (#111 and #112) out of three Residents (#105, #111, and #112) reviewed for smoking. The facility identified the following seventeen Residents (#04, #06, #10, #14, #15, #24, #27, #33, #38, #43, #47, #53, #62, #63, #77, #85, #105) as smokers. The facility census was 145.Findings include: 1) Review of the medical record for Resident #111 revealed he was admitted to the facility on [DATE]. His diagnoses included emphysema, chronic angina, chronic kidney disease, anemia, hyperlipidemia, obstructive sleep apnea, fatty liver, major depressive disorder, edema, anxiety disorder, and congestive heart failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #111 was cognitively intact. The assessment did not indicate the resident utilized oxygen. Review of the active care plans for Resident #111 revealed there was documentation related to the resident smoking or any behavior related to not following the smoking policy. Resident #111 was care planned for the use of oxygen as needed. Review of the Safe Smoking Review dated 05/19/26 at 12:54 P.M. revealed Resident #111 was marked as having short term memory issues and the resident was assessed to smoke safely. Resident #111verbalized understanding of the smoking policy. Review of the nurse's progress note for Resident #111 dated 05/19/26 at 9:26 A.M. and written as a late entry on 05/20/26 at 9:29 A.M. by Assistant Director of Nursing (ADON) #103, revealed the resident was talked to about smoking in his room. The resident stated he bought the cigarettes after his appointment yesterday. The resident was informed he had the right to smoke but it must be in a designated smoking area and he must be supervised. The resident voiced understanding and stated he would not smoke in his room. The power-of-attorney (POA) was notified of the incident. Review of the nurse's progress notes for Resident #111 dated 05/19/26 at 12:42 P.M. and authored by LPN #101 revealed staff entered the resident's room and found him in bed smoking a cigarette. LPN #101 educated Resident #111 on safe smoking and the facility policy. Review of the nurse's progress notes for Resident #111 dated 05/19/26 at 11:27 P.M., and authored by Registered Nurse (RN) #104, revealed Resident #111 was escorted to and from the smoking area by an unknown certified nurse aide (CNA) and assisted back to his room. Review of the nurse's progress notes for Resident #111 dated 05/20/26 at 7:17 P.M. and authored by (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN#100, revealed during medication administration pass staff, identified the smell of smoke coming from Resident #100's rooms. Entered the resident's room and observed him lying in bed on his left side smoking a cigarette. The resident was educated on the importance of not smoking in his room and while the use of oxygen equipment was in use. During an interview on 06/10/26 at 2:28 P.M., ADON #103 stated Resident #111 was observed smoking in his room and the staff were able to redirect Resident #111. ADON #103 stated the resident had cognitive impairment, and he forgot that he does not smoke. ADON #103 stated Resident #111 obtained his cigarettes when he was out on an appointment. ADON #103 stated the staff took his lighter and cigarettes on a separate occasion when he was smoking in his room. ADON #103 stated the resident was not actively care planned to be a smoker because the resident did not want to smoke. ADON #103 stated it was the Administrator's discretion for what steps would be taken when a Resident does not follow the smoking policy. During an interview on 06/10/26 at 10:35 A.M., Resident #111 reported he was discovered smoking in his room by the nursing staff. Resident #111 stated he purchased the cigarettes at a gas station. During an interview on 06/10/26 at 3:50 P.M., LPN #100 stated she had concerns related to Resident #111 smoking in his room. LPN #100 stated the notes were confusing on how many times Resident #111 was found to be smoking in his room. LPN #100 stated she knew of three separate times in a 24-hour period. LPN #100 stated three different nurses found him smoking in his room. LPN #100 stated she did not know why Resident #111 wasn't on smoking list because she has observed other staff assist Resident #111 to smoke. 2) Review of the medical record for Resident #112 revealed she was admitted to the facility on [DATE]. Her diagnoses included end stage renal disease, congestive heart failure, diabetes mellitus, COPD, asthma, depression, and GERD. Review of the new admission MDS assessment for Resident #112 dated 05/21/26, revealed Resident #112 was at the facility for rehabilitation following an acute hospital stay. Review of the care plan for Resident #112 dated 05/21/26 revealed the resident required assistance from staff with activities of daily living (ADL) related to impaired mobility. The care plan was revised on 06/08/26 to indicate the resident was as a smoker and the resident exhibited behavior of smoking in her room with goals of Resident #112 complying with the facility smoking policy. Review of the nurse's progress notes for Resident #112 dated 05/29/26 at 2:10 P.M. and authored RN#104 revealed Resident #112 was found smoking in her room. Resident #112 was educated on safe smoking and the facility policy. Review of the nurse's progress notes for Resident #112 dated 06/06/26 at 2:30 P.M. and authored by LPN # 100, revealed Resident #112 had filled up her denture cup with water and used it as an ash tray in her room. Resident #112 was educated on safe smoking and why it was unsafe to smoke in the room. During an interview on 06/10/26 at 2:28 P.M., ADON #103 verified Resident #112 was found smoking in her room on a few different occasions. ADON #103 stated the resident worried about her spouse and she would forget where she was at. ADON #103 confirmed Residents #111 and #112 were not listed as smokers because neither one of them smoke. ADON#103 stated Residents #111 and #112 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chose not to smoke at the facility. During an interview on 06/10/26 at 2:36 P.M., the Administrator stated if a resident was found smoking in his/her room or not following the facility smoking policy, it was up him to decide how to handle the situation. The Administrator stated he had no additional details regarding Resident #111 and #112 being observed smoking in their rooms. During an interview on 06/10/26 at 3:50 P.M., LPN #100 stated she found Resident #112 on 06/06/26 smoking in her room sitting in her recliner. LPN #100 stated the resident filled up her denture cup with water and used it as an ash tray. Review of the list of smokers provided by the facility on 06/10/26, revealed Residents #111 and #112 were not listed. Review of the facility smoking policy titled, Smoking Policy, July 2017, revealed the facility shall establish and maintain safe resident smoking practices. Smoking was only permitted in designated resident smoking areas, which are located outside. Any smoking-related privileges, restrictions, and concerns (for example, the need for close monitoring) will be noted in the care plan. If a resident was found to be smoking in non-designated area, a care conference would be held, and a discharge may be initiated due to the safety risk associated. This deficiency represents non-compliance investigated under Complaint Number 3038703.