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	06/25/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, facility failed to treat residents with dignity and respect. This affected two Residents (#39 and #106) of the three residents (#39, #106 and #110) reviewed for resident rights. Facility census was 138.Findings include:1) Medical record review for Residents #39 was admitted to facility on 09/11/24 with diagnosis including vascular dementia with psychotic mood disturbance, chronic pulmonary obstructive disease and osteoarthritis. Review or Minimum Data Set (MDS) dated [DATE], revealed Resident #39 to be cognitively impaired. Resident required moderate assistance with toileting and bathing. Observations of the Memory Care Unit (MCU) on 06/22/26 at 2:04 P.M., revealed Resident #39 was knocking on nurse's station office door requesting assistance to the bathroom. One staff person who was not visible, stated to the resident just go to your room and go to the bathroom. Resident #39 again said she needed to go to the bathroom and another voice in the nurse's station, told the resident to go to her room and use the bathroom. Resident #39 began walking away from office still requesting assistance to the bathroom. Licensed Practical Nurse (LPN) #21 came from down the hallway and assisted Resident #39 to the bathroom. Registered Nurse (RN)/Unit Manager #118 came out of the nurse's station and stated Resident #106 usually knows to go to her room and go to the bathroom. Review of [NAME] Care Dementia Care Program Training dated 06/05/24, revealed staff were to assess resident's psychosocial needs, validate their feelings, and treat them with dignity and respect when dealing with resident issues. During an interview on 05/25/26 at 1:36 P.M., The Administrator stated the staff should have gotten up and addressed the resident's needs. 2) Review of medical record revealed Resident #106 was admitted to facility on 06/27/24 with diagnoses including vascular dementia, asthma, schizophrenia, heart disease and dysphagia. Review of the most recent MDS assessment revealed Resident #106 was severely cognitively impaired and has a legal guardian who makes all healthcare decisions. Observations of the MCU on 06/22/26, 06/23/26 and 06/24/26 revealed Resident #106 to be ambulatory and roaming through the unit. At times she was sitting at tables coloring or writing and then resuming her wandering. The resident would interact with other residents at times as well as interact with staff. Observation of the MCU on 06/23/26 at 3:38 P.M., revealed Resident #106 was walking through the main dining area and approached a red door which she found to be open. Resident #106 went into the room and was in there a few moments. When she came back out of the room, LPN #28 saw her coming out and from across the room, yelled no, no you can't be in that room. LPN #28 started walking toward the resident and continued to express her displeasure in a full voice and stating the resident steals stuff when she is the room by herself. Resident stated she just wanted to play Bingo. LPN #28 responded to the resident that she could not play by herself and she needed to go down the hall and watch TV with everyone else. During an interview on 06/23/26 at 4:43 P.M. the Administrator stated that scolding a cognitively impaired resident was not appropriate in dealing with someone with dementia. The Administrator stated all staff on the MCU go through specialized training and should be aware of the proper way to redirect a resident. During an interview on 06/25/26 at 10:35 A.M., the DON stated scolding a resident was not the proper way to intervene in (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

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	06/25/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a situation such as the one she found involving Resident #106 on 06/23/26.This deficiency represents non-compliance investigated under Complaint Numbers 2700629 and 2576942.